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Ethnography of aging in place in a rural town: Health care access and relocation

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Ethnography of Aging in Place in a Rural Town: Health Care Access and Relocation

by

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DISSERTATION

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To Meredith

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ABSTRACT

Ethnography of Aging in Place in a Rural Town: Health Care Access and Relocation

Diane L. Norcio

University of California San Francisco, 2006

Objective: To identify, describe, and analyze factors that influence aging-in-place or relocation of community-dwelling rural elders.

Design: An ethnographic study using participant observation and in-depth interviewing.

Population: People over 65 living in the field site at least 30 years; civic leaders who allocate senior program resources; and, senior services providers. Hispanics, African Americans, and non-Hispanic White people were represented across all interviewees.

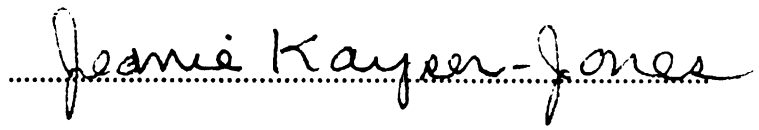
Major Concepts: Aging-in-place and political economy of aging in a rural area.

Methods: Participant observation and ethnographic analysis. Additionally, data were analyzed within the context of political economy, and formally collected over a one year period. The researcher has lived in the area for 8 years.

Findings: Responses about the factors influencing aging in place or relocation of rural elders revealed wide variation as well as areas of similarity among the three groups interviewed. Community residents' perspective on services needed for them to remain in the area can be summarized as: help in the home with daily activities they can no longer perform and transportation. Many also expressed a love of the area as a reason for aging there. While health care providers did say that supportive assistance in the home was needed, their emphasis was on a multi-layered clinical approach. Government officials/civic leaders, largely believed residents would relocate given the resources, and

no one would want to live in the local nursing facility. Some residents included the local nursing home as a long-term care option for them to remain in the community. Tipping points for relocation were related to caregiver issues and lack of local nursing home beds. Analyzing the findings from a political economy perspective, this study has shown that historical constructs of state and private industrial relationships, current reimbursement policies, and a disjointed federal to local long term care planning path have conspired to make it difficult for these rural seniors to age in their home community.

Implications: Nursing care of rural elders dictates knowledge about historical, political, cultural, social, and economic context of the meaning of community, health care seeking behaviors, and caregiver issues specific to aging in place and relocation factors of any particular community.



Jeanie Kayser-Jones, RN, Ph.D., Chairperson

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CHAPTER ONE: PURPOSE AND RATIONALE

This ethnographic study investigates the factors, at the individual and societal levels, influencing the decision of rural elders to age-in-place or relocate. Aging in place posits that seniors can stay in their present, familiar surroundings.

The specific aims of this study are to identify, describe and analyze: 1) factors increasing the likelihood for rural elders to age-in-place; and, 2) those that contribute to forced or voluntary relocation of elders out of the rural area in which they live. The overall purpose of this research is to improve access to health services.

This study took place in a former company town, called Timbertown. (To provide anonymity, all names of places and people are pseudonyms.) Many of the people who have lived and worked here are now senior citizens. This study focuses on those who have remained in the area long after the boom town days of yesteryear. Since its beginning 100 years ago, this logging town has been through a history of economic development and decline that has had an impact on the aging citizens and their families. Political economy is employed at the larger societal level of analysis to examine the complex characteristics of rural health and aging. This research takes the reader through a trajectory from the history of company towns; to the history of rural health care and the health care in Timbertown; to corporate industrial flight and the collapse of the economy of Timbertown; and the effect of that collapse on families including caregiver issues and interruption of intergenerational continuity and connectedness; and, finally, to recommendations of a contemporary rural services delivery system that would offer affordable choices for seniors to age in their community.

This is an ethnographic study. Ethnography is the most appropriate methodology because it is suited to the study of political, social, cultural, and economic factors that

influence health status, health delivery strategies, and resources (Robertson & Boyle, 1984). Ethnography employs multiple information gathering methods such as interviews, participant observation, and review of historical, visual and archival records to more fully understand the factors influencing the decision of rural elders to age-in-place or relocate. Residents over 65 who have lived in the area for 30 years or more; government officials/civic leaders who make decisions on allocation of resources; and, health care providers were formally interviewed, 27 altogether. Over 55 other people, such as business owners, Timbertown community residents, members of health care teams, members of service clubs, and museum curators were engaged in informal interviews about their perceptions and experiences of life in the area.

Rurality

Currently, 50 million people, 17 percent of the population of 281.4 million live in rural areas, representing 75 percent of the land area of the United States. Approximately 8.2 million elders, comprising 23.4 percent of adults 65 years of age or older in the United States, live in rural areas (Census, 2000). Hobbs & Stoops (2002) demonstrate rurality in terms of population density and show the four regions of the United States in descending order of density with approximate number of people per square mile in parentheses: Northeast (320), South (110), Midwest (70), and West (30). Population density levels reflect a combination of population and land area. Although the Northeast represents only 19 percent of the 2000 population, it represents 5 percent of the U.S. land area. By contrast, the West represents about 22 percent of the U.S. population but has 50 percent of the U.S. land area (Hobbs, 2002). In northern California, Timbertown fieldsite location, one third of the land mass of the state is populated by 4.8 per cent of

California's population. The County, in which the fieldsite is located, has a population density of 7 people per square mile.

Many of these areas are under-serviced for senior housing and healthcare, are geographically isolated, and have experienced significant economic decline (Coward, Netzer, & Peek, 1996). Rurality has long been equated with limited access to formal services among older adults (Goins & Mitchell, 1999; Harris, 1976; Krout, 1994). While urban area health care access questions revolve around whether all segments of the population have access to a continuum of care, rural access questions focus on whether there are any services to access (Duncan et al., 2006). In "Health Care Quality: The Rural Context, A Report to the Secretary," the National Advisory Committee on Rural Health and Human Services (2003) reported that in a survey of 182 rural residents conducted by University of California Davis in 2001, "residents who perceived their local health care services to be of poor quality tended to leave their communities in search of services." It is unclear if this is true for elderly, impaired residents who cannot economically afford to move or who would leave behind their social support networks. The aging-in-place of rural elders and the relationship between health care access and relocation have been the subject of few studies. Health care accessibility is at the top of the national agenda for rural communities. In *Rural Healthy People 2010*, it is stated that access to quality health services was rated as the top ranking rural health priority (Gamm, Hutchison, Dabney, & Dorsey, 2003).

Relocation Sequelae

Most of the studies about elder relocation stress report on older adults moving to or from a nursing home or hospital, and report factors associated with relocation including stress, functional changes, decreased quality of life, anxiety and depression

(Carpentio, 2000; Choi, 1996; Glassman, 1998; Harkulich, 1992; Horowitz & Schulz, 1983; Thorson & Davis, 2000). In some cases, mortality is increased when older adults with co-morbid conditions relocate (Aldrich & Mendkoff, 1963; Blenkner, 1967; Bourestom & Tars, 1974; Cartier, 2003; Harkulich, 1992) including a pre-existing mental illness (Anthony, Procter, Silverman, & Murphy, 1987). In extreme cases suicide can result (DeLeo & Ormskerk, 1991; Haight, 1995). A link between the responses to relocation of elders in institutional settings with elders relocating from their homes to another community in general has not been firmly established in the literature.

While this study did not investigate the sequelae of relocation of rural elders, a pilot study by the author did establish relocation sequela of retirees new to a rural area. Besides revealing that all would move out of the rural area in their old, old years due to a lack of health services, some pilot study participants also reported depression, feelings of isolation and sadness, irritability, and regret at having left their former homes (Norcio, 2004). This pilot study informed the questions for the current dissertation research as the author wanted to investigate aging-in-place and relocation decision-making for the long time residents exposed to the same rural health care system as the retirees who were intent on moving in their older years. The evidence that increased morbidity or mortality can follow relocation for older adults lends importance to the study of the factors contributing to the relocation of rural older adults.

CHAPTER TWO: BACKGROUND ON RURAL HEALTH AND AGING ISSUES

Milton Roemer (1976) wrote what was to become a classic book on rural health care. He was intent on outlining longstanding issues inherent in the provision of both quantity and quality of health services. This chapter will highlight some of the more recalcitrant issues of rural health care. A review of definitions of "rural" will precede and give context to this exploration and a demographic overview of the research setting will follow.

Definitions of Rural

Characteristics that distinguish rural and frontier places from urban communities have important effects on health service delivery and access (Ricketts, Johnson-Webb, & Taylor, 1998).

A wide variety of definitions of "rural" have been employed, and there is no commonly accepted standard definition of "rural" (Bosak & Perlman, 1982; Deavers, 1992; Willits & Bealer, 1967). "Rural" was first used by the Census Bureau in 1874 when it was defined as the population of a county living outside cities or towns with 8,000 or more inhabitants (Ricketts et al., 1998). There are two principal definitions of rurality used for federal health care policy. The Census Bureau bases its definition on a combination of population density relationship to cities, and population size. The Office of Management and Budget (OMB) classifies counties on the basis of their population size and integration with large cities. All territories, populations, and housing units that the Census Bureau does not classify as urban are classified as rural. An urban area is defined as a central place with an adjacent settled surrounding territory as having a minimum of 50,000 people (Census, 2000). The U.S. Agency on Aging has created a

ZIP-code-based system of identifying rural areas to apply provisions of the 1992 Amendments to the Older American Act.

Many departments of the federal government have their own definitions of rural. They are detailed and specific to department policy. U.S. Department of Housing and Urban Development (HUD) says: "'rural' and 'rural area' mean any open country, or a place, town, village, or city which is not part of or associated with an urban area and which (1) has a population not in excess of 2,500 inhabitants, or (2) has a population in excess of 2,500 but not in excess of 10,000 if it is rural in character, or (3) has a population in excess of 10,000 but not in excess of 20,000 and (A) is not contained within a standard metropolitan statistical area, and (B) has a serious lack of mortgage credit for lower and moderate-income families, as determined by the Secretary and the Secretary of Housing and Urban Development" (Ricketts et al., 1998).

Defining rural areas is both simple and complex. It is simple because most people have an intuitive understanding of rural territory (Deavers, 1992; Weinert & Boik, 1995). Small town and open country are defining characteristics of rural localities. Nearly 90% of America's incorporated cities and towns outside metropolitan counties have fewer than 5,000 people. About 40 million people make their homes in rural areas in the U.S. Other defining characteristics of rural areas are their geographical and social isolation as well as the specialization of their economies such as agriculture, resource extraction or manufacturing, for example (Deavers, 1992).

For the purpose of this study, rurality will be defined adopting the 1874 Census Bureau definition of living outside cities or towns of 8,000 or more. In this case the entire Stone County, in which Timbertown is located, falls within this definition.

Characteristics of US Rural Health and Aging Access Issues

Compared to people living in urban areas, the following differences for rural dwellers have been noted. Rural health care systems tend to care for more elderly patients and patients with more advanced or chronic conditions than do urban regions possibly due to delay in getting health care. Rural residents have higher risk profiles than the general population. Health status and co-morbidities tend to be worse in rural areas. Rural areas also face greater shortages of health care providers (Coward, McLaughlin, Duncan, & Bull, 1994; Goins, 2005; Krout & Maiden, 2003; Longino, 1998; Mainous & Kohrs, 1995; Rabiner et al., 1997).

One very clear example of the magnitude of the rural-urban disparities is in oral health among rural elders when compared with their urban counterparts (Vargas, Yellowitz, & Hayes, 2003): 58% of rural elderly population and 47% of urban elderly population had not seen a dentist in the previous year; 37% and 27% respectively had not seen one in the previous 3 years; 72% of rural and 66% of urban elderly population lack dental insurance; 37% of rural elders and 27% of urban elders are edentulous (Vargas et al., 2003). The link between poor health and poor oral health among older persons has been well documented (Ettinger, 1997; Kayser-Jones, 1981; Peterson, 2003; Surgeon General, 2000). Oral health is just one of many similar health disparities between rural and urban elders. Other major conditions of difference are: A greater proportion of California residents of rural counties have been told by a health professional that they have diabetes (7.9% vs. 6.8% respectively) and/or high blood pressure (7.9% vs. 6.8% respectively) compared to residents of non-rural counties (California State Rural Health Association, 2005). For White rural residents of the United States the rate of diabetes is 2.31% compared with 1.93% for metro counterparts. For Black rural residents of the

United States, the differences in the rates of diabetes (DM) are even more pronounced when compared with Blacks in metro areas (5.34% vs. 3.61% for DM) (Slifkin, Goldsmith, & Ricketts, 2000). Rural depressed individuals had a higher rate of suicide attempts, a 3.05 times the odds of being admitted to the hospital for physical problems and 3.06 times the odds of being admitted for mental health problems than their urban counterparts (Zhang, Fortney, Smith, & Smith, 1998). Rural individuals have fewer mental health visits per person diagnosed with depression in a calendar year than urban individuals (Lambert, 1999; Petterson, 2003). A higher proportion of elders in nonmetro than metro counties reported a functional limitation (40.5 percent vs. 34.3 percent) (Rogers, 2002).

Rural nursing home residents are more likely than urban residents to have multiple hospitalizations (Coburn, Keith, & Bolda, 2002). Higher rates of nursing home use due to a dearth of community based services, greater supplies of hospital beds and lower physician ratios are factors influencing this trend (Coburn et al., 2002). This has significant ramifications for the spouses of these rural hospitalized nursing home residents since research by Christakis and Allison (2006) shows higher mortality rates among elderly spouses of hospitalized patients than non-hospitalized individuals.

Poverty

Nationally, a significant body of research has found that rural elders have lower incomes; poorer health status; fewer housing and transportation options; and less well-developed health and social service systems (Bellamy, 2003; Krout, 1994; Krout & Maiden, 2003; N. National Advisory Committee on Rural Health and Human Services, 2003; U.S. Department of Health and Human Services, 2000). "Poverty is more pronounced among older women, older persons living alone, and the oldest old" (Rogers,

2002). Poverty is both an indicator of and barrier to needed health care. The most remote rural areas have the highest poverty and also slower growth in population and tax bases (Rogers, 2002; Rogers, 1998).

Access to Informal Care

There are stereotypes of rural residents that negatively affect accurate assessment of health care access. One of the strongest stereotypes of rural areas is that familial ties are stronger than their urban dwelling counterparts even though researchers have not found a rural advantage in this area (Krout & Maiden, 2003).

Little literature exists about the health care access issues of rural elders living in former company towns where mass out-migration over the past 20 to 30 years has left many residents without a caregiver generation. Barker (2002) found that unpaid, non-professionally trained, unrelated caregivers were vital assets, assisting approximately 10% of frail elderly population to remain living at home. Whether such caregivers are equally or more important for rural elderly adults has not yet been well established.

Caregiver Self-rated Health Status

Sanford and Townsend-Rocchiccioli (2004) noted that rural caregivers had a statistically significant lower perceived, self-rated health status than did the general population. And, it is well established that self-ratings of health status are associated with mortality rates. The nature of this relationship in rural areas is understudied.

Effect of Geography

Another barrier to care is geographic. Lack of transportation, inclement weather, poor road conditions, and distance between services and homes are often great. The National Advisory Committee for Health and Human Services said that the Committee was made aware that no issue facing rural seniors was more pressing than transportation.

This is a national rural health priority (Krout & Maiden, 2003; National Advisory Committee on Rural Health and Human Services, 2003; Sanford & Townsend-Rocchiccioli, 2004; Severance, 2001).

Shortage of Providers

There is a chronic shortage of providers in rural areas (Bull, Krout, Rathbone-McCuan, & Shreffler, 2001; National Advisory Committee on Rural Health and Human Services, 2003; Schur & Franco, 1999; Stearns, Slifkin, & Edin, 2000). Rurality has long been equated with limited access to formal services among older adults (Goins & Mitchell, 1999; Harris, 1976; Krout, 1994). According to Johnson (1991), "Inadequate health service delivery systems in rural compared with urban areas may be partly responsible for the finding that rural elders are more likely to report nutritional, sleep, exercise and alcohol consumption practices that are not conducive to good health" (Johnson, 1991, p.148). The linkage between high tech medicine and perceived higher quality health care has been reported to the US Secretary of Health and Human Services by the National Advisory Committee on Rural Health and Human Services (2003). The report states that people who perceive poor quality of care locally will seek those services elsewhere.

Health Insurance Coverage Issues

The reimbursement scales for MediCal do not recognize the increased cost of care per person given fixed overhead and a sparse population base. Private pay patients simply cannot afford the high fees established to subsidize the difference between what it costs an agency to provide the service and what the state reimburses. Reimbursement to providers who practice in rural areas tends to be less than their urban counterparts, particularly for Medicare patients (K.J. Mueller, 2001; Stearns et al., 2000). Rural home

health care agencies have been crippled by the new payment system for visits to Medicare patients (Sanford & Townsend-Rocchiccioli, 2004).

Rural workers have less employment-related health insurance due to greater levels of self-employment, small businesses, and part time work (Larson & Hill, 2005). Rural residents are less likely to be insured due to a combination of employment patterns, retirement benefits and lack of funds (Schur & Franco, 1999). Access to health care, as it is currently conceived by the US health care system, may be a paradigm lightly embraced by rural elders. For example, for rural elderly research participants in a former mining town in New Mexico, health was consistent with avoiding contact with the health care system (Averill, 2002).

Federal Rural Budget Allocation Inequities

The federal budget for FY 2006 (starting October 1, 2005) continued a trend, which started in 1994 of spending two to five times as much, per capita, on urban than rural community development, and one third as much on community resources in rural areas, an annual $16.5 billion rural disadvantage. This trend continues in the federal FY 2007 budget proposal despite the fact that rural median family income is 25% lower, and rural poverty rates 28% higher than those in metro areas. In fact, rural counties now comprise 88% of the persistent poverty counties in the United States (National Rural Health Association, 2006). During the past two years the National Rural Network (2006), comprised of 70 national organizations, and the National Rural Health Association have engaged in an organizing effort to reverse this trend. The National Rural Health Association (2006) reported that the Senate approved a budget resolution on March 15, 2006 that would fully fund all rural health programs in Fiscal Year 2007. The resolution

reflects an increase in funding by $235 million over the President's request. The House has yet to approve the resolution.

In March, 2005 the National Health Policy Forum, based in Washington D.C., conducted a study of California's Rural Health System. It was funded by The California Endowment. The following is a synopsis of their findings. (For additional characteristics of rural California, see Appendix A, page 172).

1. Despite efforts at the state level, there is limited rural voice in the health policymaking process in California.
2. Rural needs are not well integrated in state regulatory policies, and this can affect rural providers negatively.
3. Federal (budget and reimbursement) policy has a major impact on rural providers.
4. Primary care in rural areas is dominated by a few models, and primary care providers find unequal distribution of reimbursement dollars because of them.
5. Federal financing incentives encourage a focus on acute care as opposed to prevention and primary care.
6. Telemedicine does not solve the access problem.
7. Managed care has potential if safeguards protect access to care.
8. The mental health system in rural California is failing.
9. Farm workers (including timber workers) tend to suffer from chronic conditions like diabetes and hypertension but face significant barriers to accessing care. The health system serving them is geared toward acute not primary preventive care.

Demographic Overview of Stone County & Timbertown

Timbertown, the fieldsite of this research, is located in Stone County in northern California. The population is less than 50,000 (Census 2000) 23,700 people live in unincorporated areas of the County with a population density of 7 people per square mile. There are no towns with more than 7,600 people, and thus no metropolitan areas in the County. The largest incorporated community has less than 8,000 people; and the smallest, less than 1,000. There are 9 incorporated communities in total. The per capita income in the County is $20,430 (Census, 2000).

Several western mountain ranges, over 7,000 feet, meet in Stone County (Center for Economic Development, 2003) making travel difficult and some winter roads impassable.

The California Long Term Care County Data Book 2002, www.caads.org/ltc/ltc_data.html, reports that Stone County ranks 3rd in the state for percent of persons 65+ living alone (41.3%); and that the population of people over 85 years old grew by 42% between 1990 and 2000. The California Department of Aging, www.aging.ca.gov, projects that from 1990 to 2020, the population of adults in Stone County 85 years of age and older will increase up to 150%. In the 2004 (Delta Consultant Firm, 2004) Community Health Assessment commissioned by Catholic Healthcare West, Stone County showed the following: 12.8% of adults are diagnosed with major depression; 19.5 age-adjusted suicide deaths per 100,000 (CA average = 9.5); 196.6 age-adjusted cancer deaths per 100,000 (CA average = 172.7); and 27.4% of adults without health insurance (CA average = 17.3%, US = 15.3%). In the same report, approximately 40% of Stone County adults reported difficulties or delays in receiving needed health care in the past year. This number increases to 67% for those living below the poverty level.

Stone County's economy, until the present, has been based mainly on resource extraction. The numbers of people have fluctuated with the availability of gold, timber, and water (for bottling). At the turn of the century, sawmills were established to process the million acres of valuable forests into lumber. The founder of Timbertown established one such mill which developed into the City we know today, the fieldsite for this research study. (Note: citations that identify the town have been deliberately omitted for confidentiality reasons. They will be supplied to the reader on written request.)

Timbertown is surrounded by national forests, plains, and volcanic formations. There is a small airstrip outside town that is a staging area for National Forest Service fire and search and rescue protective services. The population of Timbertown is less than 3,000. Timbertown is an economically depressed former company town with a declining population (Census, 2000) and vacant storefronts with recent hints of revitalization. Retirees new to Stone County skirt Timbertown in their settlement into the area. Instead, there is a growing region in high desert northwest of Timbertown where many retirees are buying land and building enormous homes.

The people of Timbertown represent a racially and ethnically diverse community. The racial/ethnic makeup of Timbertown is as follows: 71% White; 12.8% Hispanic or Latino; 9.3% Black or African American; 4.6% Asian; 1.9% American Indian and Alaska native; 0.5% Native Hawaiian and other Pacific Islander. There are a higher percentage of people of color living in Timbertown than is common in the U.S. Overall, 17.2% of the population is over 65, compared to 10.6% in California and 12.4% in the U.S. Educational attainment trails that of California and the U.S. with 5.2% and 2.1% of Timbertown residents having attained Bachelor's and Master's degrees respectively (Census, 2000). This low number of college degrees per capita may be explained by the numbers of Timbertown residents who leave for college and professional schools and never return. Those left behind reason this as a job availability issue. The unemployment rate in Timbertown fluctuates with seasonal economy between 10 and 15% (Census, 2000).

CHAPTER THREE: METHODS

Ethnography

Ethnography is the descriptive analysis of a culture (Gitlin, 2003; Glittenberg, 1981) and is an inductive mode of research which may use many methods of information gathering over an extended period of time (Robertson & Boyle, 1984). It is rooted in anthropology and is a qualitative research process. Ethnography refers to a particular method or set of methods whereby the ethnographer participates in peoples' daily lives for an extended period of time, watches what happens, listens to what is said and asks questions (Hammersley & Atkinson, 1993). This facilitates an investigation of the context in which people's health beliefs and practices evolve (Robertson & Boyle, 1984).

Concerned with the context within which data are uncovered or discovered, ethnography investigates the intricacies of human behavioral processes and studies people in their space and time.

Ethnography as Methodology of Choice

Ethnography is the methodology of choice for this study because of the complex dimensions and process-bound nature of the interplay between health care access and relocation of rural elderly. Ethnography, as context-sensitive, is an appropriate method because long-time residents of the area are situated historically in the cultural and economic remnants of a former company town and in the contemporary reality of a shifting economic industry catering to retirees new to the area.

Rural health research that focuses only on health care access by measuring utilization, without identifying factors driving access issues, is not always useful to policy-makers (Slifkin, 2002).

Further, ethnography is the chosen method because it bears a close resemblance to the routine ways in which people make sense of the world in everyday life (Hammersley & Atkinson, 1993). It is concerned with the meanings of cultural behaviors and events from the point of view of the people themselves (Spradley, 1979), and is a means of gaining access to health beliefs and cultural practices of rural elders from their point of view. Garro (1982) said that "cultural factors are the major component in health care decisions" (p. 1451). Therefore, ethnographic method is suited to unravel the multi-layered processes inherent in the topic.

Etic and Emic Approaches

Kenneth Pike, well known for his contributions to linguistics, developed a theoretical framework called tagmemics which processes language and behavior from the observer's viewpoint. In this framework he states his convictions about the nature of language: how it operates from the insider's or emic perspective ... examined from alternative points of view by the observer. and all which help a person to relate to the "physical. social, aesthetic, and philosophical environment. These terms come from the words phonetic and phonemic. The terms *etic* and *emic* are well established in the social sciences (Franklin, 1996).

This study will incorporate both etic and emic approaches. Etic approach to understanding includes the larger theoretical understanding about a topic. Scientists interested in the local construction of meaning, and local rules for behavior, will rely on emic accounts; scientists interested in facilitating comparative research and making universal claims will rely on etic accounts (Pike, 1967). What is already known about rural health and aging, aging-in-place and the political economy of aging (etic) was used as background information. The study participant's point of view from their perspective

(emic), as they have been affected in their lived social world, was sought using open-ended questions in guided interviews about their perspectives of events and experiences, imagining their own futures, and then employing member checks in the form of feedback from study participants.

Kayser-Jones (1999) quotes Rubinstein in outlining the goals of anthropological methods in gerontological research: 1) to learn about elders and the meaning of their experiences as individuals and members of communities; 2) to produce knowledge with a human face; and 3) to use the findings for social advocacy and to educate appropriate persons. The use of anthropological methods in this study aims: to learn from rural elders about the meaning of their experiences of aging-in-place; to become knowledgeable about this particular group of rural elders in this particular place in time and how health care access influences decisions to age-in-place or relocate; and, to make recommendations for health policy based on how access issues are influencing aging in place/relocation decision outcomes.

Set in a rural former company town, the study sample are the elderly people who have lived and worked in the area for the past 30 years or more spanning major local economic, social, and cultural transitions. In addition, health care providers caring for these people as well as government officials/civic leaders allocating resources to senior services were also interviewed.

Field Site

The field site for this study is Timbertown, the small rural city of less than 3,000, and its immediate environs. The field site is completely surrounded by unincorporated land and therefore has no contiguous incorporated communities. The County is a mix of alpine and high desert terrain.

The field site is a former lumber company town in a county familiar with the population migration shifts of an economy reliant on resource extraction since the mid 1800's (first gold and then timber and water). The rural elders of the field site have lived through the decline of the timber industry. Today, these seniors, the remaining generation of a more prosperous time, have beliefs about health care and remaining in their homes and communities or relocating during the last phase of their lives. This study, then, is an investigation of those reasons leading to a decision to age-in-place or relocate.

Study Population

The total sample size for formal interviews was 27, selected from the following three groups: people over 65 who have lived and worked in Timbertown for 30 years or more; government/civic leaders who make senior services resource allocation decisions ; and health and human services providers (See table on participant characteristics in Appendix B, page 174).

The three major racial/ethnic population groups of Timbertown are comprised of 9% Black; 12% Hispanic; 71% non-Hispanic Caucasian. (Other groups include people who are Laotian Hmong, Native American, and East Indian.) Of the 27 people formally interviewed for this study, 11% were African American; 22% were Hispanic; 63% were non-Hispanic Caucasian; and, 4% were East Indian.

Given the complex issues inherent in decisions to relocate or age in place and given the disparities with regard to health care access among various groups, it has been important to purposely include participants from the dominant racial and ethnic groups.

The University of California San Francisco Committee on Human Research reviewed and approved this research and its protocols before research commenced.

Sampling

Sampling for this study was purposive. This approach focuses on obtaining the richest and most complete selection of information (Schatzman & Strauss, 1973). Since the phenomena were complex and layered, purposive sampling was chosen as the best frame for collecting the full range of the phenomena (Robertson & Boyle, 1984). The goal was to include study participants who represented the various aspects of the phenomena and perspectives of those experiencing the phenomena. Informational adequacy is more important than sample size. In addition to the formally interviewed participants, many more people were informally interviewed who did not fit the inclusion criteria for the formal, taped interviews.

Data Gathering

Participant Observation

Participant observation is concerned with behaviors as well as settings and circumstances in which behaviors are seen (Robertson & Boyle, 1984). Participant observation can be defined as spending long periods of time in watching people in conjunction with talking with them about what they are doing or thinking to gain knowledge of how they understand their world (Delamont, 2004; Streubert & Carpenter, 1999). It means participating enough to get a "felt sense" of the nature of their experience: the pleasures and pains, the smells and sounds, the physical and mental stresses. The goal is to understand what the world looks like to the people we seek to understand. With regard to fieldwork roles, Emerson (2001) speaks of Gold's classic work in 1958 as describing that participant-observation falls in the middle of a continuum from complete observer behind a one way mirror to "going native." And, that the middle of the continuum is where the participant is the observer and the observer is a participant.

I have lived and worked as a nurse practitioner and administrator for the past eight years in the field site area. In addition, I conducted a pilot study with a different population for a different purpose in an adjacent area. Study participants, retirees new to the area, indicated that they would move as they aged and when they found that they needed more health care due to the lack of health care services in this area. This made me curious about the aging-in-place or relocation decision-making processes for the long time residents. I wondered if they too projected a plan to move as they aged and what would those factors be that would keep them in the area or provide a basis for decision to relocate. This curiosity has led me to this dissertation research.

What does it mean to enter into the experiences of the people we seek to understand? Coburn et al. (2002) delve deeper and ask what they can learn from participant observation that could not otherwise be gleaned using other methods. They learn that "it is not so much just being in a place and observing, but the sustained connections with people that one makes in the participant's own environment" (p. 99).

Some situations in which participant observation were used included the tone and detail of Timbertown residents' descriptions of their memories of what it was like when it was a company town compared to descriptions of their contemporary and future living options; the contrast between the residents and health provider perspectives on aging-in-place and relocation factors; and, the differing attitudes of the government officials toward the elders of Timbertown. Since many of the interviews took place in residents' homes, I was able to observe the inside of a typical company home. In addition, comparing images of neighborhoods and living conditions between photographs and descriptions of company town days with contemporary observations was also possible.

Early in the research process, I realized that every place was an opportunity for observation from the grocery store parking lot to a chance meeting with a health provider in a gift shop who wanted to talk about hospice care.

Some participant observation occurred at regularly scheduled events such as the week-long summer "Carnivale" where residents gather to engage in games like bocce ball and ring toss and to eat and drink together while the children enjoy the Ferris wheel and other rides. The Historical Society annual dinner, Sons of Italy meetings, and "Weeds and Wildflowers" parade and street party were some of the other venues where I observed the town. I also visited the two skilled nursing facilities in the County, one of which is in Timbertown, as part of the observation process.

Interview information collected could suggest a focus for observation of certain practices (Robertson & Boyle, 1984) I visited and observed some of the places residents' spoke about, in their interviews, as being favorite or significant places they held with particular regard.

My observations were accompanied by fieldnotes either written or voice recorded. All four types of field notes as described by Bernard (2002)), were used. They are: jottings (on the spot recordings), diary (personal musings, feelings), a log (record of money and time), and descriptive field notes. For accuracy of recall, I found it important to record my observations with descriptive field notes soon after the event. In some circumstances it was even possible to write during my observations.

Fieldnotes led to conceptual ideas and theoretical memos. Analytic memos, described by Schatzman and Strauss (1973), began to emerge from my theoretical memos and eventually developed an organization for analytic thought. Ethnography is a

reflexive process and information gathered in field notes provides clues to interview questions (Robertson & Boyle, 1984).

Interviewing

Interviewing informants is another method used to gather information by ethnographers. Intensive interviewing of rural older adults gave insight into their experiences. In depth, open ended questions allowed informants to give voice to their own ideas and meanings. The researcher may guide the interview with some questions to focus attention on a topic area but care should be taken with the wording of questions to minimize "leading" the informant. In addition ethnographers do not always know ahead of time exactly what questions they will ask nor do they ask the same questions of each person (Hammersley, 1993). (See Appendix E for interview guides used in this study).

After explaining the study and obtaining consent, each person was interviewed one or two times for between one to two hours each time. Open ended questions allowed the informants an opportunity to give voice to their ideas and meanings. Separate interview questions for each group were used to guide the interview and probing sentences like "Could you say more about that?" or "What do you mean by _____?" were used.

Interviews were recorded and transcribed with accompanying fieldnotes from participant observation. The interviews for the residents occurred in their homes with the exception of two, which were in private places. The health providers and government/civic leaders were interviewed in their homes, offices, or in my home.

Subsequent to the formal interviews, I had informal, and in some cases, sustained contact with some of the study participants. For example, a resident called and asked if I would visit her again; and we had 7 or 8 visits. And I see many of the participants at the local market, the hair dresser, or at community events.

Data Analysis

Ethnographic Analysis

In ethnography, data analysis and information collection are not linear chronological activities but rather synchronous events each informing the other at every step of the process (Pelto & Pelto, 1978). Hammersley and Atkinson (1993) say that data analysis formally takes shape in analytic notes and memoranda but that informally it is embodied in the ethnographer's ideas and hunches. One of the pilot study findings, of retirees new to rural areas, was the projection of another move as they age due to health care accessibility issues. This piqued my interest in factors that might influence aging-in-place decisions of rural elders living in the area for many years. For close to a decade, it has been fascinating to observe this multi-racial, multi-ethnic community whose initial and only purpose for existence as a society was the processing of timber from forest to lumber or other wood products. I wondered how intervening events such as the automation of that industry and the subsequent geographical separation of family members and breakup and reformation of social networks might affect seniors' decision-making processes for staying or relocating. These questions, born out of hunches that historical and political and economic constructs were integral to late life choices, led to the use of political economy as a model for analysis.

Data in this study were coded for common patterns which gave way to emerging themes based on factors influencing rural elders' decisions to age-in-place or relocate. Recurring themes were noted and became the bases for theoretical and reflexive memoing. Those theoretical memos and other data were analyzed within the context of The Theoretical Model of Social Policy and Aging: Estes Version (1979). An application of the Estes model to rural health and aging constructs resulted.

Validity and Reliability

In qualitative research, content validity has to do with description and explanation and whether or not the explanation fits the description (Janesick, 2000). In other words, is the explanation credible given the description?

In qualitative research construct validity requires looking for the presence of indicators when naming a concept. If the concept is "aging-in-place," the indicators you would expect to find would be behaviors like remodeling a home to make it more accessible, contracting for in home supportive services, enrolling in an adult day health care program, for example.

Member checks are essential in this process of establishing construct validity and the validity of any interpretation. Study participants have been asked to review findings. I have also asked outsiders to review my fieldnotes and read transcripts. Construct validity required bringing the findings back to the study participants to investigate if the processes described are recognized by them. In so doing, a great deal of care has been taken to protect confidentiality.

Lengthy stay in a community, extensive and intensive data collection, continuous data analysis during the project (Robertson & Boyle, 1984); triangulation of data gathering methods and use of multiple samples (Brannen, 2004) all contribute to validity.

Triangulation is a method, touted by ethnographers as one of the strengths of fieldwork, which is the practice of checking multiple sources of data as well as checking an interpretation through their congruence (Wolcott, 2001). Triangulation has been employed in this study by cross referencing historical information gathered from interviewees and other informants with written documents from the Timbertown Museum; the County Museum (in both cases the curators engaged in discourse); the College of

Stones special collections of Timbertown documents (the Director of the Library guided document retrieval and search); the Stone County Recorder's Office.

In ethnography, reliability is established the same way that it is in survey research, that is, if I ask someone the same question again will they give me the same answer or tell me the same story? Information has been collected from a wide variety of sources: people, documents, photographs observation, and my own experience living in the area. The results of formally interviewing three groups to gather information about aging in the area or relocation decision-making illustrates both commonality and divergence in responses. Those have been analyzed and discussed.

Summary

This study investigated the factors that influence a person's decision to age in this rural area and the reasons why some people relocate. Ethnography was the best method to observe (Spradley, 1980) and explore everyday life as it occurs (Agar, 1996) and the most appropriate research method because of the historical, cultural, and political context within which the study participants have been situated. Formal interviewing and participant observation spanned a 12-month period and was preceded by 6.5 years of living in the area. I agree with Clifford (1986) who says, "Cultural analysis is always enmeshed in global movements of difference and power" (p.22). It was for this reason that Estes' (1979) model was chosen as a theory base for the analysis of this study.

CHAPTER FOUR: HISTORICAL CONTEXT

History of Company Towns

When Josiah Wedgwood opened the Etruria Factory near Burslem in Staffordshire England on June 13, 1769, he probably had no idea of the influence he would have upon thousands of United States residents, years later. Josiah designed and operated the first of what would come to be known as company towns. He was in the business of creating and producing Wedgwood pottery. It was difficult to find and retain good craftsman and it was common to recruit (or "steal") workers from competing potteries. Wedgwood offered not only homes but also health and retirement benefits as a way to entice and retain both skilled and unskilled workers. When word of the amenities offered at Etruria became known, workers were attracted in sufficient numbers (Dolan, 2004). Like Wedgwood's Etruria, company town bosses of the Pacific Northwest wanted to create a better life for their employees: decent housing, good schools, and a 'morally uplifting' society. In return, they expected stable, hard-working employees (Carlson, 2003).

A company town can be defined as any community which has been built wholly to support the operations of a single company, in which all homes, buildings, and other real estate property are owned and operated by the company including public services (Allen, 1966). Timbertown, because of its isolation and because of its need for literally hundreds of workers in the forest and mill sites combined, was the perfect environment for the development of a company town.

Many company towns began disappearing from the scene all at the same time. Depleted timber supplies have eliminated many towns and many companies were frank to admit that company towns were an economic burden which they gladly would have

relinquished (Allen, 1966). Allen further voices, "The company town is nothing more than a passing detail when compared with the vast operations of some of today's huge enterprises. The towns have had their place in the development of the lumber industry, but are only incidental to the corporations" (p. 56).

In a sentinel book on company towns in the United States, Crawford (1995) relays that between 1913 and 1925, company towns flourished. Barrett (1998) attributes this to the presence of the railroad which provided means for extraction industries to move their goods from remote areas to shipping points for consumption or exportation. Crawford goes on to define a company town by way of contrast. "The difference between a company town and a town where there is a single employer is that in a company town the company owns a substantial part of the real estate including the houses" (1995 p.1). While company town bosses were motivated by economics, industrial environments drove the reasons for such an arrangement. In situations where the industry was in a remote area, the companies had to provide housing, often quickly, in order to accommodate the influx of workers. In populated New England mill towns, bosses, like Wedgwood of England, were pushed by the competition to lure both skilled and unskilled workers to production sites. In the vast forestlands where the timber industry thrived, there simply were no other accommodations for them (Carlson, 2003).

Regardless of the situatedness of the industry, company towns orchestrated social structures to build a community that would ultimately benefit the profitability of the owners. Religion was used as a way to enforce the moral code of the worker; neighborhoods were built grouping skilled and unskilled workers, paralleling class-reinforcing social order; and recreation facilities were built to further social bonding (Carlson, 2003; Crawford, 1995). Carlson notes, "But those who lived in company towns,

even for only a few years, are likely to remember them with joy and delight...One woman called it 'the experience of a lifetime'" (pg 207).

From the descriptions of company towns, ubiquitous in the U.S. not that long ago, they do not sound much different from the non-company owned tight knit communities across the land. "The irrefutable difference is the issue of ownership. In communities that companies owned, every job could depend on the company—the company's success and on the boss's dictates" (Carlson, 2003, p. 208). When company towns shut down, social consequences were part of the aftermath. People moved out of neighborhoods to seek jobs elsewhere. Others bought the home from the company and remained. And, in some towns that were planned as short-lived, their closure was and is still mourned (Carlson, 2003).

Memories of a Company Town: Study Participants' Perspectives

Roger Allen still remembers the day he got the job at the lumber mill in 1945. He was 20 years old. He had been in Stone County only three weeks when some of the older Louisiana men, relocated in the early 1920s when Long Bell Lumber Company opened the Timbertown mill, offered to get him a job. They were "good with the boss," and took him to the manager. "'Mr. Jones, I want to give this boy a job-- this here boy here. He's been working up there for the Southern Pacific.' 'Alright. Tell him to come back at 2o'clock.'" So Mr. Allen went down to the planer mill and the man said, "'You want a job?'" Mr. Allen exclaimed, "Yes, I want a job!" The man told him to "'...go on down and see Dr. Sid (as they called him) and have him to check you out and come on back here.'" Dr. Sid, was a company doctor—"They did work for the company. They was right there—that place that used to be the hospital. There was three of them doctors." So Mr. Allen got checked out and got his job. "I had a good job then. I worked that job for

40 years. It was a good time. It was hard work, but you enjoyed it because you had a good job...I ran that machine until I--'til I--'til it shut down." Mr. Allen remembers that it was a 'good time' because he got vacation. "Yeah, with pay (laughing with delight) with pay—three weeks pay with vacation! When I retired off of that job in 1985, I was making 15 dollars an hour. That was good money then." He was 61 years old.

A sawmill in the area was established and then moved to what later became the town of Timbertown in 1901. He sold his controlling interests in 1905 to Long-Bell Lumber Company but they didn't change the name until about 1927. From that time until 1961, when it incorporated as a city, Timbertown was a "company town" owned by Long-Bell (Gilman, 2000; Jones, 1950).

Long Bell owned the town when Mrs. Joy was born in 1940. "I was raised here in Timbertown and never left. I never left Timbertown." She, like many, remembers good times. Her face was aglow recounting her memories of company town days. "Oh, it was great... Ah! It was beautiful. At Christmastime it was just a big family. A community--family. Everyone, everybody it was family...I used to walk downtown to the Timbertown Bakery and get fresh French bread and go to the Angel Valley store ... And I used to walk or ride my bicycle down to the store to get whatever Mama needed. And, um, when Christmas came when Long Bell had it, we'd all go down to the Timbertown Merc (the building of the company store), where it is now. We'd stand out there and we'd sing Christmas carols... I mean I remember when it was sooo wonderful -- I mean there was nuts and candies and fruit. I mean this is what Long Bell did in those days back then." She ended her exuberant reminiscing on a more sober note as if to draw the connection between how they were taken care of and the profitability of the company, "And, they made money. I mean they made money from here!"

In 1923, a laborer in the lumberyards made $3.60 for an 8 hour shift and paid $1.10 to the company a day for room and board (Langford, 2000). Long-Bell recruited Black men from Louisiana to work at the mill and by the mid-twenties 1,000 Black people lived in Timbertown when the population reached over 6,000 (Langford, 2000). It then became a company town. Mr. Allen remembers how Long Bell was a good place to work as a Black man because the wages were equal. "You got paid by the job. And another thing...if you had seniority for that job, you got it." Several interviewees said that years ago a Black person could get a job in the mill and expect to get equal pay and seniority for the work they did. But, there were several interviewees who relayed stories of being excluded from eating establishments. One interviewee said that a Black person could not sit at the soda fountain and have his food. Another said you could buy it there but then had to leave.

Mrs. Gomez, a 75 year old Hispanic woman has lived in Timbertown for 57 years. She recalls, "I came here to Timbertown – I started working as a waitress – and I usually worked with Black people who worked in the kitchen –the ladies would cook –got along fine. They were very nice people. I don't know why people always were trying to put them down. I never did understand that. And, I remember working in one restaurant—Black people were coming and wanting to be waited on. Well, they wanted to have the dinner—I had to put it all in a paper bag and handed it to them because they couldn't (weren't allowed to) come in and eat."

Others remember the boom times as "busy—a lot of activity going on." Mrs. Gomez recalls the company store as a "going concern" where you could buy everything. "There was a grocery store, clothing...It carried beautiful clothing. There were lots of bars too (snickering)." She recounted 9 in all. By other accounts there were 11, and

some say 13. Many residents remember the Mercantile company store. Barrett (1998) a southern Oregon and northern California historian described the Timbertown Mercantile Company Store has having grown into a large business "that was typical of other company stores in the early 1900s" (p, 147). Among the list of goods were clothing, a tailor, groceries, a butcher shop, the Timbertown post office and a Wells Fargo office.

During this same period of time, there were bars and brothels thriving in Timbertown. It was considered to be the "Sodom and Gomorrah" of Stone County. Conductors on passenger trains that stopped in Timbertown advised all not to go into town. Gambling, prostitution and liquor were some of the main attractions.

Mr. Clement, now 65, remembers when he worked for the company. "You learned your job and did your job. It was the same group of people you went to high school with and that was your support group." He talked about how people went right from high school to work in the mills and how there were no other educational opportunities unless you sought them out. "It took a pretty rare person to say, 'Hey, I need to go to school.'

Dorothy Jones recalls how she and her brother used to go in and out of the veneer plant, where her mother worked for Long Bell Company, like "we owned the place. Nobody cared." Dorothy lived in a company house on Stringtown Street. "You had a front room and the kitchen and two bedrooms, and the bathroom was out in the outhouse. Our house was just kind of catty corner across from the opening of the veneer plant where they loaded the things. We would go in after school, and the women would take smoke breaks and we would lay the slats for making the fruit box tops...we had a ball doing it. I was seven years old. These big machines roll around and you put the little end pieces in, and then you throw the thin ones across and that makes the fruit box."

There were several churches in Timbertown during company town days. The first was the Timbertown Community Presbyterian Church built in 1906. In their 50 year commemorative celebrations brochure, "No history of the church would be complete without recognition of the significant role played in its progress by the Long-Bell Lumber Company...This applies to other religious groups in Timbertown as well" The recognition continues with a listing of all that Long-Bell has donated to the Church through the years: "...new building, materials; renovation; heat, utilities; cancellation of the building debt and "other beneficences too numerous to mention." The people attributed this concern as stemming "from more than mere duty."

Union organizing played a pivotal role in the history of Timbertown. Mr. Jamison remembers the first attempt to organize in 1921. It was during the strike in 1922 that Long Bell brought Black men from the recently closed Louisiana mill to work in Timbertown. Residents recall that the men were brought here to union bust. The strike failed. It was discovered after the mill was closed that Long Bell Co. had kept three lists of names of several employees involved in union organizing: "Men who left employment" (142 names); "Undesirables, April 20, 1922" (147 names); and, "Men to investigate before putting back to work" (9 names) (Linville, 2000). The first strike was 14 years before the National Labor Relations Act (Wagner Act), which gave workers the right to organize and join labor unions, to bargain collectively and to strike. At that time there were no provisions in the Act allowing government to delay or block a strike that threatened national interests (Wagner, 2002).

It wasn't until October 15, 1941 that the workers organized and went out on strike again. This time there was solidarity and they were successful. Motivating the strike were arbitrary firings. "If you got in an argument with the boss, they could fire you on the

spot." In addition to job security, wages and one week of paid vacation per year were also negotiated. Mr. Jamison talked about fighting for the union organizing but he said, "It was scary at times because you didn't know whether they might shut the plant down and just move out of here." The success of the 1941 strike was attributed to the interracial solidarity among all employees which was noted as lacking in the 1922 strike (Linville, 2000). Not two weeks after the strike of 1941 began, Mr. White, the president of Long Bell, decided to do business with a local contractor. The picketers saw Mr. White enter the building and sound the alarm to summon several hundred men preventing Mr. White and the contractor from leaving. Those present recall Mr. White saying, "I've been running this town for 19 years, and there is no reason why this man can't get it (his lumber)." Hayes Royal, a Black union man stepped forward. "Yes, Mr. White, you have been running this town for 19 years, but we are running it now." White threw his hat on the ground and went to his office. The strike was successful and the picketers got everything for which they bargained (Linville, 2000).

But there was a regional and nationwide labor movement afoot, which contributed to the success of the union strike as well. There were nearly 4,300 strikes called by union officials across the Country that same year. The Union and the Company agreed to federal arbitration due to the entry of the United States into WW II. The Company recognized the Union for the first time in Timbertown (Linville, 2000).

In 1942 the National War Labor Board was created. It gave the president power to issue directive orders to settle labor-management disputes that "might interrupt work contributing to the effective prosecution of the war. Designed to encourage a strike-free "labor peace," it did not stop the escalating number of strikes across the Country (Kendrick, 2001). Congress passed Taft-Hartley Labor Act in 1947. The government

was empowered to obtain an 80-day injunction against any strike it deemed a peril to national health and security. It was viewed as the "new guarantee of industrial slavery" by 28 Democratic members of Congress (Wagner, 2002).

In 1954, the last Union strike at the Timbertown mill was called. The union became a "full union shop" whereby every worker had to join or be fired (Linville, 2000). In 1955 International Paper Company (IPC) bought Long Bell. They called it International Paper Co, Long Bell Division, Timbertown Branch. In 1959, International Paper, who was not "in the real estate business", sold the company houses to their inhabitants, their employees. Mr. Jamison remembered that the people who bought them paid about the same per month for mortgage as they were paying in rent. The houses sold for between $2,000 and $3,000. On November 12, 1959, a local newspaper reported, "Nearly a fifth of the houses and lots offered for sale by the International Paper Company last week had been contracted for by Tuesday of this week. The company will finance the purchase of the homes with 10 percent down, 20 years to pay the balance at five percent interest" (Editor Herald Press News, 1959, p. 4. Note: reference suppressed--available upon request).

The City of Timbertown was incorporated in 1961, five years after the sale of the Long Bell Company to International Paper in 1956 and seven years after the last Union 1954 strike. Mr. Jamison, once head of the Union Shop, denies that this last strike was the reason for the sale of Long Bell Lumber to International Paper. He had heard that Long Bell executives were ready to retire and that fact prompted the sale of the company.

Mrs. Joy noticed a change in the people and the level of activity when IPC bought out Long Bell. "It was not as busy as it was when Long Bell was here...Well I think the economy was starting to change. People were starting to change—you know production

(of timber). She blames the decline in timber industry on the environmentalists. "Give me a break! That damn owl is going to relocate." Now banging her fist on the table, "I remember when there were 5500 in this town. It was a booming, booming town!" She interpreted the dismantling of the company town as a sign that IPC was not interested in people the same as Long Bell was, just the profits. "(IPC) is a corporation that really didn't care about the people just the numbers."

There were various opinions about the cause of the decline of the timber industry in Timbertown. Linville (Linville, 2000a) notes that technological developments were partly responsible. Many participants remembered that when automated production technology was available, many people left to find jobs somewhere else. It was at that time, there were massive layoffs and a mass exodus from Timbertown of working age people and their families. December 10 of 1981, the plant was closed down and moved out of Timbertown. The payroll was close to $6,000,000 a year (Linville, 2000a).

Documents from the County Farm Bureau (Stone County Farm Bureau, 2000), regarding timber, show that while board feet production has decreased, profits have increased. The loss of jobs due to automation of the process reduced the payroll expenses of the company. The increased price per board foot coupled with decreased payroll expenses account for the increased profits.

For a historical timeline illustration of the establishment of Timbertown from pre-mill days until the closing of the International Paper Company Plant, see Appendix D, page 175.

CHAPTER FIVE: HEALTH CARE IN TIMBERTOWN: HISTORICAL TO CONTEMPORARY PERSPECTIVES

Historical Perspective

Roy Jones, MD, in his book about the physicians of Stone County in the early 1900s, describes the period of his childhood as "the period when Argonauts were neighbors" and "Doctors astride light-limbed horses, alighting and throwing their saddle bags across an arm hurriedly enter the sick chambers...The distant visitations were, of necessity, made on horseback" (Jones, 1950, p. 8). There have never been enough doctors in the County. In the early 1900s, tuberculosis, pneumonia, diphtheria, scarlet and typhoid fevers had taken many lives in the county. In the late 1890s bacteriological laboratories appeared in metropolitan centers, but rural Stone County did not have that advantage and many lives were lost (Jones, 1950). In Timbertown in 1906, the first physician, Dr. Treble, averted a smallpox epidemic by the use of quarantine and a pest house. It was at that same time that nurses were deployed into homes where assistance was needed, and though there were some deaths, the disease was kept from spreading (The Bicentennial History Committee, 1976). Antibiotics were only a dream, even by 1910, and emergency surgery was the rule. Gunshot wounds, stabs, crushing injuries, and all kinds of fractures and other things treated today in emergency practice were treated then on the scene or in a "log cabin with dirt floors" (Chapple, 1996).

Mr. Jamison, a lifelong Timbertown resident and the second of four generations to work at the mill, remembered the pre-employment physical with the company doctor. They "made you cough with the hernia check. And they wanted to make sure that your hearing, eyesight, heart and lungs were good." He remembers that they also were

concerned that a person be in "good mental condition." But, he did not remember how they tested for that.

Residents relayed that the Company built the hospital in Timbertown before 1919 and it was torn down when the doctors built the one in a town 10 miles away in the late 1950s.

One of the key informants in this research, a former company town doctor, speaks to the issue of physician autonomy. He said they didn't like anybody from the company trying to interfere with medical practice. There was a significant amount of pressure, "It was hard to tell who you were working for sometimes. What do you do: fire your boss?" He explained that in the case of disagreement, you smooth it over because you had to keep going. He didn't seem to want to say too much more about it. Timbertown company doctors were not the only ones concerned with the issue of autonomy and their corporate employment. It was an issue in other company towns in the United States. Starr (1982) wrote about physicians employed by corporations, such as company towns, from 1900-1930. "Physicians became uneasy (about) threatened autonomy...practitioners wanted to keep their relations with patients unmediated by any corporation" (p.198).

Residents' references to health care in company town of Timbertown are numerous and corroborate chronology of physicians who followed each other in practice as well as the places of health care and the fact that they only used it when they were sick. Dorothy Jones prides herself on having been delivered in their company home by the first Timbertown physician. Long Bell owned the town then. At the time, her dear relative, Gloria Helm Coutney, was the head nurse at the Timbertown Hospital and daughter of the man who settled the town of Helmtown in Stone County. Jones described Coutney as a "special lady" who later trained her housekeeper to be a nurse's aide.

Mrs. Clement, 94 years old, didn't go to the doctor too much growing up and as an adult, only to have her children. She remembers Dr. Nulty and his predecessor Dr. Treble coming to the house if she ever got sick.

Eva Smith, a key informant and resident of Timbertown since 1965 remembers the scheduler, Della Fields to whom people referred as "Dr. Della." Eva's mother told her that you had to plead your case to her as to why you should be scheduled to see the physician. Eva said that "nothing got by her."

Eva confided that a lot of her high school friends wouldn't go to doctors' office in Timbertown because there was no privacy. "They didn't want their fathers hearing that they were in there asking for birth control pills." Eva said that even when she was married, she went to Coachville when she was pregnant because she didn't want her family to find out before she could get home to tell them about the pregnancy. She said, "...and I was married!" She attributed the lack of privacy to it having been a small town where everyone knew each other.

Not only does this time period far pre-date HIPAA privacy policies, but also any standardized procedures for adoption of children. Eva relayed a story about a relative who was adopted. Her family member told a woman in town that she admired her children and just said in passing that if she ever wanted to give her one of her babies to just let her know. Well, she got a call from the doctor who said, "This baby was just born and you have 5 hours to make up your mind. Otherwise, we're going to the next person on the list." So, she adopted him. Eva said that this woman and others in the town thought that the doctors "walked on water." She named her daughter after the doctor's daughter.

Many study participants referred to the Timbertown Hospital and the subsequent doctors' offices that were built there after the hospital was razed in 1959.

In the 1980s and early 1990s, Mrs. Alameda, a Timbertown resident and a nurse, remembers taking care of 10 patients at the local Moosewood hospital without an aide. She said the unions made the situation safer. "So now they got the union in there now because, they were giving us too many patients to do a safe job. How in the world can one RN and take care of nine or ten patients by yourself without a nurse's aide, safely! And you know some of those people have NG (naso-gastric) tubes and some of those people have subclavian lines and all that kind of stuff. Some of them got TPN (total parenteral nutrition) running." She said the union organizing was done so secretly that even she didn't know it was happening. That was in the 1980s.

The residents in the study felt that they had all the health care they needed during company town days. There was a hospital and doctors. Only one study participant knew of someone, her sister, who had to travel to another city to get medical care during that period of time. "I know they took her to San Francisco to see what to do with her." But as for herself she never went to the doctor as a child. "No. Oh, No!"

Some of the general present day issues surrounding health care for today's Timbertown residents in general follow. A more extensive treatise of health care issues related to aging in Timbertown or relocating to another area are presented in subsequent chapters of this paper.

Health and Safety of Company Workers

Although not the focus of this research, the interviews uncovered information that affected the health and well being of residents of Timbertown and points to the need for further study. Cathy Jones, a health care provider, was born and raised in Timbertown

and has been a resident for 43 years. Her uncle worked for the company for years. He died of asbestosis a few years ago and the family is going through a law suit settlement process now. Ms. Jones said that almost everyone who worked for the company got some disease; she named asbestosis and leukemia as especially common. She said, "Well, they used to dip those logs in creosote there. Some are still alive while most have died."

Mr. Jamison talked about people who were maimed or lost their lives doing the mill work. "You see guys a lot of times with two or three fingers. People lost their hands and feet and stuff like that in the cutting department. I think there were at least three or four people that I know that got killed in the sawmill."

Roger Allen lost much of his hearing and tried to get something from the company when the mill closed, but he was told he was too late in filing a claim. He had tried many times. The machine he ran for 40 years "...went Bam! Bam! Bam! all the time."

Mrs. Alameda lives in an area with a high breast cancer rate. Her two daughters were diagnosed in 1991 and 1998. She named many neighbors within a two block area that had breast cancer. Some have died. Then she said, "Practically all the men on these couple blocks have prostate cancer." She thinks it may have something to do with the chemicals from the lumber mills. She said one time she was coming home after working a late shift and the chemical smell was really strong. She said the mills used to refill the chemicals at night. She thought this was the wrong time to do this because people were "breathing deeply" while they were asleep. The night it was really strong, she called the police—the sheriff—and he came out and said it did smell really strong. She said they used to use creosote to soak some of the wood.

Another resident talked about her late husband who worked at the mill and then died of lung cancer. "He worked for the company for 26 years when it was Long Bell. When he got sick, he got cancer in the lung; he only stayed 3 months alive"

Residents' Attitude toward Use of Health Care Today

It is difficult to differentiate whether the attitudes of residents toward primary care can be attributed to the lack of prevention services available to them over time in a rural area or to their experiences with the health care system. Their history as a community employed in physically demanding jobs may also give context to being physically functionally fit as an index of health. Thus, the expression by a research participant of the physician as being where one would go to "get a pill or to get cut (surgery)" makes sense in this context.

The former company town doctor revealed that some of the older people do see the value of preventive medicine but many do not. He thinks that there may be a couple reasons why people don't access preventive medicine—that there are financial issues meaning that people may not have insurance coverage or that people don't see a value in it. There are no HMOs in the entire County today. In hindsight, he thought the HMOs would have been good for people because they offered primary care. "When they were here, we didn't think we needed them."

Most residents do not go to their health care provider unless they are sick - and quite obviously so. One resident who has had two heart attacks within the past year does not want to go to the doctor or hospital so she doesn't tell her husband "half the time" when something is wrong.

Mrs. Joy only goes to the doctor when absolutely needed. "They give you a pill or cut you." She sees a chiropractor once a month to keep herself physically functional so

she can keep up her regular activities. As for mammograms or other preventive tests, she, like some of her counterparts in the study, "doesn't believe in that baloney."

Mrs. Clement does not go to see the doctor unless she has a problem. At 94 and the oldest person in the study, she is very active. When asked about her seeing the doctor now, she said she would go if she broke her leg because she trusts her doctor. A family member quipped, "The doctor said, 'Whatever you're doing at 94, keep doing it!'"

Similarly, Mr. and Mrs. Gomez, a Hispanic couple said they used health care "only for problems."

In the past, the method of payment could have influenced resident's use of health care visits for primary care. One interviewee's husband worked at the mill, they had to pay cash to see the doctor in the office, but any hospitalizations were covered. Original payroll records in the local museum show a $1 deduction per month for hospitalization insurance.

Contemporary Health Care Resources in Stone County

Today there are two family doctors and one family nurse practitioner in Timbertown. There are two chiropractors and one dentist. A satellite office, of the hospital 10 miles away, sees patients for physical therapy.

In Stone County, there is a shortage of primary and specialty health providers including mental health clinicians. Most primary care is provided by family nurse practitioners and physicians. The distribution of these providers is uneven throughout the County. Population base in the south county area, where Timbertown is located, does not account for the distribution. Rather, the communities with more robust economies have more available health providers. For example, the town 10 miles south with only 600 more people than Timbertown has 22 family physicians; whereas, Timbertown has only 2.

In the County, there are two podiatrists, a cardiologist, one geriatrician, and several orthopedic surgeons. There is one gerontological nurse practitioner. There are no dermatologists, nephrologists, and only 1 psychiatrist who only sees people in the behavioral health county system. Pharmacists, nurses, nursing assistants, dentists, nutritionists, and mental health providers are in short supply. There is one visiting urologist and neurologist. There is no affordable assisted living. Senior clinics are non-existent. There are two adult day services facilities in the County serving approximately 40 people combined. There are two hospitals, neither of which is equipped for cardiac surgery. Most cardiac patients are airlifted to hospitals (approx 75 miles in either direction). There are two long term care facilities with one slated for closure following closely behind another that closed last year. People are currently sent to nursing homes in cities 75 miles in either direction or to the city 4 hours away because of lack of available beds due to short staffing issues. There is one home health agency owned by the two hospitals with a memorandum of understanding for operations. Reimbursements are inadequate and they operate in the red. They employ no home health aides. There is no identifiable source of information for home health aide referral in the County. A study participant told me that her orthopedist recently moved his practice to the closest city, 75 miles south, because he can make more money there. He relayed to her that he can work four days and make the same amount as six days in the study fieldsite.

CHAPTER SIX: AGING-IN-PLACE AND RELOCATION FACTORS: THE COMMUNITY RESIDENTS

Roger Allen is an 83 year old African American who moved to Timbertown from Louisiana to work in the lumber mills over 60 years ago. He lives in the same neighborhood where he raised his children and cared for his wife who died of cancer. He would like to stay in the community as he ages. In fact he can't picture it any other way. He figures when he can't take care of himself anymore, he can go to the nearby skilled nursing facility which the locals refer to as "The Convalescent" just up the street. Many of his friends are there, and for years he has gone to visit them as a member of the Church choir. What he doesn't know is that "The Convalescent" is for sale. It is marked for closure by the national chain that owns it. He has no other plan for his future. Years ago, his children moved to a city five hours away years ago to find jobs, and they have no intention of moving back to the area.

Mr. Allen's story is not unlike that of some of his contemporaries who have lived and worked in this once booming timber town. Many want to live in their homes as long as possible and often see moving to the nursing home as one of the few stable options of remaining in the community, clinging to the remnants of the once vibrant social network of company town days. Some have family or neighbors nearby ready to help and others do not. A web of circumstances will determine the likelihood of aging in the area or of relocating from the perspective of residents, health care providers, and government/civic leaders. This is the first of three chapters describing those perspectives and will focus on the residents' perspectives. The three categories of interviewees are: residents (people over 65 with more than 30 years in residence); health care providers; government/civic

leaders responsible for senior services resource allocation. This chapter focuses on responses of the residents.

As mentioned above, the purpose of this study is to examine the factors affecting the likelihood for rural elders in this specific northern California former timber company town to age-in-place and those factors that contribute to forced or voluntary relocation.

In each of these three chapters entitled: *Aging-in-Place and Relocation Factors*, I will first describe the existing conditions that facilitate older adults remaining in Timbertown, followed by a description of services that are not available but would increase the likelihood of older people remaining in their community. Lastly, I will describe the "tipping points" or "last straw" that precipitates relocation. Each chapter will be from the perspective of one of the three groups interviewed: residents, health providers, or government/civic leaders.

There are two main sections of outcome factors that would increase the likelihood of rural elders staying in Timbertown as they age. They are: 1) services needed for people to stay in the area; and, 2) conditions that already exist.

Fostering Aging-In-Place: Services Needed, That Do Not Already Exist, In Order For People to Stay In the Area

Help in the Home with Daily Living

Overwhelmingly, the long time residents expressed a need for minimal services in the home that would enable them to remain there. For every resident in the study, who envisioned remaining at home, their focus was on getting help with daily living. Whether it was cutting the grass, helping them with food shopping, or assistance with bathing, people thought of the help they might need to remain in their homes. A 70 year old African American woman said: "...if I could just get somebody who could come and

do the things that I can't do for myself." She wasn't sure what those things might be, but she did know that there would eventually be some things that she could not do for herself anymore. A Hispanic woman, crippled by arthritis and without any family members, projected her need for housekeeping, "Maybe hire somebody or to have help cleaning the house."

There was a concern among some of the residents that they wouldn't have a place to go if they had to leave their homes. One resident talked about the people who didn't have other options, "But see, some people don't have nowhere to go and nobody to go to. That's why if we had that type of service (help in the home with daily tasks) in this area; it would be beneficial to some people."

Another resident couldn't name exactly what she would require, but the message was the same—to do whatever was needed. She said "I think it would be to have some kind of home health aide come in and help you. And that seems to be whatever you needed. You know, because there's a lot of things that when you get up there, you can't do."

Some of those "things" included yard work, hauling and stacking wood, changing light bulbs, light maintenance, food shopping. In general it was difficult for people to picture specific tasks in the home they wouldn't be able to do anymore, but they knew that the day would come when they would need help so that they could stay in their homes.

Residents who did not have the financial and social capital to envision in-home support knew that for them, any resources forthcoming would be appreciated as making a difference. One member of the African American senior community, whose per capita

annual median income in Timbertown is $8,000, said, "You know this area here is very poor and any kind of senior aid (would help)."

Three people, all White, said they had enough financial resources to remain in their homes without worry. They described those resources as including some or all of the following: long term care insurance, family in the area with whom they had daily contact, a physically accessible home or plans and resources to renovate. For the interviewees who had money, there was less worry about the future, but they also felt that they would need to have help in their homes if they were to remain there. A 65 year old woman explained, "Yes, I have money of my own. And, I have insurance (when) I need somebody to come in and help me take care of myself. I have (long term care) health insurance."

Some residents with family in the area talked about all the things their families already did for them when they needed help. Some felt that they would be able to depend on them when they could no longer take care of themselves and their homes. One African American woman thought that her family in the area would not be able to take care of her and her husband because "they have their own problems." She said that her children in Timbertown depend on her to take care of her grandchildren. She explained that her oldest daughter, now living and working in a city four hours south, would come up to take care of her when needed. "She was just here in (August) to take care of me after my surgery. She took off work to do that."

Residents realized that they could not turn to the home health agency in the County for in-home support. The agency does not employ health aides nor do they retain a registry for referrals. There is no infrastructure in the entire County for such referrals. Several years ago a private party brought a law suit against the agency because of the

behavior of one of the aides they had informally recommended. Because of the dire need for in-home supportive care on the part of their home health patients, the agency began to gingerly recommend people again. And, again, they became the focus of unwanted attention when one of the aides they informally recommended filed for unemployment when the family no longer needed/wanted her services. Although the home health agency recognizes the need for such services, they no longer give those informal referrals that would link families with potential in-home support services. There is no other agency in the entire County providing this service.

Some residents had had experience with home health services. While none complained about the quality of care, many felt that the amount of time reimbursed by Medicare for the service was inadequate. "I don't think there are adequate home health services in the area. The insurance will not cover any of that unless the doctor has requested that they do."

Transportation

After help at home with personal care and household tasks, improved transportation was a commonly stated factor that would increase the likelihood for residents to stay in the area to age. "Here, there is nothing like that – not even a taxi."

All residents thought that the transportation in the area for grocery shopping, social visiting, and medical appointments outside the area inadequate. Every resident mentioned medical appointments that they have had in two major cities. One is 75 miles north; and the other, 75 miles south of Timbertown, each over mountainous highways sometimes impassable in inclement weather. They ask friends or family to take them to these appointments, but it is often dependent on the person's work schedule. Some people missed or delayed appointments due to unreliable transportation.

Like many other services in this rural area, public infrastructure for medical transportation for specialty services is fragile to lacking. The obligation to piece together this essential service is left to private individuals. Gaps in health care can often be traced to a lack of dependable, predictable transportation.

Roger Allen's wife was diagnosed with cancer years ago. He was told to take her to the city 75 miles south for treatment everyday for one month. He did not know how he could afford to take her every day. "Every day, yes, every day. I did not know where the money was coming from to go every day—every day...Then, it was there. People took collections. Oh, thank God, the money was there every day...Then they told me I had to take her to (the hospital five hours from Timbertown). I didn't know what to do. My daughter drove from (where she lives) to pick her up (4 hour drive north) and then took her to the hospital (5.5 hour drive south). We didn't have any other way to get her there."

Need for Better Emergency Care

Residents talked about the difficulties they have experienced because better specialty care is needed in the emergency rooms.

"I lost the sight in this one (points to eye). It hemorrhaged one night ...It started hurting right above here like somebody hit me. I was sitting here all by myself, and so I had to call my son. I wound up in the local emergency room (10 miles south) and they thought I was having a stroke. The emergency room doctor couldn't see anything in my eye, because they don't know a lot about eyes here when you go in for an emergency. 'Well, there's nothing I can do for you or give you,' said the doctor. By that time, the pain had stopped and he said, 'You better call your eye doctor in the morning.' So, I went to (the city 75 miles south of Timbertown) the next day."

In addition to needing better specialty care in the hospital emergency services, ageism in the emergency room (ER) was the complaint of at least one resident. Interestingly, it was voiced as a concern more often by health care providers and government/civic leaders than by residents. Mr. Roma had been waiting in the local hospital ER for hours. When he approached the health care personnel, he was told that there were people who needed care more urgently than he did because they were younger. He told the ER staff that it wasn't fair he was being treated like that. He confided to me that he didn't want to push it too much because he didn't know if he would be seen at all. As he relayed this story at first, he was obviously angry. By the end, he had tears in his eyes. Even though residents did not articulate a need for geriatric training of health care personnel, their experiences pointed to this need particularly with regard to the treatment by some health care providers and their ill-formed attitudes about aging.

Need for Programs to Foster Intergenerational Continuity and Caregiving

The need for economic development of a stable job base in order for the working adult populations to remain in the area is urgent. Besides the rapid out-migration of the children of the resident study participants with the closing of the mills, younger adults continue to move from the area in search of a livelihood. The unrelenting caregiver generation gap created by this out-migration has left many African American and Hispanic rural elders without social capital--the local family and other networks of bygone company town days-- intact for future need. The non-Hispanic White seniors in the study have children who were able to find jobs in the area after the mill closed. African American and Hispanic study participants cited racial discrimination as a reason why their children could not secure jobs in the area.

Social capital refers to social networks that can be mobilized for community problem solving and trust building. The central premise is that social networks have value and that within them, there are norms of reciprocity (Putnam, 1995). The power elite of company town days built and sustained an infrastructure within which its residents could engage in building social capital. The withdrawal of the industry from the area led to a collapse of the infrastructure supporting many of those social networks. Residents were left with the task of mobilizing community assets and remnants of existing social capital such as church groups, clubs like the Sons of Italy, and PTA groups. With the loss of the timber industry from the area went the potential for a company sponsored infrastructure to care for the community elders. Motivated by an available and healthy workforce (some of whom would be the family caregivers of the elders), the company would have had labor market forces behind the decision for such an investment if levels of employment in production existed today.

Social capital is related to the rights of citizenships, interconnectedness and individualism. With a belief in interconnectedness and the rights of citizens regardless of life chances, company recognition of the contributions of all of the residents—laborers, in-home caregivers, and others—of the company town to their accumulated wealth, would result in provisions for the care of those residents now in their old age.

Fostering Aging-In-Place: Conditions That Already Exist

The second area of outcome factors increasing the likelihood of staying in the area falls into the category of conditions that already exist in a person's life. These include: local involved family; a love of Timbertown as a place; involved social circle.

Local Involved Family

Some residents had families who were involved in their daily lives. Besides consistent daily or weekly contact, these family members would provide rides to medical appointments, cook meals, and help with chores. One Hispanic resident (the only one with children in the area) expressed, "My son...usually stops here in the evenings on his way home or in the mornings. And my daughter calls to make sure—to see that I need anything. They're real good about that...checking up on me--so are the other kids (her grandchildren)."

A Caucasian resident, 90 years old, is a caregiver for his wife who has Parkinson's disease. Their family is close by and very involved in caring for both of them. "...all three of them (their grown children)--and they take turns bringing dinner to us so I don't have to do all the cooking."

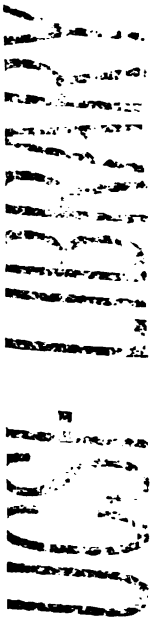
Some older adults in the study help their children with whatever they can do. They speak of having a purpose and wanting to contribute to their family. One Caucasian 66 year old study participant spoke about his mother, 94, who likes to cut wood for the family and iron their clothes. He explained, "I think elderly people –if they have a purpose in life, they are healthier. I've seen that with Mom. She takes care of the whole family. No matter what, she is still the matriarch." I later interviewed his mother and asked her, "Does that feel like it's good for you to do those things?" She exclaimed, "Oh, I have to! Or I'm just going to sit there."

Love of Timbertown as a Place to Live

The residents, who were intent on staying in Timbertown, and happy about that, all had one thing in common—they loved the area. Interviews and conversations with residents were filled with stories that portrayed how they grew up in these now familiar

places. Many stories, although unique in plot and setting, had one theme—a love of Timbertown as a place to live.

Mr. Ellis, a 90 year Caucasian man who has lived in the area since he was 2 years old and was one of four generations in his family to work in the mills expressed a childhood fear that his family would be forced to move to another area. "But my biggest fear in all the years I was going to school was that my dad would lose his job (at the lumber mill) and we'd have to move away from here-- from Timbertown." He has many favorite places with stories about each. The Timbertown cemetery was run down years ago with tumbleweed all over it and a broken fence. He had two plots for him and his wife in a small city, ten miles away that he wanted to sell or give away when the local Timbertown cemetery was fixed up. So he sold them and bought two plots in Timbertown. "I told somebody about that and he said, 'How come you bought the lots out here when you had those down there (in the other city)?' And I said, 'you know the old saying?' I didn't want to be caught dead in (the other city)!'" And I said to him, "Only somebody from Timbertown would understand that!" And, still laughing, he said "Yeah!"



A 94 year old Caucasian woman whose father was a high ranking official of the Lumber Company mused about all the places she drove in her Model A. Every place had a familiar story and her affect, like the others who loved the area, was light and engaging. She also talked about the familiar places that haven't changed and a place that reminded her of a favorite relative. When I asked her if there were any places in the area that were of particular importance to her, she said, "Just knowing that my Aunt lived there...I rode by it everyday. I drove up to my daughter on that street. You know we

lived right on the corner not far from it. ...All that's familiar. They haven't changed since I was in there. That's 60 years ago."

I asked her whether or not she would ever move from Timbertown. "NEVER! I don't remember ever wanting to. I don't mind going (on vacation). We went a lot, but it was sure nice to come home—knowing I was coming home."

Social Network

Mrs. Dora, like most others in the study who are planning to age in the area, has a large social circle and still sees them or talks on the telephone "No, most of them are still here. A lot of them were friends of (her husband) who he had known. I'm still friends with them. A lot of them passed away." When her husband was in the nursing home, she made friends among the residents and continued to visit them for a couple years after that. When I asked why she did not continue to visit she said that some had died but also because she didn't have transportation.

Church community was important to many people in the study. Their social circles often included friends from church. In addition to worship services, the churches provide a regular place for people to see friends and engage in structured social activities such as seasonal fundraisers, community dinners, and festival celebrations. It was also a place where people could serve on committees and provide other volunteer community service. Some people have used their church priest or minister for spiritual and family counseling. About half the residents interviewed stated that they did not have any church affiliation.

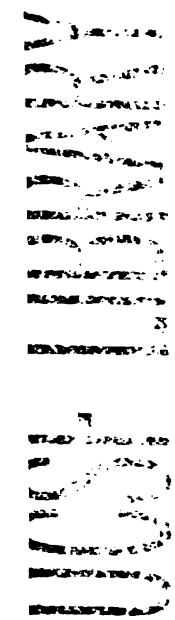
There is a group of men who meet at the local restaurant every morning at about 7AM. Several men in the study talked about the group and two of them stay away from the group because it is loud. One of them called it a "bull session." Both are friends with

people in the group but cannot stand the tenor of the conversations. Most of them have been friends since grammar school and all of them are older than 70 years.

Cannot Afford To Move

This section has been describing the factors that already exist that would "foster" aging in place. The title assumes that if people are not voluntarily relocating, that these factors would be desirable. There was one resident study participant for whom this was not the case.

Mrs. S., 71, wanted to move but felt she couldn't financially. She didn't have any family in Timbertown or the city 4 hours south, which would have been her destination to be with close friends. She never felt comfortable in Timbertown. It was "too rural" for her coming from Mexico City at the age of 19. She was thinking of one of her friends who moved to a southern city and wanted to be near her, but also realized her friend was sorry she moved. Her house in Timbertown was paid, but now she has to pay rent where she lives in her new location. Mrs. S did not want to find herself in that predicament. "We cannot afford to sell this house. Now, like Catherine: I think she feels sorry that she moved."



Tipping Points to Relocation

In the previous sections, resident study participants expressed the need for services that, if in place, would contribute to an elder's decision to remain in the rural area of Timbertown. The conditions that already exist to promote aging-in-place were also identified and described. In the next section, factors that contribute to forced or voluntary relocation of elders out of the rural area will be identified and described.

One business owner in his 50's, also a resident of Timbertown for about 30 years, summed up the reasons why his friends and some of his family have moved from the area:

"...simply because they don't have health resources here...weather is too cold for COPD. There aren't enough specialists in the area. There is no affordable housing and all the younger people are leaving. There is no good transportation."

Can't Get Help with Daily Care

Almost all of the residents interviewed told stories of friends or relatives who moved because they needed help with their daily care. Many were reluctant to say that in terms of their own future but talked about others who had to move for that reason. When I asked a resident, also a nurse, why would someone have to leave home to relocate she said "Well you know like stroke patients that can't take care of themselves; you know some people get that crippling arthritis where they can't really provide for themselves and just maintain daily—just do their daily care for themselves. Some people's vision gets bad. They can't see well enough to take care of themselves...dressing, walking, and taking their baths. I think one of the most important things would be their daily living." One of the most common activities mentioned in this regard was toileting. If a person could not "clean themselves up" after toileting or if the person developed incontinence, they were often relocated.

Moving Because of Weather

Timbertown was settled because of the wind. There were no dry kilns for the lumber and so the placement of Abner Timbertown's mill was calculated because of this attribute. It is not uncommon for the wind to be relentless for days on end with gusts of 60 to 70 mph. While this was an asset to the industry 100 years ago, it is often a nuisance for residents now residing in its path. When the wind is mixed with snow and freezing temperatures, it prevents even the hardiest mountain dweller from leaving the house.

This was not a common reason for leaving but for a few, when added to the other reasons, it tipped the scales in the direction of relocation.

Loss of Caregiver Base

This factor is very similar to the factor above, "Can't get help with daily care." The people for whom this is a tipping point have family living in another geographic region and they want to be near them. They have maintained an ideology that when the family is together again geographically, that whomever needs care will have access to it.

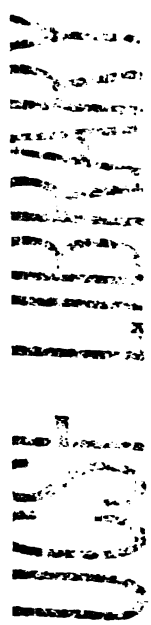
Maria and Nacho Ruiz, a Mexican American couple in their middle 70s have lived in Timbertown for 45 years. It was here they raised their children and Nacho worked in the lumber mill for 23 years. This year, they will be moving to a city 4 hours south to be near their daughter and granddaughter. Maria said, "My daughter needs us to help with our granddaughter and we need to go because we are old." Very good friends of theirs just relocated to that city two years ago to be with their family. The friend's daughter moved to go to school and found a job and then stayed there. They said one of the reasons why she didn't come back to the area after school was because there weren't any jobs for her. "The younger generation moved when they went to different places to school and they met somebody in that area, got married, or found a job and then stayed there." Even though they will be leaving some friends in Timbertown, they are not going to miss the extreme weather conditions in the winter anymore. "...snow, the rain, the wind, and the freezing temperatures."

One resident, mentioned above as financially deterred from moving, had many close Hispanic friends who moved from the neighborhood to be near their families. Another Hispanic woman, a research study gate keeper, spoke of several friends who had moved back to Mexico to be with family when they were in their 70's and 80's. She

illustrated a common theme in her stories about these neighbors. Their families were too busy to spend much time with them. The stories are mixed and varied, but the common element is that the people moved to be closer to family members who were younger and who relocated years before to find jobs. Now in mid-life, their children are busy with jobs and children and rarely visit.

All of the resident study participants who had relocated or were preparing to do so were Hispanic or African American.

Irene Jones' friend, a 96 year old African American woman, moved from Timbertown to San Francisco to be with family "because it was too hard on her daughter and grandkids to leave their jobs and come back up here to take care of her." In addition, Mrs. Jones' sister, Mrs. Black, went to live with her daughter, in the city 75 miles to the south, because she couldn't self-administer medications.



Future generation of caregivers who are currently living in Timbertown cannot afford housing and/or jobs. In the past year, the housing has gone into a boom market. There are many reasons for this but the result is the same for many areas of Stone County. Timbertown is no exception. People, with starting level salaries, who do not own property, cannot afford the housing costs. In the 1960s, when International Paper Company sold all the company houses built by Long Bell Company, residents could and did buy them for $3,000. Social discourse, real estate flyers, and first hand knowledge by interviewees has shown those same company houses to be selling for over $100,000 and in one case for $220,000!

African American interviewees spoke of how their children could not find jobs after the mills closed. They said the big employers would not hire Black people because they gave the jobs to family and friends who were White. Some of the ones who didn't

move out were said to have gotten into selling drugs to make a living. Others worked in janitorial jobs, sometimes they had two jobs because each was not enough to survive financially.

Because of the loss of a geographically proximal family, caregiver burden became a tipping point for several residents.

Caregivers no longer able to care for people in their homes (Caregiver Burden)

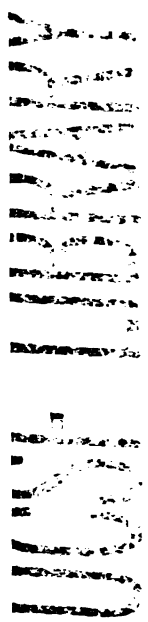
Residents and health providers (next chapter) told stories about how caregivers, usually spouses, could no longer care for their loved one because of functional decline of one or both of them. Caregiver burden occurs when the primary caregiver does not have the physical, emotional, or financial resources to care for a person. The foregoing section, "Loss of Caregiver Base" focuses on an absence of familial support due to an earlier relocation by others. This section focuses on the interruption of a caregiving relationship because of a change in circumstances of either the resident or the caregiver. Resident study participants never used the term "caregiver burden" whereas health care providers did (see the following chapter). The residents used language descriptive of the functional changes that made it impossible for caregivers to continue the same activities they had performed in the caregiving relationship to that point.

One 83 year old resident study participant was the primary caregiver for her husband who had dementia. She had difficulty getting help in the home but was able to manage with a patchwork respite schedule of family and friends. It was at the time of her own knee replacement that she could no longer care for her husband in their home. So, he went to the local nursing home. "I had to have a knee replacement. And I knew I wouldn't be able to take care of him." She said she was able to visit him there quite often since it was within a couple miles from her home. Her children and friends took turns

driving her and occasionally her husband would be brought home for visits on a regular basis. This eventually stopped because he didn't recognize where he was and would ask to "go home" to the nursing home. This couple represents well many other town residents: those who viewed a move to the local nursing home as still living in the community. For these people, relocating to the nursing home was not relocation out of the area. "Some of our friends were living there... and I still visited them after he died."

For decades, Geneva Salazar, kept the house sparkling clean just the way her husband liked it. She was up 1 hour before the 6AM mill whistle blew to cook him breakfast and pack his lunch. He worked for the mill for 26 years and retired with a pension which supported both of them until he died of lung cancer. Mrs. Salazar, 50, at the time learned from the Long Bell Lumber Company that she would not be receiving survivor benefits from the lumber company. "He told me that I'm not going to have a pension because I was 50 years old and he says, 'You got to go work to keep yourself alive.'" With only two years of formal education in Mexico, there were few options for work. She had worked in the fields in Mexico from the age of 6 until she moved to Timbertown as a young wife. So, after her husband died, she worked in a local restaurant for 6 years until it was destroyed by fire. Subsequent to that, she married her current husband for whom she is the primary caregiver. He left Union Pacific railroad with a lung disorder after 24 years. He would have received his full pension after 25 years, but he was too sick to continue working. Mrs. Salazar said, "I buried one husband (who worked in the mill) with cancer in the lungs and he (the second husband) got bad lungs because he used to operate a machine (for Southern Pacific) that was so dirty and all the grease and everything, he swallowed. He had to quit and those people didn't give him anything." She talked about how she cooks and cleans and cares for her husband. She

also does upkeep on the entire outside of the house. She doesn't know how much longer she will be able to provide care because of her arthritis. During the interview, she hung onto the table with every step she took. She was crippled with arthritis. She has no family and all of her friends have moved away. Mrs. Salazar's story is an example of the many women who provide years of unpaid caregiving of partners who work for companies such as Long Bell and Union Pacific and then care for them when they become ill in their later years. She projects the need for help with cleaning so that she can stay in her home, but has no family and her friends have relocated out of the area.



CHAPTER SEVEN: AGING-IN-PLACE AND RELOCATION FACTORS: THE HEALTH CARE PROVIDERS

This section continues to examine the factors increasing the likelihood for rural elders in this specific northern California former timber company town to age-in-place as well as the factors that precipitate relocation. It is from the point of view of the health care providers. Recall that there were three groups interviewed: residents over 65 living in the area more than 30 years; nine health care providers who have cared for elders living in the study area; and government/civic leaders with resource allocation responsibilities to senior services. Almost all of the factors deal with services that are not available but that providers think should be in order to increase the likelihood for residents or themselves to age in the area.

Fostering Aging-In-Place: Services Needed, That Do Not Already Exist, In Order For People to Stay In the Area

Need for Geriatric Specialty Services

Overwhelmingly, health care providers interviewed voiced the need for geriatric specialty services. Currently, there is one board certified geriatrician in the County. For four out of the five counties that comprise a 25,000 sq mile area, he is the only geriatrician. He practices in a small community 10 miles away and is the doctor for some Timbertown residents. He candidly speaks about the difference in care for seniors between someone who is trained in geriatrics and one who is not: "I think geriatric training is a must for every practitioner. Whenever any patient comes to me, I do geriatric depression care, memory assessment, functional scale assessment, social support assessment—so many other issues. In a whole comprehensive way I examine the patient. And the most important thing: setting up the end of life care. So many unmet things I see

when the other doctors are assessing the patients so I insist on hearing and vision assessment. I want them to be as functional and active as they can so those things are very important. And, I always want to involve the family in many things. There are many of these things many doctors are not doing. That's what I feel. In the urban hospitals, they ask for geriatric consults. Here I am only getting one or two referrals a year from other doctors. They don't know what geriatricians do, what others cannot do—what exactly."

One of the nurses who have worked in adult day health and home health services speaks about the need for geriatric care: "I think for the most part there isn't enough specialized care for the elderly. The doctors that they see are primary health care providers so they don't focus primarily on geriatrics. As we know, it's a specialty in itself, providing the best care for an elderly person with all their chronic illnesses."

And, a hospital staff nurse noted the need for geriatric care in that setting or referral to geriatric specialists. She said, "There aren't many specialists ... They're just general doctors that care for them (older adults). I think they get pretty stumped sometimes."

A senior manager in a skilled nursing facility caring for Timbertown residents expresses the need this way: "I don't think that we have enough geriatricians ... They are few and far between." She sees some of the fallout of this as inadequate diagnosis: "I think that in the mental illness and dementia areas that we are not ruling out many things before the drug is given."

The geriatrician interviewed said that he has diagnosed many older adults with mental illnesses, previously undetected by other physicians. He also used tele-psychiatry

through University of California Davis so that his patients have had the benefit of psychiatric services.

Better Quality of Care Needed Related To Medication Management

Health care providers see problems with medication mismanagement. One health care provider drew a link between mismanagement and poor nutrition: "I think that the number one thing is that doctors prescribed many times too many meds, because they haven't reviewed what they have already prescribed and suddenly the poor patient is spending their whole Social Security check on pills or not spending it at all on pills in order to eat."

Some health care providers felt that people were being given medication inappropriately. "Something's wrong with people going without food to buy medications. Who knows—if we really had good food, and some exercise—which always make people feel better, maybe they wouldn't need so many of the meds and not be toxing out their livers and their kidneys, and seeing more problems down the line."

The same provider feels it is really important to listen to patients because sometimes the older adults are lonely and that they may be seeking contact with health professionals out of loneliness. "I mean it just breaks my heart that some of these folks are just lonely. I have a woman who comes in and she talks nonstop All I have to say is, 'oh, really? Wow!' It's amazing to me! It's amazing to me! You know, it's not right that we don't love them and respect them, and be there."

One nursing home health care provider noted that instead of time with the patient, medication is given. "The doctors are saying that these are elderly people so that we expect this of them so let's give this (medication) to them rather than taking the time -- because time is money -- we're not spending enough time in really sitting down and

talking with the family and the patients...I think that the elderly are not listened to enough."

Assisted Living Needed

Many health care providers spoke of a need for assisted living that would increase the likelihood of seniors aging in the area.

There was a difference of opinion among health care providers as to whether elders were better off moving to a purpose-built or organized assisted living facility or staying in their homes with in-home support. A physician and a nurse expressed that assisted living was preferable to remaining in their own homes.

One of the nurses who was born and raised in the area and had worked with Timbertown elders said that when she herself gets older, she wants to be in assisted living. "Because I think I would be too homebound. I would want to be able to be with other people. I wouldn't want it to just be me and the caregiver." She said, "a lot of things fall through the cracks when you get older. You get tired. You get forgetful, maybe depressed. So, that's what I'm thinking -- if there is interaction with other people maybe that's a reason to want to get up in the morning, or take a shower, or wash your hair, or whatever it is, and put on a nice outfit. If there's nothing there, you're not going to do it for yourself."

The geriatrician believes it is better for people to be in an assisted living facility rather than at home because of the socialization factor in the assisted living. He believes that help in the home is fragmented care. In addition, caregiver fatigue is a big issue when people stay in their homes even with home aid help. He thinks that if people were in assisted living, they would get better nutrition. "If you have affordable assisted living care--that is the best for many, many of the patients. Or semi assisted living... a little bit

less than the assisted care, but somebody can supervise the safety; somebody that can provide the food instead of 'Meals on Wheels.' That is the best arrangement."

Assisted living was acknowledged as a living situation that would allow some nursing home residents with a level of independent functioning, an alternative. One long term care nurse said that there are patients in the nursing home today who could function well in an assisted living facility if Timbertown had one. "There are a few in-house that we're trying to place ...They are at a point where they can do a lot but they still need supervision, yet they are quite independent in their activities."

Senior Center for Senior Wellness and Other Activities Needed

Providers expressed a need for activities for seniors that would promote physical and social well being. One of the health care providers in the local nursing home mentioned that a senior center or the planned community center would be the best venue for such activities. "There's not enough areas such as swimming available to the community, other than the community pool, which is filled with children where the seniors would feel uncomfortable in going. So if we ever get a bigger pool or a covered pool or something for couple of hours every day could be utilized by the seniors it would be a great benefit to them. I think even going to church groups, if we ever get the community center and we have a community center room that I think certain days should be set aside for seniors like dancing, weightlifting, and so forth."

A community center in Timbertown for all age groups has been in the planning stages for years. A philanthropic organization promised years ago to match community efforts in the building of the center. So far, efforts to float a tax measure have been defeated and other fundraising ventures have not reached stated outcomes. In the meantime, the local community college offers some classes for seniors in their gym and

there is a private physical therapy pool within a 20 mile round trip of Timbertown. Transportation to these facilities must be secured privately. The community churches were mentioned as a place where community education meetings and wellness programs could take place. Other senior needs mentioned by health care providers that could be offered in a senior center venue were: help with financial planning of needs; education about 'communicating with your health professional' and 'medication procurement resources'; and, 'education of caregivers' were mentioned as topics.

Mental Health

All of the health care providers interviewed regarded the mental health services for seniors as inadequate. Typical replies to the question of mental health services were met with negative impressions of existing services followed by suggested future services designed to meet the needs of seniors. One nurse began to visualize herself in connection with mental health practitioners being part of the solution, "I mean I really could see a mental health, a drug rehab place popping up here. Like maybe if I'm here longer, getting to know the ins and outs... maybe, somehow this kind of thing will start to come... Maybe, more psychologists will come this direction and will see that there is an opportunity."

Concern about the training of physicians to treat people with mental illness was expressed. One of the interviewees in the long term care industry offered, "I don't think that enough of the current physicians are really trained in treating mentally ill patients or demented patients"

And a nurse questioned the availability of mental health services for herself and her family if needed in the future. She spoke about the County mental health service and said they were inaccessible because of a long waiting list and because the people with severe

mental health problems have priority. She said, "I don't know if we (ourselves) had emotional problems, that we would have someone to go to and that we would have our health covered."

The geriatrician views mental health as a big problem. He sees poverty and mental health issues as intertwined. He knows that some of the patients he has diagnosed with major mental health disorders have been seeing physicians in the area for a long time. "It's a big problem! Many patients--many many. It's a low income group area with a lot of mental health problems. They're intertwined. I come from one of the poorest countries in the world. I know social economic struggles-- physical health as well as mental health. Many of my patients are bipolar, depressed. I have diagnosed so many schizophrenics this year which have been undiagnosed and they have seen many doctors for many years.

Adult Day Health Care Needed

The suggestion of adult day services, including day health and day care, were initiated by the health providers. One of the nurses had worked in the local adult day health care center four years ago. In the interview she talked about fiduciary abuse and care neglect by relatives prior to enrollment in the day services. "The part about the adult day health center which was really good was that at least that person was pulled out of that home (during the day) and assured socialization, assured getting their medications and assured having meals."

I asked a physician if money were no object, what kinds of services he thought should be added to the area. His response: "More elderly day care. One of the recent patients I've seen...she has high blood pressure and heart failure. She's taking a lot of canned soups so I ask her to make more regular food. But, I don't think she can get up

and walk around to make regular food, even if somebody brings groceries to her. She is able to have two good meals at elder day care. They can talk and chit chat—it's like a group thing. Probably, her quality of life will improve."

Transportation Needed

All health care providers expressed that more transportation for seniors would increase their likelihood of being able to age where they are. When one of the nurses was thinking about what she might need to age in the area she responded, "In an ideal world, I'd have a chauffer! I'd have—yeah, I'd have help to go anywhere and everywhere."

The lack of adequate transportation coupled with the distance seniors must travel to access health care was recognized by providers as a hardship for seniors and their caregivers. The deficiencies in public transportation with its minimal stops and long periods between pick ups were noted. "When you are traveling and you are 65 or over you may need a chauffer to drive you and you can't rely on public transportation. Public transportation doesn't always travel when we need to go someplace...and that can be a hardship on the caregiver also." And another nurse, "Transportation really is one of the biggest (issues in accessing care) I think."

There are no taxis, shuttles, or other door to door transportation systems for hire in the County. There is a free van that will transport people to health care local providers if they are affiliated with Catholic HealthCare West and the Adult Day Health Care Center provides transportation to their service only. There are no transportation services to specialty providers, grocery shopping, airports, or other destinations in or out of the County.

Help with Activities of Daily Living (ADLs) and Independent Activities of Daily Living (IADLs)

Health care providers said that assistance for elders with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) (R. A. Kane & Kane, 2000) was needed in order for them to remain where they are. ADLs are understood as bathing, dressing, grooming, toileting and transferring or ambulating. IADLs are understood as shopping, cleaning house, doing laundry, cooking, managing medications, and maintaining the business affairs of one's life by being able to use a telephone and manage finances. Health care provider study participants pictured themselves being in the community as an older adult, envisioning what they might need: "Somebody to do shopping. Somebody to help... if I want medications-- somebody to fill the medications just so I can take them appropriately. I'm not going to be able to read the bottles. And, you know, help me with just basic hygiene..."

One nurse who has been working in home health for "a third of her life," talked about how the government was cutting back and not paying for caregiving to the same degree they used to and that families were expected to provide in-home services that used to be reimbursable by Medicare. "What we're moving to, I feel, is that the government isn't paying for stuff anymore. Everything is cut back. More and more it's coming to you have to take care of your own family." She talked also about the difficulty of the caregivers having to hire home aides and to get the senior's transportation to get to the physician for things that used to be covered in the home health visits. "We had a huge drop in the number of people we saw. And, what that did is that families had to-- they had to take over either hiring caregivers or doing that caregiving themselves. And, getting

transportation in getting their family member out (to the physician)... I mean it was a shock."

This is an example of citizenship based on individualism. When the government excludes services previously reimbursed by Medicare, the responsibility falls to the individual (and caregiver) to procure the service or suffer the consequences. Individualism does not account for the financial and other resources an individual (read and caregiver) might not have due to life chances, as a family caregiver for example, with unpaid contributions made to the success of the labor market. On the other hand, in this example, citizenship based on interconnectedness would acknowledge those contributions with reciprocity of state programs with affordable elder programs as needed.

Fostering Aging-In-Place: Conditions That Already Exist

Support Networks

Health care providers, unlike the residents, thought of one factor that already exists that would increase the likelihood of an older adult in Timbertown being able to stay in the area: support networks.

One of the former adult day health center nurses said that familiar people is the main factor that promoted a senior's remaining in the community. She recalled an adult day health center participant who used to exclaim, "These are my people!" The nurse felt that this summed up the importance of familiarity regardless of the setting. It is a small community so that seniors, who have lived in the area for a long time, will recognize people in just about any setting. This nurse voiced what other providers expressed about the importance of familiarity in health care facilities. "When you know people, you can go there and one old person will know maybe two or three people who are taking care of

them because they knew them when they were babies. So there's just kind of, sort of continuity. They know 'their people' and that's important."

A social worker talked about how she and her neighbors are involved in the lives of many older adults in Timbertown. "If you live here as a senior, you are lucky. There is always someone watching out for you." She told the story about how someone's trailer crashed into the fence of one of her neighbors who didn't have the money to fix it and didn't want her insurance rates climbing because of a claim. "So, a group of people in the neighborhood got together and fixed her fence. The guy who owned the trailer was right in there with the rest of them."

Tipping Points to Relocation

This section focuses on factors that would cause an older adult resident of Timbertown to relocate from the perspective of health care providers.

Caregiver Burden

Most health care providers talked of the burden on the caregiver as a factor for relocation of an elderly Timbertown resident. This was often coupled with the lack of a registry of caregivers in Stone County or some other service that would help people find caregivers. The County's only home health agency had been sued about 10 years ago for informally recommending a caregiver who later was found guilty of fiduciary abuse. There is no infrastructure for bonding and formally referring in-home paid caregivers in the County.

One of the health providers in the Timbertown nursing home knows first hand of caregiver burden and why most people are relocated out of their homes and into their facility. "And there are a lot of times where the families just cannot take care of their

loved ones. They need a rest. It's gone beyond what they can do. They're just not capable or able, be it the stress or physical."

Several providers mentioned their experiences listening to spousal caregivers who are looking for residence for their loved one in a skilled nursing facility. When a disease is exacerbated, the doctor may tell the caregiver to look for a nursing home bed because the care may be too great for the caregiver.

One of the nursing home managers just received a call that morning "...the care has become so ...burdensome that the lady can't take care of her husband anymore. He happens to have Parkinson's. It's rapidly exacerbating. The doctor's advice was to look for future placement probably in two or three weeks. We have many that call and say, 'I can no longer take care of my husband. I am sick.'"

"So, a lot of times people stay at home as long as they can; and they try to be as independent as they can. And the families say, 'OK, this is good.' But then they have a fall and they are by themselves like that for days."

Another interviewee talked about the trajectory of the effects of a deteriorating condition on the caregiver individually as feeling overwhelmed and on the relationship between the caregiver and the loved one: "With a rapidly exacerbating disease like Parkinson's; caregiver gets ill; home health not available; falls & caregiver cannot pick them up; caregiver burnout; stops eating; caregiver and patient fall out of relationship (and the caregiver says he's) 'just a shell...no soul'; urinating on floor; endless screaming; afraid of house being burned down."

Another nurse commented on the difficulty of finding in-home aides and the liability associated with an underdeveloped referral system. "We have a caregiver list that our social worker has compiled which is a big can of worms and a big liability. We

have it because it is a necessity because how can you help people and get them resources if nobody is willing to have some kind of Registry-- if you call it that?" She confided that recently one of the aides they recommended filed for unemployment. The people who hired her had not paid into taxes so now there is a problem that is coming back to the agency who informally recommended the aide to the family.

Health care providers realized that when a family caregiver is burdened that other options to keep people in their homes can be expensive and that residents may have limited resources. One long term care nurse manager exclaims, "The more we can keep old people at their homes, content and in their familiar environment, the better off we are. Where-- where the heck is the money to do it!"

Finances

Besides the rarity of available trained and bonded home health aides and a way to find them, providers also point out the lack of financial resources of the residents of Timbertown. When I asked one former home health nurse if she recognized any kind of "one last straw" that would make it so that people cannot stay in their homes anymore, she responded "Finances." She explained, "Yeah, finances because there's a lot of very low income people in that area who are on a pension so they don't have enough money to spend for wages (for in-home help) whether it's two hours a day, let alone, 24 hours a day. Sometimes people will go without food or medication in order to pay a caregiver." She was asked, "Are you saying then that if people had in-home care—regardless of the finances now—that they might be able to stay in their homes?" She replied, "I believe so. Yeah."

According to the director of home health services, home health care for Timbertown and other residents in Stone County lost 25% of its revenue in 2003. There

was a 15% across the board Medicare cut in reimbursements for homecare throughout the country. In addition, rural areas had a 10% cut because additional travel money was no longer funded. Before that, the Balanced Budget Act of 1998 reduced reimbursement for many home health nursing services. So, residents of Timbertown, as did others, lost the benefit of many hours of nursing care that has not been replaced by Medicare reimbursement for a lower paid worker.

Not Enough Room in Local Skilled Nursing Facilities (SNFs)

There are currently two nursing homes in the County to serve a population base of over 40,000 people in an area big enough to fit Rhode Island, Massachusetts and Connecticut. For the past year, there have been no available beds in either of these facilities.

People, who have lived in Timbertown and want to remain in the community by going to the nursing home, will often be turned away. One local nursing home employee talked about a Timbertown resident who was desperate to find a place that would care for her husband. She had been his primary caregiver and called for help because she could no longer manage without it. "The lady says they can't live any longer like this. 'I need to get my husband into a nursing home.' And I didn't have the staffing at that time so I could not accommodate her. So I don't know what happened to that one."

The administrator of this facility said that the reason why they cannot keep aides on staff is that the (chain that owns the home) will not increase the salary of the aides. Therefore, even though they have the beds to accommodate the desperate pleas of people in the community, they don't have the staffing ratios to accommodate them. She explained that the wages for the health aides are not enough to retain them.

The closure of one of three skilled nursing facilities in the County two years ago, and the lack of adequate staffing has created a shortage of skilled nursing facility beds. When the nursing home closed, families remained in the area but seniors were forced to relocate to other counties and states. "We didn't have enough people available to care for them...put it that way...And, so, we had to turn a lot away. Henceforth, a lot of the residents there had to go distances, where facilities were available. They went 75 miles north or the same distance south to the closest cities. Some went even further.

The loss of this facility was felt by many people in the County. "Many of the family members were very heartbroken—I'll use that word—to have their loved ones so far away. But, there wasn't anything closer."

A financial administrator in the other remaining nursing home in the County said the facility has 30 beds, was filled to capacity, and there was not an available bed in the County. She relayed a story of a woman who could not care for her husband anymore. He had dementia. They had to not only turn him away but tell the woman that the only available bed for her husband was in a city—4 hours away!

Recall that many community residents said they liked the idea of going to the nursing home because for them it felt like a part of the community—it isn't really relocating. But, in fact, people need to relocate for nursing home residency because of a lack of access to professional staff. So, the company town mentality that would include the nursing home as part of the community is out of reach now and will continue to be with the aging of the County population. It cannot be matched by corporate America's medical industrial complex—nursing homes outside the geography of Timbertown community.

Ironically, the critical mass of staff that is "missing" is the professional equivalent of informal or family caregivers: the home health aides and the certified nursing assistant. These are the least skilled, lowest paid, but most family-like professional carers.

The nursing home providers and administrators spoke about the low reimbursement rates to rural facilities compared with urban ones as a cause for a lack of available beds. One explained that if the nursing home takes a loss between cost and reimbursement, then every bed that is filled could represent a loss to the nursing home. "Say it costs roughly $10,000 per month to care for someone in either of the two nursing home facilities. This facility is reimbursed $8,000 from Medicare. The Timbertown nursing home is reimbursed $5,000 because they are not attached to a hospital like we are." She explained further that the reimbursement rates in rural skilled nursing facilities are less than for urban ones. For example, the Medicare Reimbursement rate for the County is typed as "Rural" based on the wage index coded as 1.0915. This allows for a per-person, per Diem rate of $353.57 in the Timbertown skilled nursing facility. The same services in an urban skilled nursing facility are reimbursed $468.63. The per diem MediCal reimbursement rate for the Timbertown facility is $122.79; and in the urban area, it is $146.81.

The erroneous assumptions behind these differential rates are that the cost of living in a rural area is less than in an urban area so the wages must be less; and therefore, the reimbursement rates must be less. The reality is that the wages in Stone County have remained low while the housing prices and other costs of living have increased dramatically over the past two years. The reimbursement formula does not recognize this disparity or the consistently higher price of gasoline and groceries especially produce, between the rural study area and urban centers. Nor does it factor the increased travel

required to procure the necessities of daily life such as food, clothing, and household provisions. (Many travel 75 miles in either direction to the closest city for household goods unavailable in Stone County.)

This is another area where the political economy issues are evident. The children cannot afford to stay in the area because of the increased housing prices and the lack of jobs. At the same time, the long-term care health services need staff yet will offer only the lowest level of pay for this critical work of nurses' aides. So, the medical industrial complex exacerbates the demographic deficits, increasing the risk of unintended relocation of the older adults out of their community.

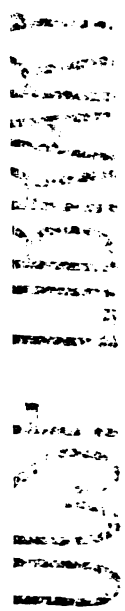
Beds/Services Not Available for HIV Patients and Active Drug Takers at local Timbertown Skilled Nursing Facility

Even if there were available beds, people with HIV in Timbertown cannot find a skilled nursing facility bed in the local nursing home. It is the same for alcoholics or active drug takers. Once they cannot take care of themselves in their homes, they will need to relocate out of the community. "If (there were) a different staff we would take everybody we could appropriately care for. There are many that I cannot appropriately care for who are alcoholics or active drug takers...HIV." The skilled nursing facility 10 miles from Timbertown does accept people with HIV. Due to the advances in treatment of people with HIV and AIDS, people are living into their geriatric years. Any elder in Timbertown with HIV or AIDS who requires nursing home care will have to relocate out of the community. In addition, elders who are alcoholics or active drug users currently must relocate out of the County for nursing home care.

Winter Weather Conditions

Two providers mentioned the difficult weather conditions as a reason why older adults would relocate. One, a chiropractor, bought her house from someone who had moved for that reason. "—you know the snow and just the living skills of dealing with that. Even the folks we bought the house from…'Oh, get me out of the snow here!' So I know the weather and just the physical maintenance –the physical living skills of winter. Some of my older women clients—you know they fall on the ice."

Another provider spoke about how some roads are not plowed and people have to wade for 100 yards above their knees just to get to a plowed road, "My road does not get plowed when the snow is deep, literally you hike out up to here (points to thighs) to the main road before you can, even really drive (laughing). It's only about 100 yards in snow, but that's a hike when you're 80 something years old!"



CHAPTER EIGHT: AGING-IN-PLACE AND RELOCATION FACTORS: GOVERNMENT/CIVIC LEADERS

This section continues to examine the factors increasing the likelihood for rural elders in this specific northern California former timber company town to age-in-place as well as the factors that precipitate relocation. It is from the point of view of government officials/civic leaders. This group consisted of five people representing federal, state, and local leadership who had senior services resource allocation authority. The language used to describe services was more technical and bureaucratic and less descriptive than the resident study participants. They spoke of home and community based services, aging-in-place, continuum of care, and other euphemisms not mentioned by residents and occasionally by health professionals.

Fostering Aging-In-Place: Services Needed, That Do Not Already Exist, In Order For People to Stay In the Area

Home and Community Based Services Including Transportation

When asked what services they thought were needed for seniors to be able to age in the area, three out of the five interviewees in this category mentioned transportation as currently inadequate and that better transportation would be needed for seniors to age in the area. "Going back to the old ways of watching out for your neighbors..." whereby her regional government agency could provide neighborhood linkage networking program. Picking up groceries and medications for neighbors were a couple of the ways people who do not drive could get some of their necessities. More broadly, she has plans to set up a non-profit corporation in order to receive funds from private philanthropies to reach some of the most remote seniors, in the service area, to bring transportation and other programs. The two other government officials thought door-to-door transportation was a

way to solve the problem. One mentioned a cab voucher program. That would be good but there are currently no cab services in the County. The public transportation system is inadequate with buses running infrequently with some stops over a mile apart.

One interviewee said that the amount of home health care currently allowed under reimbursement policies is inadequate and implied that longer-term in-home support was needed: "Home health care (is needed), and that's very limited-- very limited provision usually pretty short-term proviso I think."

One person, who in the past was a local administrator of funds for the Older Americans Act, listed a litany of needed services: "Oh, a variety of in-home services... Um, you know things that will (address) activities of daily living, respite care,... transportation...You will need more day health care--where they are also managing in-home services, home health services. If you can supply home health aides in home health services and then couple it with in-home services and good transportation..."

One regional state official believes that seniors are better off aging in their homes and that there is not enough in-home help to do that. She translated the mission of the Older Americans act into needing more services in the home, "And so I think that the Older Americans Act needs to be redesigned to focus more attention toward caregiving and in-home services. And I think that's going to be the trend. And, again that's our mission-- to keep seniors in their homes as long as possible with the greatest independence possible-- with dignity." She noted that she had heard that having enough in-home services is a statewide problem and not one that is unique to the area under study. "At our state meetings-- that's an overall, greatest gap in services-- is in-home supportive services.... throughout the state. It's a statewide problem." These would include home

maintenance and repair. "One of the most common unmet gaps in service is in-home help for house repair and yard help."

Leaders mentioned the growing need for more home and community based service workers and some of the reasons why they are not working in the capacity they were trained. One voiced concern that trained certified nursing assistants are leaving the profession because of burnout, injury, low wages (minimum wage prevails in Timbertown for this job title). "We've started the campaign-- and we are trying to affect legislation as well that there needs to be proper training and education and pay for care workers in California. A lot of hospitals and care centers here—they'll work people too many hours, and its awful conditions. And, so what's happening is nobody wants to-- nobody wants to stay in that position for long. And, there are minimal background checks to these care workers. There are so many problems in this field. What we have is a growing need for these workers-- for these care workers and a diminishing support. We say that we need them, but we pay them so little. We worked them so hard and it's not reasonable the amount of patients per worker load that they have. It's just not reasonable. And, they are getting hurt. They are getting burnout. They are leaving their profession. They'll do anything else but that. I hear that time and time again. They'll go work at the grocery store!"

In addition to paid caregivers, four out of five leaders interviewed mentioned access to nutritious hot meals as a needed service. Right now in Timbertown, there is only one day a month when a senior can get a hot meal at a designated site. There are home delivered meals, but they are considered by many to be nutritionally poor. There are no meals that address health conditions such as diabetes, hypertension, inability to chew and other intake specifications.

More Hospice Services Needed

There are two organizations in the County offering hospice services. One provides hospice care in-home and at their residential facility. The other provides in-home hospice care. One official felt that more education of all ages of people is needed to help them accept the dying process. "So I think that I would like to see more hospice type, educational, getting people away from the fear of death." The director of one of the hospices corroborated the need for more onsite hospice beds and the need for reimbursement of that service.

Senior Involvement in the Community

One civic leader voiced concern that there are not enough organized activities so that seniors can get involved in the community. "Like a volunteer program -- like a senior volunteer program."

Need for Geriatric Specialty Services

One government official gave an example of inadequate care of a patient with depression and made a case for more education of physicians and the public about depression. "And, what is happening, typically, is that seniors will start not being able to get a good night sleep and they'll start to feel run down. And, they'll end up in the doctors' offices. The sad thing is the doctors said, 'exercise more, don't eat before you go to bed, drop down your coffee.' He's not looking at what's the accumulating result of this person not getting enough sleep. 'And, come back six months later.' By then, his health is really deteriorating and he's giving him the same words. And so they're ending up depressed, and their health deteriorates. They're just on the downhill slide. So, we need to educate doctors-- make the whole public more aware of depression. Depression is common in rural and remote areas."

Fostering Aging-In-Place: Conditions That Already Exist

Social Network of Friends and Built Up Social Capital

One government official who now works for the federal government was ruminating on the idea of the strengths of the area where he used to live in Stone County, not far from the fieldsite. "It's the idea of neighbor taking care of neighbor...that's exactly what happened. So somebody's house caught on fire, you had 12 neighbors there to make sure that they got everything that was salvageable; leveling the land; and starting to build a house again. They didn't ask for much in return, and they got it done."

When asked if she would stay and age in the area or plan to relocate in her older years, one leader participant answered unhesitatingly, "Actually, if anything, I would stay because I know how important that friend-network is and how important that social capital is."

Home Modification Money Available

One leader said that he thought the home modification money available to the Timbertown residents contributed to the possibility that they would age in place. He listed some of the common home repairs his agency does for these residents. "So we end up dealing with senior citizens who need the ADA, the American Disabilities Act work done. Their bathrooms, their tripping hazards in the house-- we need to deal with. There is an uneven floor. We get into a house-- they have an old staircase they've fallen down-- We have to try to make that safe for them, you know-- hand rails, shower guards, special toilet additions that we deal with for people."

Seniors Trapped In Timbertown—Destined To Age-In-Place!

Only one of the five government officials interviewed lives in Timbertown. She said, "I like living in Timbertown. I feel safe here."

Two of the four officials who lived elsewhere regarded Timbertown older adult residents as people who would move out of the area if they only had the resources. Residents were regarded as "trapped"-- perhaps stuck-in-place. "How must the seniors feel trapped in a town-- you know they can't up and move to another place that's better? They are in this town with this environment that is different from when they moved there. How must they feel about that?"

Without the resources, these leaders regarded Timbertown residents as destined to stay: "You will not get somebody to move from Timbertown--I mean a lifetime citizen of Timbertown--who, who is low to very low income. They're not going to move to Stockton! They do not have it in their mindset that they can pick up and move and go somewhere else where it's cheaper or go somewhere else where maybe there's more medical--or maybe there's more specialty for their problems. That is not even in their thought process--from my experience with them."

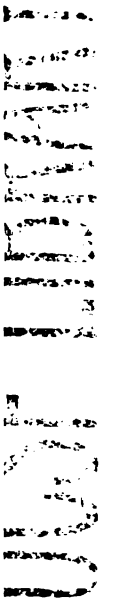
Tipping Points to Relocation

No Long Term Care Beds and Other Services Available

One government official believes that people relocate because more skilled nursing facilities will not open and the other services necessary for aging are not available in the area. "I think it's really a dim future (for the senior residents of Timbertown). I hate to say that for them. Because, it's realistic that 10 more skilled nursing facilities are not going to go up in Stone County, bottom line--they have to go to (a city 75 miles south) for medical help. They try to make do as long as they can, and then they end up either having to sell their place in Timbertown and have to move to where the services are available—(south) or somewhere else-- and that's devastating to them. You know the facts about people moving in that age group-- I mean, they die. And, and then they have

a broken heart because they are selling the house that means everything to them and they can't afford to buy the house where the services are available because the land is more expensive there. It's just an awful downhill spiral. I hate to be so negative."

Another leader expressed a somewhat opposing view, that people don't want to go to the nursing home and that they will move instead of doing that. She thinks that people will relocate out of the area if they are looking for a more intensive health care situation. "A nursing home is no place anybody wants to go anytime."



CHAPTER NINE: COMPARING AND CONTRASTING RESPONSES OF THE THREE PARTICIPANT GROUPS

Services Needed to Remain in the Area

The residents' perspectives on what services were needed in order for them to stay in the area as they age can be summed up as, "help in the home with daily activities that they can no longer do for themselves and transportation." Almost all of this care associated with help in the home with necessary activities that enable normal life to continue, especially but not exclusively in winter, is not reimbursable by health insurance: activities such as stacking wood, light yard and home maintenance work, assistance with personal care, and shopping as well as transportation for medical appointments, food shopping, and other activities. Residents stated that supportive in-home help and transportation were essential in order for them to remain in their homes. Some of this help is available through the State's In Home Supportive Services, but not everyone is eligible and those who are have often complained that not enough hours are allowed to provide adequate services. The highest daily rate for an IHSS home health aide in Stone County is $60.75, and that is for nine hours of care. A person has to be totally disabled to be allotted this number of hours.

Health care providers also thought that transportation for seniors was important. While health care providers did say that supportive assistance in the home was needed, the emphasis was on a multi-layered approach to care with a clinical focus. Providers saw the need for geriatric training for all health and mental health professionals providing an array of services from primary health care to mental health to urgent care. Their descriptions about a better quality of care that was needed for medication management were detailed and included an understanding of the tradeoffs between paying for food,

medication, and in home supportive care. They also noted that patients were being given medication instead of time interacting with the provider. Government officials also cited in-home supportive services as needed in the area, and two spoke about how this is a federal and statewide priority as well.

None of the residents mentioned assisted living as a viable option when they could no longer care for themselves in their homes. This may be due to the unavailability of this type of housing in their community. However, all of the health care providers saw it as an option, and two providers thought it desirable over residents staying in their own homes because they thought socialization and quality of care (including nutrition) would be better in an assisted living situation. The residents have not been exposed to a variety of assisted living options, and the few that exist in the County have had controversial quality of care histories. In order to remain in the community, the residents viewed the local nursing home, located in the heart of Timbertown, as a viable option over assisted living.

Other services viewed by health providers as needed for elders to age in the community included a senior center with an array of services from physical activities program to regular nutrition program, education of caregivers, and education about communicating with health care providers. None of the residents mentioned these as needed services for them to age in the community.

Changes in local emergency room services were mentioned by residents. A need for readily available emergency specialty care and a change in attitude toward older adults were mentioned. Concerning the latter, one patient was told that there were younger people who needed the care so he would have to wait. Health care providers and

government officials also spoke of ageism but framed it as a geriatric education issue for health care providers.

All three groups of the study participants felt that the mental health services were inadequate but only the health care providers felt that general mental health services were needed in order for the older adults to age in Timbertown.

Factors That Already Exist To Keep People in the Area

Only the residents mentioned a love of Timbertown as a factor keeping them in the area. They expressed a felt sense of "home" as they talked of fond memories of familiar places. Only one resident said she never liked the area because she missed the city. The perspective of most government officials was the opposite. They thought that any resident who had the resources to leave the area would do so.

Local involved family was seen by residents as the major factor that would allow them to age in the area. Some residents, especially Black and Hispanic elders, did not have local family they could count on as potential caregivers because they moved to find jobs, and their future living situation was uncertain. Local involved family was not a major theme mentioned by health care providers and government officials as a reason for staying in the area. These two groups emphasized the existence of a social network as a factor facilitating aging-in-place. Residents saw social network as important but not as important as local family in keeping them in the area.

Tipping Points to Relocation

Only the residents made a connection between the lack of available jobs and subsequent out-migration of their children and projected caregiver problems in their future. Racism was named often as a reason for a lack of availability of jobs to people of

Color who had to move elsewhere to secure them. However, the health care providers did recognize the lack of family caregiving as a potential tipping point to relocation.

Finances were mentioned by health providers as a factor for relocation out of residents' homes because it was thought they would not be able to afford in-home care. Conversely, some government officials thought that finances would keep them in their homes because they couldn't afford to move. Residents framed the issue of financial resources differently. Only one resident spoke about having long-term care insurance and cash savings for enough of her care. Other residents linked their long-term care to family caregivers either in or outside the area. If in the area, they planned to stay. If the family caregivers lived outside the area, they were planning to move or were hoping their family would move back to the area when they needed them.

The residents who spoke of the local nursing home as a long-term care option for them to remain in the community said they had friends there. While some of the health care providers thought the nursing home bed shortage in the county would only get worse, government officials thought that no one would choose to go to a nursing home. Health care providers spoke about many people needing nursing home beds who recently relocated because of the severe shortage in the County.

Health care providers were keenly aware of reimbursement issues and many spoke of the difficulties of maintaining staffing and services because of that. Health care reimbursement issues were mentioned by one government official as affecting the accessibility of services and not at all by residents.

Both residents and health care providers mentioned harsh winter weather conditions as reason to relocate; however, weather did not stand alone and was not a common reason for relocation.

The discrepancies among the three groups' perspectives, of priorities for aging-in-place and relocation factors, point to the need for communication among these stakeholders in a mutual, collaborative planning process. The findings in this research reveal that each group can teach and learn valuable lessons in moving toward a long-term care plan for rural elders and their families.

CHAPTER TEN: CONCEPTUAL AND THEORETICAL CONSTRUCTS

The aging-in-place of rural elders and the relationship between health care access and relocation has been the subject of very few studies.

This Chapter explores the theoretical and conceptual constructs of political economy of aging and "aging-in-place." Topics related to the importance of place are presented in summary but not in detail as the focus here is on the linkage between aging in place and the political economy of aging in a rural community.

Deconstructing the Concept of "Aging-in Place"

There are many definitions but the concept of aging-in-place that is generally agreed upon in the literature reflects Cutchin's (2001) definition where he says "aging-in-place" is a complex set of processes that is part of the universal and ongoing emergence of the person-place whole, and the creative social effort to reintegrate the whole in a meaningful way when problems arise, compounded by an older adult's evolving situation" (p. 1079). Akhter and Levinson (2003) define a system that promotes aging-in-place as one that will permit seniors to age gracefully in place even when in ill health, encouraging healthy lifestyles, providing expert coordination of care, involving family and friends, and making seniors informed, active participants in decisions about their health care. And Rosel (2003) simply says, "Research on aging in place appropriately emphasizes the value of familiar surroundings" (p. 77).

Aging-in-place is linked in the literature with elder adult population migration and demographic change and notions of place attachment (Cutchin, 2001; Morrill, 1995). Other authors link aging-in-place with assisted living (Chapin & Dobbs-Kepper, 2001; Gorshe, 2000; Tanner, 1991) and environmental home modifications (Clark & Davies, 1990; Gitlin, 2003).

Aging-in-place is seen as an alternative to residential nursing home care, as a new model for long term care in the United States. Most older adults in the United States prefer to age-in-place (Callahan, 2001). The public's negative view of nursing home placement has been confirmed by studies that find that an older adult functionally declines with each move (Marek & Rantz, 2000). In 1994, Goldberg wrote "expensive nursing facility care...is now perceived as care of the 'last resort'" (Goldberg, 1994), p. 157). Beidler & Bourbonniere (1999) developed a model for community-based care of rural elders that includes nurses as coordinators of a collaborative system of care.

The literature does not reveal who coined the phrase "aging-in-place" but the concept rapidly spread throughout the literature in the early 1990s and is used ubiquitously today. Policy-makers and the public alike have become attuned to the desire to age-in-place and have responded accordingly (Cutchin, 2003). Services for vulnerable older adults rapidly expanded in scope in the 1990s (Kane & Kane, 1995). To accommodate older adults' wishes to remain at home or "in place," community-based services for older persons have grown dramatically (Cutchin, 2003).

President Clinton's *Health Security Reform* (President Clinton, 1994) plan contained a well-designed long term care plan for home and community-based services systems. That plan did not succeed but it articulated "the belief that individuals should have autonomy and should be able to live as independently as possible for as long as possible" (p. 157).

In November 2000, the Agency for Health Care Research and Quality (AHRQ) sponsored the conference "Expanding Long-Term Care Choices for the Elderly." It was for senior state and local health officials from around the Country and was designed to offer a closer look at the dynamics of today's long term care system strategies by States

to shift funds from institutional to residential and in-home services in order to offer expanded choices to elderly people. Whitelaw, Vice President for Research at the National Council on Aging, stated, "More than 27,000 community organizations support aging in place within the home (Whitelaw, McNickle, & Blaser, 2000). These include senior centers, adult day service centers, Area Agencies on Aging, senior housing, meals program, multipurpose organizations, faith-based organizations. The services provided include home-delivered meals, case management, counseling and education, day care, respite care, health promotion and prevention, homemaker and chore services, information and assistance, personal care, socialization and support, and transportation. The conference brief goes on to state, "Most of these organizations and services are not considered 'health care' in many sectors, yet they are key to delaying disability and maintaining quality of life for older Americans" (Whitelaw et al., 2000, p.1).

Although Medicaid spends $41 billion on institutional care, only $11 billion is spent on home and community-based services (Whitelaw et al., 2000). The emphasis on aging-in-place, as reflected by the supporting constituencies, is not reflected in the government appropriations priorities.

Unlike the government, foundations are responding by funding projects that create and sustain community-based systems to replace institutional nursing care. Examples of several philanthropic grants for aging-in-place initiatives follow. The Robert Wood Johnson Foundation and others gave $460,000 to the VNA of New York to assess community preparedness to support older adults remaining in the community. The California Endowment awarded $2.5 million to the University of Southern California for start-up of a center focusing on housing-related concerns and successful aging. The Arlington Health Foundation gave almost a half million dollars to the *There's No Place*

Like Home project of the Area Agency On Aging offering elders access to a full range of needed services to stay in their residences (Grantmakers Health Resource Center, 2000).

A burgeoning private assisted living industry uses the concept of "aging in place" to attract the ever expanding population of older adults and recognizes that "Support of older adults' capacity to age in place is a core concept of the assisted living philosophy (Chapin, 2001).

Aging in place may require modification of the home. The study of home environments within the field of environmental gerontology (Gitlin, 2003) offers a unique setting for constructs of person-environment fit. For many people their homes represent proximity to social and heath care networks and, most of all, to familiar surroundings.

The Community and Home Injury Prevention Project for Seniors (CHIPPS), is a health promotion program of the San Francisco Department of Public Health. CHIPPS, one of the first home modification programs of its kind in the Country, has injury prevention as its goal. The program expanded with a grant from the National Institute of Health to University of California San Francisco, which has established a sub-contract with CHIPPS. This program called "The Safe Houses" project will assist seniors and their families to make minor home safety modifications which reduce or eliminate hazards in the home (Radetsky, 2003; Judith Barker, telephone conversation, August 18, 2004). Community and Home Injury Prevention Program for Seniors (CHIPPS) is an ongoing program of the San Francisco Department of Public Health and provides educational presentations, workshops, home assessments and small home modifications to San Francisco seniors. They advertise that all services are free (San Francisco Department of Public Health CHIPPS Program, 2005).

Market forces, evident by the plethora of advertising on the web and beyond have capitalized on the notion of home modification or senior housing as the vehicle for aging in place. Some for-profit entities are partnering with non-profit academic or local government groups to promote aging in place products or services. It is an issue around which public and private partnerships have been forged over the last decade. For example, Slippers Corporation (specializing in senior housing) co-sponsored The Aging in Place: Planning for the 21st Century conference with the National Resource and Policy Centre on Housing and Long Term Care at the University of Southern California. Dr. Pynoos, key speaker, said what much of the literature purports, i.e., that housing and support are the two key elements of aging in place (Pynoos, 1997). Slippers Corporation "Flexhousing" was highlighted at the conference.

The National Reverse Mortgage Lenders Association publishes an Aging in Place Guide "In Partnership With the National Advisory Council for Aging in Place" The guide's first sentence is "One of our greatest fears, as we grow older, is the prospect that one day we may have to leave our home...the source of our memories...comfort...our sense of control" (Pynoos, 1997, p. 1) Reverse mortgages are controversial and may not be well understood among elderly people and may not be for everyone.

There is a Certified Aging-in-Place Specialist (CAPS) program with the tag line "Houses for Living. Homes for Life" (National Association of Home Builders, 2004). It was established in collaboration with AARP to provide "comprehensive, practical, market-specific information about working with older and maturing adults to remodel their homes for aging-in-place" (p.1).

The value of aging-in-place to the older adult is to retain familiar surroundings including their home and pets, neighbors, social support networks and health care

providers, and way of life. It may also keep the family traditions intact and retain the "place" of the older adult as matriarch or patriarch within the family. Trips to grandma/grandpa's house for summer vacation and holidays may give them a sense of belonging by being able to provide a place for family celebrations and enjoyment. Such would not be the case if grandma or grandpa lived in an assisted living facility with rules and maybe a room where family were asked to pay for their stay. In addition aging-in-place results in the avoidance of the stressors associated with relocation.

The dilemma of aging in place in a rural area may mean traveling long distances for needed health care or foregoing those services. Aging-in-place in a rural area may mean the mobilization of years of building up social credit (Cannuscio, J., & Kawachi, 2003) with members of the community and being able to live in a slow-moving, often beautiful area without having to relocate. It would mean the retention of familiar life-worlds and day-to-day routines such as meeting places, health care providers, and agreed upon ways of joining-up with peers.

Importance of Place

Writings on "place" recognize the importance of place (Basso, 1996; Casey, 1993, 1997; Malpas, 1997; G. Rowles & Ravdal, 2004; G. Rowles & Watkins, 1993; G. D. Rowles, 1978; Tuan, 1975). The influence of cultural geography of health care on relocation decisions (Gesler, 1991) informs the proposed research. The tensions between the need for health care services and the importance of place-continuity for rural elders are integral to the conceptual framework for this study. Gesler maps cultural geography of health care theory as structuralism (social context of human interaction) and humanism (importance of place and meaning in every day life).

Cultural geography of health care recognizes forces within society that shape human actions (Gesler, 1991). "...The possibilities for positive human relational practices in health care settings and in public health policy are structured not only by physiology,...and market economics, but by the spatial circumstances of those settings and the larger social geographies in which policies are situated" (Malone, 2003, p. 2243). Some of those forces include Medicare reform laws, political historical residue of the company town power elite shaping expressions of the political will of the people and their view of authority and political power contrasted with their own.

The "places of health" (Casey, 1997) and health care provision matter (Cartier, 2003; Malone, 2003). Frequent relocation of the elderly people can have negative health consequences (Cartier, 2003).

Casey (1997) talks about "lived places: places regarded...as loci of intimacy and particularity...They are known through customary bodily actions" (Casey, 1997, p. 145). Tuan (1975) refers to habit fields or places of deep ecology. Closely linked, he speaks of fields of care that human beings establish. And "unlike public symbols (or places), fields of care lack visual identity" (Tuan, 1975, p. 241)

Political Economy of Place

Globalization brings to the forefront the importance of place in rural areas where in and out-migration of workers follow industrial patterns of movement. If places are thought of as settled, coherent worlds of their own, then they are surely under challenge in an age when the importance and uniqueness of place is hard to sustain.

Geography dominated the decisions that gave birth to company towns (English-Lueck, 1996). Acres of forested land were the necessary natural resource required by the timber industry. Geographies with coal or gold rich earth and snow-capped mountains

determine the nature of extraction industrial activities. Regardless of the type of resource, geographies with an abundance of natural resources are fertile grounds for the establishment of a company town. Graham trenchantly points out, "Key to such towns are the power relations. Company towns extend direct or indirect control into the realms of local government, housing, schools, health facilities, churches, utilities, recreation, police and fire protection and local media" (as cited in English-Lueck, p.1).

Political Economy of Rural Health and Aging

Nationally, a significant body of research has found that rural elders have lower incomes, poorer health status; fewer housing and transportation options; and less well-developed health and social services systems than their urban counterparts (Gamm et al., 2003; Krout, 1994; National Advisory Committee on Rural Health and Human Services, 2003, 2004; Streubert & Carpenter, 1999). It is not entirely defined what the particular forces are that shape health care access and the decision making processes of whether to age-in-place or relocate. This research investigated those forces.

Evolution of the Political Economy Theory

This approach attempts to understand the condition and experience of aging drawing upon multiple theories (conflict theory, feminist theory, critical theory, cultural studies) and levels of analysis. The political economy of aging theory is a third generation theory of social gerontology (Bengtson, Burgess, & Parrott, 1997). The political economy of aging (Estes, 1979, 2001; Estes, Biggs, & Phillipson, 2003) is rooted in (1) conflict theory, contending (and following and elaborating on Karl Marx, Max Weber, and Antonio Gramsci) that society and its social order are held together by dominance of certain groups and structural interests over others (Collins, 1988; Dahrendorf, 1958; Weber, 1946); (2) critical theory, which is "designed to criticize and

subvert domination in all its forms" (Bottomore, 1983); (3) feminist theories, which emphasize "the importance of gender by examining the gender biases in social policy on aging (Estes, 2001, p. 37); and (4) cultural studies, which aim to understand and expose the mechanisms of power relationships and examine how these relationships influence and shape cultural practices (Sardor & Van Loon, 1997).

A unifying tenet in the Estes model is that the problems faced by elders are socially constructed and result from societal conceptions of aging and the aged (Estes, 1979, 2001). Those societal conceptions view old age as a disease and contribute to the marginalization of the aged. Corporations, engaged in the production of goods and services, have built a multi-trillion dollar industry on the commodification of the process of aging. Elderly people are told what they need by "health" professionals, who have been trained in the disease model of aging. In addition, health care reimbursement policies yield to powerful corporate-funded lobbying interests which may not improve the health outcomes, including quality of life, of the older adults. These processes stigmatize the aged and create a societal environment where domination by corporate interest groups is inevitable. Furthermore, it is generally known that older women as a group have lesser access to financial resources in old age than men and the gender bias in some social policies further exacerbates these inequities. In addition, the stigmatization of the aged can affect their societal relationships as other generational groups perceive that there will not be enough after the aged have consumed all the goods and services for themselves.

Theoretical Model of Social Policy and Aging

The Theoretical Model of Social Policy and Aging: Estes Version (Estes, 2001) depicted in Appendix D page 177, is a multi-level analytical framework. To summarize,

there are three facets of this model: the individual citizen and the public as a collective whole are at the center of the model and subject to the state, post industrial capital, and family/sex/gender systems that operate within the cultural ideology realm of race/ethnicity; gender; age; and class (Estes, 2001). I have chosen this model for this study because the conflict and critical theoretical constructs are appropriate for the examination of the power relationships of company town society and their influence on health and aging choices available to those former company town workers. This model also employs the aging enterprise and the medical industrial complex as central characteristics, both of which lend further dimension to analysis of data in light of the research topic of this study: health care access and other factors influencing aging-in-place or relocation in old age.

The aging enterprise and the medical industrial complex have been produced as the consequence of the complex relationship between postindustrial capital and the state (Estes, 1979, 2001; Estes et al., 2003). The medical-industrial complex and the aging enterprise refer to the multi-trillion dollar health care industry. It includes all of the physicians (salaried and fee for service), nurses, all other health care personnel, hospitals, nursing homes, managed care organizations, home health agencies, community-based services (senior day and day health centers, nutrition meal services, primary care health and social service centers), hospice, research organizations, lawyers, administrators, marketers, planners; long term care (personnel, buildings, and other holdings), drug companies, supplies and supply companies, real estate, construction and Wall Street investment capital. As the Ehrenreichs (cited in Estes, 2001) note, "the structure of the medical industrial complex suggests that the primary function of the health care system is

not the delivery of services but, rather, the pursuit of profits, with secondary functions of research and education", p. 166).

The State

The state, composed of social, political and economic institutions including all branches of the government, is a key element in gaining an understanding of aging policy (Estes, 2001). In capitalist societies, private wealth finances the state largely through taxation and the state supports the interests of private capital and private property as the basis for economy. As shown in Theodoulou & Cahn (1995, p.77), C. Wright Mills speaks of this phenomenon, "The modern corporation is the prime source of wealth, but, in latter-day capitalism, the political apparatus also opens and closes many avenues to wealth." The state, in turn, has interest in facilitating growth of private capital (Giddens & Held 1982 as cited in Estes, 2001). Private capital exerts influence over the health and social services agenda because distributive resources by the state are dependent on success of private industry. Domestic social spending for the needs of income and health compete with other political priorities. Laws reinforce industrial domain over the private lives of individuals and families and do not protect those people from societal and economic collapse in the aftermath of corporate flight. For example, laws do not hold industries accountable for the sequelae of abandoning communities with resource extraction dependent economic infrastructures such as the one under study.

Decisions in the allocation of resources controlled by the state and the private economy are political (Estes, 2001). The political and economic struggles around the social welfare resources allocations reflect a tension between support for capital profit rather than support for social welfare programs (Estes, 2001). The allocation of funds to uphold the rights of older adults to age in their homes does little to grease the private

profit making machinery of the aging enterprise. There are competing interests between profit capital and the rights of older adults to continue to live in their homes with the social programs essential to support that choice. Spending funds on social programs to pay for the wages of in-home support workers to prevent older adults from being subjected to the increased risks of morbidity and mortality associated with relocation and potential homelessness does little to ensure maintenance of the flow of capital for profits and investments. Based on the relationship between the functions of the state and profit building enterprises, there appears to be little incentive for the allocation of resources to fund such social welfare programs, unless they are commodified or otherwise advance the interests of private capital, the medical industrial complex, and the aging enterprise.

As cited in Estes (2001), Alford and Friedland, and O'Connor explain that the state has the power to: 1) allocate and distribute scarce resources to insure survival and growth of the economy; 2) mediate between different needs and demands across different social groups; and, 3) ameliorate social conditions that potentially threaten the social order. Since some interests are able to impose their views on other, the actions of state policy makers are highly consequential for old people and their families (Estes, 2001).

There are two major opposing models of citizenship that are relevant to this dissertation. One is based on individualism in which citizen rights are based on labor market participation and property. The opposing view is based on social rights with recognition of life course interdependence (Estes, 2001, 2006). The life chances of any individual traversed in a life course determines access to social and financial capital resources in old age. The view of citizenship rights in old age based on interdependence recognizes a life course of interdependence. This takes the form of childrearing, household services, and care of family members. For some, these activities preclude

many, usually women and people of lower social class, from participating full time in the labor market, excluding them from pensions and other retirement benefits for their use in old age. This recognition of life course interdependence leads to a sharing of resources in old age and may be the reason why there is a reluctance of such recognition. As Twine notes, such an acknowledgement would carry the responsibility of compensation to those who have borne the cost of progress (as cited in Estes, 2001). Such an ideology would lend logic to the creation of policies to provide the requisite resources to level the health and human services playing field and other compensations to rural older adults who built the accumulated wealth of corporations with their labor.

Postindustrial Capital

Currently, postindustrial capital refers to concentration of corporate capital, enterprises that are under the control of a few. Postindustrial capital and its globalization affect old age policy in many ways in the U.S. Privatization, the hallmark of globalization, threatens the existence of state programs that have been designed and financed by the people to insure income and health care to citizens upon reaching the age of entitlement. Globalization has supported capital flight of the U.S. for profit corporations, a diminishing tax base, outsourcing and corporate loyalty over nation state loyalties. Globalization has supported not only an escape from taxation on corporate capital but threatens the welfare state provisions that have been designed to provide for the future of older persons. Globalization has created a form of financial imperialism with few controls on labor practices (Estes, 2001).

Post industrial capitalism and informationalism frame the issues and definitions of national policy agenda on aging. Recall the privatized advertising campaign against the Clinton Health Care Plan that would have insured every American for health care. This

campaign ran on the ideology of choice and played on the fears of the American people that they would loose their choice with a national health plan. This campaign was funded by private dollars, whose interests were ironically protected by the state.

Research shows that in the United States as the powerful wealthy few in various geographic locations imprinted entire communities with their influence. Consider, for example the classic ethnography called "Middletown" of Muncie Indiana. The researchers, Helen and Robert Lynd (Lynd & Lynd, 1968) illustrated the domain of influence and the grip of control the Ball family (of Ball mason jars) had on the people of the town in the early to mid 1900's (the same time period of the Timbertown logging height):

> If I'm out of work I go to the X plant; if I need money I go to the X bank, and if they don't like me I don't get it; my children go to the X college; when I get sick I go to the X hospital; I buy a building lot or house in an X subdivision; my wife goes downtown to buy clothes at the X department store..." (Comment by a Middletown man, 1935) (Lynd & Lynd, 1968, p.42).

Family and Sex/Gender system

Sex and gender and family systems are issues in political economy model because state policies reflect the traditional role of women, sometimes referred to as the patriarchal structure of family life (Pateman as cited in Estes, 2001). The greater economic dependency of women on the state in the institution of old age is well documented. Older women's greater vulnerability has been attributed by many scholars to their subjugation as women in the broader society (Dressel, Minkler, & Yen, 1999; Estes, 1979, 2001; Estes et al., 2003; Holstein, 1999; Minkler & Stone, 1985). According to Estes, the experiences of gender and old age are socially constructed in accord with how aging and old age are constructed in society (Estes, 2001). Influence of family, labor market, and public policy shape the disadvantaged status and health of many

women. The feminization of poverty in old age necessitates the examination of interlocking oppressions (Collins, 1990) of race, gender, class, and distinct life experiences that produce the marginalization of older women. This is also known in gerontology as the double or multiple jeopardy (Ferraro & Farmer, 1996). Significant sources of this economic disparity are the differential caregiving responsibilities, work-related benefits between men and women, and marital status. Women's dependency shifts in old age from the man to the state (Brown, 1995), particularly in the form of dependency on state programs such as Social Security, Medicare, and Medicaid. By the time a woman is the age of 65, she is almost twice as likely as her male counterpart to be poor or near poor (Estes, 2001).

The Medical Industrial Complex and the Aging Enterprise

The medical industrial complex and the aging enterprise are represented in the Theoretical Model of Social Policy and Aging: Estes Version (2001). Estes theorizes that the relationships between the state, postindustrial capital, the family and the sex/gender system have conjointly produced the medical industrial complex and the aging enterprise (Estes, 1979). Actors engage in struggles with one another and resultant policies can be traced to the dominant player. The needs of the elderly have been transformed into commodities for specific economic markets. Economic products, not social good, have become the object of medicine within the commodification of heath care (Estes, 1979; 2001; 2003). The needs of the elderly are processed into profit-making enterprises, medicalizing old age and increasing the dependency of the elderly (Estes, 1979; 2001; 2003).

Interlocking Systems of Oppression

Patricia Hill Collins (1990), Black feminist theorist, distinguishes between seeing systems of oppression as interconnected or seeing them as distinct. Within this theoretical framework of political economy and social policy and aging there are interlocking systems of oppression of race, ethnicity, patriarchy (sex/gender systems), class, age, state, capital, labor, ideology, aging enterprise, medical industrial complex, politics, economics, and culture that have multiplier effects (Estes, 2000). A critical perspective on social policy and aging requires a life course perspective when considering "life chances" and the access an individual or group has to health care and health insurance. This approach links access to health care with work across the life course (Estes, 2001). These systems are "processed through gendered institutions, including the state, the economic system, and the sex/gender and family system" (p. 134). The empirical validity of cumulative advantage/disadvantage theories of Crystal and Shea and O'Rand have been demonstrated (Crystal & Shea, 2003; O'Rand, 2003).

Social Class

Social class is a key element in the political economy model, and it is reflected in power struggles over the control of policy, resources, and others in society. Estes (2001, 2003) argues that policy in the U.S. is based on a system whereby benefits are distributed on the basis of legitimacy (with the poor often blamed as undeserving) rather than need. Pre-retirement class (labor force conditions, individual life, and the class stratification of work and society that significantly affect one's "life chances") is a major factor affecting post retirement conditions of the elderly (p. 14). Social class, race, ethnicity, and gender are directly related to resources on which a person can draw in old age (Estes, 1984; Estes, Gerard, Zones, & Swan, 1984).

It is widely accepted that social class affects health outcomes (Singer & Berkman, 2001). Older people are more likely to have a healthy lifestyle if they have higher incomes and are more advantaged in former occupations and have higher education (Kendig, 1999). "Activity is facilitated by economic resources and education appears to be associated with both knowledge and motivation" (p. 83).

Social class and gender are linked to poverty in old age for women (Minkler & Stone, 1985). As Estes soberly illustrates, older women are more likely than men to live in poverty, to have less access to a secure retirement, and to pay an increased percentage of their income on out-of-pocket health care costs compared to older men (Estes, 2001).

Women also bear the burden of caregiving and the multiple costs associated with it (Dautzenberg, 2000; Erera, 2002; Stuckey, Neundorfer, & Smyth, 1996). In *The 2006 Report to the Secretary: Rural Health and Human Service Issues* (The National Advisory Committee on Rural Health and Human Services, 2006), a special report on family caregiving states that the majority of family caregivers are female between the ages of 40 and 70 with the average being 46. The impact of providing in-home, long-term care includes "Isolation, resentment, guilt, anger and financial difficulties in addition to missed work..." (p. 43). One out of three caregivers reports their own health to be fair or poor. The Administration on Aging (Administration on Aging, 2005) reports that 29 percent of caregivers report physical or mental health problems and that one-third of all caregivers employed while involved in caregiving gave up work either temporarily or permanently, or took a leave of absence.

Race and Ethnicity

As Williams points out, race and ethnicity are related to global processes of imperialism and immigration (as cited in Estes 2001). Poorer health outcomes have also

been linked to race and ethnicity (Finegold & Wherry, 2004; Samuels, Probst, & Glover, 2004). Estes (in press) refers to the affect of race and institutional racism on the treatment of certain populations and their attendant lack of access to health care resources. Add to that the sequelae of corporate flight as industries abandoned societies without a plan for them in their old age, leaving entire communities without the resources to age in their homes and forcing their children of working age to seek jobs outside the geography of family living activities.

Ideology

Ideology, a system of beliefs reflecting social position and structural advantages of their adherents, is a defining element in issues of aging and in determining how policies address aging in society (Estes, 2001). Ideology as culture product represents sets of beliefs in favor of one group over another. As such, there are dominant, competing and repressed structural interests. The dominant seeks to impose its belief system as the hegemonic cultural ideology. Alford (1975) defines these three giving examples of their characteristics. The repressed structural interests are, "those of the 'community population' – the varied interest groups of the rural and urban poor...have no social institutions or political mechanisms in the society (to) insure that their interests are served" (p. 15). For the purposes of this study, the aging rural former mill workers form the repressed group because their interests to be able to age in their communities are not being served. "Dominant structural interests are those served by the structure of social, economic and political institutions at any given time" (p. 14). The interests of the timber industrial complex are the dominant structural interests in this study. They do not have to continually organize to protect their interests. The institutions are doing it for them, constantly reinforcing their dominance.

Challenging structural interests, "those being created by the changing structure of society," (p. 14) in the timber industry have historically presented themselves by environmentalists intent on preserving old growth forests for endangered species' nesting and other environmental interests. However, the industry has maintained its dominance by shifting production to other global sites, where labor is cheaper, both within the United States (to southern regions) and then to world markets (primarily Malaysia) (Dallmeyer & Ike, 1998; Karliner, 1997; Miller, Latham, & Flynn, 1998). With the technological advances allowing for the replacement of jobs with machinery coupled with financial incentives of the globalized market, timber industrial profits continue to climb even in the face of environmentally mandated decreases in board-feet production. It is at this point that the relationship between the state's powers to protect the repressed structural interests of the aging mill worker intersects with the ideology of interdependence by way of corporate responsibility to the people who over their "life course" have built their profits. This will be further analyzed in Chapter 11.

Separatism

In his now classic book *The Pursuit of Loneliness*, sociologist Phillip Slater (1970) spoke of American culture at the breaking point, and one that willingly, senselessly embraced alienation and disconnection.

In 1979, Estes wrote in her book *The Aging Enterprise* about the ideology of separatism. Old age is seen as a problem in society: that the elderly have "special needs," and that these needs separate them from the rest of society. The solution to old age, given this line of thinking, is to separate the aged from the rest of society with the provision of separate services and aging-only policies.

This ideology persists today. The ideology of conflating democracy and capitalism, as if they were one and the same, contributes to the current U.S. policy environment in which there appears to be a domination of property rights over citizen rights. In the case of Social Security privatization, for example, the dominant political and economic groups are comprised of an anti-state constituency in favor of privatizing. The competing groups are those who support social insurance, collective values, and value for government service and administration. The repressed groups consist of those who have to struggle to have their voices heard—those who are most socially disadvantaged such as minorities and poor women who would ultimately lose if social security were privatized (University of California San Francisco, S219 Social Policy and Aging Class lecture 4/6/2004 by Carroll Estes; Estes, 1983).

Public Image of Health in Old Age

The public image of health in old age can be very discouraging. There may be a belief that because old age is associated with illness and disease that quality of life must be seriously compromised. Research is heavily based on clinical population samples which present the more difficult aspects of aging. Providing and financing health care for the elderly is presented as identifying and treating illness and disease which is "breaking the bank" rather than identifying and providing for the factors necessary for promoting good health. Such factors may include adequate income, housing, and availability of services that would allow people to have their choice of living environment.

Conclusion

The purpose of this chapter has been to explore theoretical concepts most salient to the topic of aging-in-place or relocation of rural elders who have lived in a company

CHAPTER ELEVEN: POLITICAL ECONOMY ANALYSIS AND DISCUSSION OF STUDY FINDINGS

The political economy approach attempts to understand the condition and experience of aging drawing upon multiple theories and levels of analysis. The political, social, economic, racial, and rurality issues of this study are more aptly described and analyzed with their complex patterning of response using this model. The characteristics of this community, having been a company town, have created more complexity in understanding the reasons why people over 65, who have lived for more than 30 years in this rural area, will age in this place or relocate. This section will employ political economy as a macro theoretical framework within which to analyze rural health and aging and the characteristics of the political, economic, and other forces shaping aging-in-place decisions.

Political Economy of Place

Globalization of the markets for timber caused fluctuations in prices at the same time as technological change reduced the demand for labor in local rural economies reliant on extractive industries (McLaughlin, 2002). Such is the case in the research field site where automation of lumber mills as well as the industrial patterns of movement in the 1980's, and subsequent layoffs caused a mass out-migration of the working age group seeking jobs elsewhere. If places are thought of as settled, coherent worlds of their own then they are surely under challenge in an age when the importance of uniqueness of place is hard to sustain (Massey & Jess, 1995). This has been the struggle for the people of Timbertown who are surviving the economic crisis of the withdrawal of the timber industry from the place of their living. While the economy is shifting from one based on resource extraction to recreation and retirement, it is unclear if the people of Timbertown

will benefit from this turn. Many have left in search of jobs, often leaving older residents behind.

For some of the older residents of Timbertown, the importance of home as a geographical place is superseded by the ability to function in everyday life which may necessitate relocation of home. Relocation to the place of family, usually adult children who have left the area for jobs, will result in a move away from the geography, culture, social networks, familiar places and land known as home.

In the former company town of Timbertown, California, the social characteristics that have given form to the aging of community residents are based on capitalistic ideologies of accumulated wealth using human capital for labor. The entire society which included family structure; the health and hospital systems; commercial enterprises owned by the company including food and clothing stores; the jobs with wages and benefits; infrastructure of governance including emergency health and fire fighting; financial beneficences to schools, churches, and recreation center; and, later, the ownership of the housing changed when the company left the area. Geographical relocation of job-seeking, working age adults and their children resulted in intergenerational discontinuity. This was especially true for families of Color since it was more difficult for them to find jobs than their White counterparts. Adults near retirement age were forced to take early retirement without the availability of other jobs, and, often resulted in a loss of full pension and other benefits. As referenced in the findings section, Long Bell sold the company to International Paper Company (IPC) because the executives of Long Bell were ready to retire. IPC then dismantled the company town and closed the mill. Overall, corporate flight of the timber companies, without a transition plan in place, left the community without financial, social, or political

capital to create an infrastructure for health, jobs, banking, and other services dismantled by the company. Intergenerational continuity and the passing of family customs and enjoyment of familial relations had been permanently disrupted.

Now in their old age, these former company town workers are expected to live without adequate societal, and in many cases personal, resources for their care. An important ethical issue arises since the residents of this town built the accumulated wealth of elite individuals, as well as their industry; they have a right to age in their place of choice.

The needs, as expressed by residents, that if filled would allow them to age in their homes, are not elaborate, but they are not entitlements under Medicare or the timber industry, into which many have contributed for years. Assistance with tasks of daily living such as stacking wood, household and yard maintenance, grocery shopping, and other activities mentioned by community residents, are not thought of as health care reimbursable, nor are they included in any benefit from their years of work for the timber industry. They are however expressed as needed in order for seniors to remain in their homes. The resources for these services are to be borne by individuals without pooling the risks with other citizens and without any share borne by the industry that benefited from their younger years and in some cases from the giving of their health and limb.

The State

As introduced in an earlier chapter, there are two major opposing models of citizenship relevant to this dissertation: one that espouses individualism with recognition that citizen rights are based on labor market participation and property. The other emphasizes social rights and espouses the ideology of interdependence recognizing life course, including old age, interdependence. There is a reluctance to accept our

interdependence because such recognition carries an acknowledgement of compensation to those who have borne the cost of progress (Twine as cited in Estes, 2001).

Such an ideology of interdependence would provide rationale for leveling the playing field for human services delivery such as adult day health care and other Medicaid waiver programs by providing adequate reimbursement to residents in rural areas. From my own experience, building a rural service delivery program, such as adult day health care, to a sustainability level may take 4 to 6 years compared to 1-2 years in an urban setting. The sparse population base coupled with the number and expense of professional staff required by regulation increases the risk of program closure before reaching that point. Current policies do little to account for or ameliorate the particular problems and the inequities of rural life.

Policies originate at the federal, state, and local levels. For example, on the federal level, Medicare reimbursement policies for skilled nursing facilities vary according to urban and rural areas with wage/price index factor being the variable that determines the rate. The wage/price index factor is lower for rural skilled nursing facilities; consequently, in the area under study, one out of three nursing homes closed with an additional slated for closure. There would be only one remaining for the entire county.

State policies, governing MediCal reimbursements, do not recognize unique factors of rurality in reimbursing local programs such as Adult Day Health Care designed to keep people in their homes and out of nursing homes. Such a program requires that the daily fee will cover transportation but does not recognize that transportation expenses are often higher due to the longer travel distances and specialized vehicles required to travel the rugged terrain. Regulation (Title XXII) required staff who may not live in the area and

are difficult and expensive to recruit, relocate, and retain. Additionally, the sparse population base of rural areas forces community-based agencies to carry debt for years until self-sustainability is reached. This puts many agencies at risk of closure before reaching solvency. In urban areas, with a higher density, colleagues generally experience a period from start-up to self sustainability of less than 18 months.

Local County policies govern in-home supportive services (IHSS). Stone County cannot afford to add dollars to the minimum wage of IHSS workers or to fund training programs for them in the special care of the elder at home. This exacerbates an already unstable, untrained workforce. Pension policies of the timber and railroad industries, having employed this generation of area seniors, were discriminatory toward workers who became ill or were laid off (secondary to corporate collapse) before their full retirement time had passed. Data from this study demonstrates that this was true even though those illnesses are often attributable to workplace exposure.

These examples serve to illustrate the differences in services funding and delivery policies under the two opposing models of citizenship. Under individualism the role of the state is to further and protect the accumulated wealth of the industrial elite. Individuals are responsible for their own health care based on labor market participation. In other words, people who have had the resources to save money for their long term care can afford to pay privately for the care they need. Under the model of citizenship espousing interdependence, which recognizes the contribution of individuals over the life course, policies would be adjusted to include service delivery to all persons eligible on a health assessment basis and to all communities regardless of their ability to sustain such a service based on geographical differences.

Study participants: residents, health care providers, funders and government officials all reported upon the negative consequences of the rural sparse population base for the high failure rate of health and human services economic viability in Timbertown and the rural environs. Yet federal and state policies, based on urban per capita allocation of funds, prevail. Rural-blind policies perpetuate a system whereby attempts to level the playing field such as rural add-ons for homecare, rural hospitals and provider reimbursement adjustments, for example, are some of the first resources eliminated with state and federal budget cuts.

There are no state policies to buffer the economic and social losses of the timber corporation's capital flight, leaving members of the oldest generation to fend for themselves, dependent upon individual resources. The state subsidizes industries to enter locales and strip the areas of natural resources. Chad (1995) has summarized some of the ways the government subsidizes the timber industry:

- The US Forest Service (Service) does not charge its customers for most of the $100 million a year it spends to build and maintain its 360,000-mile road system.
- A provision in the 1987 tax reform bill exempts publicly-traded timber partnerships from paying corporate taxes.
- In 1991 a congressional oversight panel found that companies were cutting trees at both higher volume and value than they (the industry) were paying.

From 1987 to 1992 while the Forest Service was losing $1.5 billion on timber sales, the timber industry contributed $6.9 million to congressional candidates. Attempts on the part of some congressmen to sponsor bills to cut federal subsidies to the timber industry have been met with defeat. Such is the case with the Public Resources Deficit Reduction Act (HR 721). This would have cut federal subsidies to natural resource industries by $3 billion.

Corporations are seduced to leave a locale when forests are stripped of their natural resources with the promise of similar or more subsidies in areas replete with new resources. They are promised new roads, paid with taxpayer dollars, below value timber, and free reign to export that timber to Asia or another area where labor is cheaper thus not only stripping that area of natural resources but also the jobs to process them (Southeast Alaska Conservation Council, 2003).

The state's dereliction of duty to develop policies that insure the rights of people in their old age has left the most disadvantaged without social and financial capital to meet their needs while industries have profited from the labor of area residents. The sociological theory of class dominance provides a framework within which to view this phenomenon. Marx, in his Economic and Philosophic Manuscripts of 1844, speaks of the poverty that befalls the laborer as he produces more wealth for the (company) owner. The owner in turn is interested in accumulating wealth from these labors, and not in providing for the survival of the worker beyond that purpose. The state, under capitalism, functions to promote the accumulated wealth of the elite (Marx, 1959).

Gramsci theorizes that a system of dominance and control had to have popular support in order to maintain the status quo. This hegemony, as he termed it, meant the permeation throughout society of an entire system of values, attitudes, beliefs and morality that has the effect of supporting the status quo in power relations (Burke, 1999). This would lend understanding to the importance of the widespread acceptance on the part of the community residents of Timbertown of company town structure of dominance through control of their jobs, homes, and in effect, their societal relationships.

Interviews of government/civic leaders as well as health providers reveal a lack of collaboration and planning. This does not imply a lack of cooperation but rather no long

term care planning infrastructure. For example, only one of the civic leaders and none of the health provider administrators had read the area plan filed with the State Unit on Aging (Department on Aging in California) by the local Area Agency on Aging. Lack of planning is inefficient and expensive yielding duplication and gaps in services. Quality of health and human services care is at risk with the perpetuation of a system that does not examine, plan for, and address present and future needs of seniors.

Some seniors from Timbertown are weaving a thread of interconnectedness between rural and urban areas, once separated by geography and their degree of independent agency. Now urban centers are not insulated from the migration of the oldest old from this rural area to be near city-dwelling family for caregiving services and consequently to take advantage of the range of senior services available in the cities. This provides a type of cost sharing or pooling of resources but at the expense of relocation of an already vulnerable population with increased risk of morbidity and mortality as sequelae of such a move. This relocation places burdens on the individual, the families, the society, and an already overburdened urban health care system designed to serve only the urban area's population size and needs.

Besides pooling of societal resources for the care of all seniors regardless of regional residence, corporate taxation for the care of the workers and their families, in at least an equal match to the millions of dollars of free family caregiving, would facilitate the geographical stability of the seniors of former company towns and other societies shaped by extraction industry structures. These industries, like the one in the study, whose movements are affected by globalization and the ongoing search for cheaper labor in new geographical locations or cheaper technologies would be held accountable for the protection of this population from the instability of the economic collapse following such

withdrawal from a region. Home and community-based services, such as the ones interviewees indicated are needed for seniors to remain in Timbertown: transportation, adult day services, in-home supportive and health care, would be provided by policies recognizing the complexity of rural economic factors. While this scenario is unlikely, and some might say preposterous, it does force the issue of inevitable systemic changes necessary to care for an ever increasing aging population and a shrinking number of caregivers.

Post Industrial Capital

Political economy studies the relationship between the larger economic political and social forces (the macro) and meso level forces, the company, and the micro level, the everyday life of the people. The company management had various ways of disciplining every day life for labor to support the industry. The mill whistle became an important symbol by which people lived, worked and went to school. People lived by the whistle. They got up by the whistle, worked by the whistle. The commencement of the school day and lunch break were signaled by the whistle. Even the women's household work was gauged by the first two morning whistles, the midday whistle, the 5pm whistle. "We lived by the whistle!"

People remembered the "company town days" with a sense of being taken care of and being comfortable, of being a community united around and by the company—that their needs would be met and that life was stable and predictable. Many expressed that there were no worries and that they depended on the company for everything.

The timber industry created the company town of Timbertown approximately 100 years ago. The concentrated wealth of "company town" power elite who owned and operated Long-Bell Lumber Company controlled: family life, working conditions,

racial/ethnic composition of the town and existence of commercial enterprise. For the son of one of the interviewees, the company's benevolent behavior opened a discussion about the company's intentions. "It was an old, old management technique that I learned later in life: to pay immediately quite well for what you were doing ands so they kept you tied in that way because you were very comfortable." He went on to point out that there were no further educational opportunities which may have provided a skill set so that if one did get fired, there would be something else on which to rely. The schools were even run by the mill whistles so that the disciplining of people for company work started when they were young. There may be some similarities between Timbertown and other communities where working class youth were groomed for working class jobs from a very early age. Paul Willis (1981) studied 12 youth in Britain and found this to be the case. His book, Learning to Labour, describes his ethnographic study and the ways youth are prepared for factory work.

Sex/Gender and Family Systems

As was common throughout society in that era, the unpaid labor of women in Timbertown made it possible for mill workers to do their jobs. Women played a crucial role in the perpetuation of the state and postindustrial capital accumulation. Now, in their old age, they provide unpaid caregiving.

Some rural elders in Timbertown have cared or continue to care for their grandchildren either because the parents are working or are incapable of caring for their children. When asked if she thought many older adults are caring for grandchildren, one study participant said, "More than you know!" She then proceeded to relay how she raised her granddaughter from the age of two. Her own daughter had "gotten into drugs" and left the girl in another county with acquaintances who then abused her. When the

study participant realized what had happened, she took the girl (her granddaughter) home and raised her. She said, "There are many, many people in Timbertown who have raised or are raising their grandchildren."

The issue of relocation of seniors in this study is directly related to sex gender systems and the family. Caregiver burden, cited as the most common reason for relocation of seniors, is not unique to rural areas; however, the lack of home and community based services is. The availability of adult day health care, a registry of home health aides, and a ready supply of home assistive personnel is rare to non-existent for the residents of the study area. These factors contribute to relocation decisions.

The reimbursement rates for skilled nursing facilities in rural areas are lower than those in urban areas. For example, the Medicare Reimbursement rate for the County is typed as "Rural" based on the wage index coded as 1.0915. This allows for a per-person, per Diem rate of $353.57 in the Timbertown skilled nursing facility. The same services in an urban skilled nursing facility are reimbursed $468.63. The per diem MediCal reimbursement rate for the Timbertown facility is $122.79; and in the urban area, it is $146.81. If the facility is connected to a hospital, the rate is $299.80 for any County. The facility in Timbertown is not connected to a hospital. The reimbursement rates for both Medicare and MediCal are based on a wage index for the County. The financial burden of reduced reimbursement based on rurality has caused institutional long term care facilities to close or consider closing thus burdening the remaining facilities to function at full capacity. This further burdens the rural senior and their families by necessitating relocation to skilled nursing facilities that are in a larger city and currently as far as a 4 hour drive.

There are multiple reasons why the future generation of caregivers cannot remain in the area: lack of affordable housing; unavailable job base; racial prejudice; relocation for education without a local plan to bring them back. The reality of potential caregivers in a distant location is a burden on both the seniors and their families.

The relocation of rural elders to urban areas to be served by institutions or to be close to family members previously relocated for employment reasons can have serious illness and mortality consequences for seniors and stress to family who may be willing, but not able, to care for their loved ones. Seniors in this study are likely to relocate when they or their caregivers can no longer carry the burden of their caregiving needs.

Interlocking Systems of Oppression

Patricia Hill Collins (1990), Black feminist writer, distinguishes between seeing systems of oppression as interconnected or seeing them as distinct. Within this theoretical framework of political economy and social policy and aging there are interlocking systems of oppression of race, ethnicity, patriarchy (sex/gender systems), class, age, state, capital, labor, ideology, aging enterprise, medical industrial complex, politics, economics, and culture that have multiplier effects (Estes, 2000). Geographic location in a rural site adds another dimension to these interlocking systems of oppression.

Rural older adults, rural older women, rural older adults of color, and rural older women of color all evidence disparities in health status, health care access, poverty level, lack of affordable housing, lack of transportation (Averill, 2002; Bull et al., 2001; Coburn & Bolda, 1999; Coburn et al., 2002; Coward et al., 1994; Coward et al., 1996; Dunn & Williams, 1993; Escovitz & Birdwell, 1996; Gamm et al., 2003; Glasgow, 2000; Glasgow, Holden, McLaughlin, & Rowles, 1993; Glasgow & Reeder, 1990; Goins, 2005; Goins & Mitchell, 1999; Hermanova, Brown, Goins, & Briggs, 2001; Krout, 1994;

Mainous & Kohrs, 1995; Samuels et al., 2004; Slifkin, 2002; Slifkin et al., 2000; Van Hook, 1987; Vargas et al., 2003; Weisgrau, 1997).

Race/Ethnicity

Based on historical and study data, it appears that the company town power brokers used racial/ethnic groups to further their own wealth and control. In Timbertown, race and ethnicity are related to global processes of imperialism and immigration. First and second generation Italians immigrated to Timbertown to work in the lumber mills in the late 1800s to early 1900s. In 1919, these and other mill workers successfully established a labor union called "International Union of Timber Workers, Local #114." The timber company at that time brought African Americans from Louisiana and Mexicans to the area to work in the lumber mills. Two interviewees recalled that Black mill workers were brought in as picket force against the organized union. The president of the company, they said, picked the most trusted employees and paid their way and guaranteed jobs. This is corroborated by Linville (2000, p. 77).

The issues of race and ethnicity are complex and require further study. For the purposes of this study it was noted that on the one hand, the interviewed African American mill workers or their spouses said that the mills were a place where you could get paid for the work you did and "treated equal" with regard to seniority. But on the other hand, you couldn't go into a restaurant and sit down. You had to get your food to go. The constructs of racism in the historical company town days took on social characteristics that were subtle. The treatment of African Americans by the company with equal pay and seniority for equal work masked the racism, condoned by the company policies of exclusion of Black people from the full enjoyment of the social milieu. Their exclusion from eating establishments from their arrival through the 1950's,

for example, was expanded to exclusion from jobs located outside the mills after their closure.

There is a strong link between racism and health care access structures in this study. Disparities exist in the care of older Black residents in Timbertown today because exclusion from local jobs based on race or ethnicity necessitated the movement of the potential caregiver generation out of the area to seek a livelihood for themselves and their children. A leader in the community echoed the voices of many interviewees from all racial/ethnic groups when he said that it is more difficult for young people from his community to secure a job than for young White residents of Timbertown. His view is that the reason for this is that jobs, particularly those of the larger (government) employers like CalTrans and the County are given to the children and social acquaintances of the present employees who are White. This makes it difficult if not impossible for the children of Black elders to stay in the area, given that "They have to move away to get jobs, and the ones who do stay may get into selling drugs to make money."

With the corporate flight of the timber industry, some Black and Hispanic people, who stayed in Timbertown while their family members moved, later relocated to be near those caregiving family members. With the increased morbidity and mortality shown in relocation research (Blenkner, 1967; Harkulich, 1992; Cartier, 2003; Aldrich, 1963; Bourestom and Tars, 1974 Thorson, 2000; Glassman, 1998; Carpentio, 2000; Choi, 1996; Horowitz and Schulz, 1983), these minorities are then more vulnerable to the exacerbation of acute and chronic health conditions and even premature death as a result of relocation.

In a report to Health Resources Service Administration, Samuels, Probst, and Glover (2004) link race, poverty, and rurality with poor health outcomes saying that African Americans, Hispanics, and Native Americans are more likely than Whites to live in counties that fall into the bottom quartile for physician-to-population ratio. Thus not only are rural minorities more likely to be affected by individual poverty and community-wide economic constraints but also to have more limited access to health care resources.

The addition of rurality to the already layered constructs of power inequities adds to the cumulative disadvantage experienced by older individuals and aging communities of color. Individuals and their families are left to deal with the resulting multiple jeopardies of racism as job-seeking youth are forced to migrate to urban centers leaving their aged without the social capital to age in their home environments. In addition, there is a loss of financial capital through forced early retirement, with the forfeiture of a full pension and/or health benefits. These rural elders of color are at the mercy of the aging enterprise as evidenced by the ever-diminishing long term care private national chains fleeing the area because of lower than expected profit returns. This flight has created an environment of an extreme shortage of nursing home beds in a community with an ever-increasing demand for long term care across the services spectrum.

In a report on the physician workforce in California, Dower and his colleagues (2001) observe that 145-185 physicians per 100,000 people is an acceptable standard for a physician to patient ratio. Stone County squeaks into that by 147. There are only 2 physicians for 2900 residents in Timbertown, and this ratio fails to meet an acceptable standard. "Poverty and health care are intertwined: persons without resources cannot afford health services, and communities without resources have difficulty attracting and retaining health care providers" (Samuels, Probst, & Glover, p. 5)

Census 2000 data shows that in Timbertown, the median household annual income is about half the national ($23,333 in Timbertown compared to $41,994 nationally); for people over 75 years old, the median annual income is $18,618. The per capita median annual income for Blacks in Timbertown is $8,000, well below the current federal poverty line. The percentage of minority groups comprising Stone County population of 44,000+ is 8%. Timbertown boasts a 26% minority population! Clearly, Timbertown falls into the category of being limited in health care accessibility as measured in terms of both ability to pay for care and the supply of health providers.

Socioeconomic Issues

The rising cost of housing in the Timbertown and surrounding areas over the past two years has made it difficult, if not impossible, for young people who have grown up in the economy of the area, to afford to stay. Many respondents echoed the remarks of one resident/business owner who noted how difficult it must be for someone graduating from high school or the local community college to stay in the area. There are no proximal towns with cheaper rental housing to accommodate the desire of the younger generation who wish to remain in the area and close to their families. This breakup of the family has health caregiving, social, cultural, intergeneration passage of customs and familial bonding implications. Recent housing cost increase can undermine the availability of service-level personnel to care for elderly residents of Timbertown and the surrounding areas which would increase their choices for self determination.

There is ample evidence that nonmetro elders have higher poverty prevalence, and have a higher risk for falling into poverty than their metro counterparts (Glasgow et al., 1993; McLaughlin, 2002; McLaughlin & Jensen, 1993).

Some older residents did not get the health care coverage or full pension from the timber company or railroad industry because of forced early retirement due to industry flight from the area or physical inability to continue working. In some cases their pension raised their income marginally over the amount that would qualify them for MediCal. Consequently, they often have high medical bills and often an inability to pay for the home support services they need.

Medical Industrial Complex

All three groups interviewed (residents, providers, government/civic leaders) agreed that home and community based services were needed for residents to age in their communities, but the resources to provide these services do not exist. Providers point out the lack of financial resources of residents of Timbertown. The disturbing reality of seniors going without food and medication in order to pay for a caregiver was evidenced in this study. This was not reported by residents but by caregivers who worked in home health situations. Since our health care system policies are built on a medical engineering model (Estes, 2001), seniors needing assistance with activities of daily living brought on by chronic disease are on their own to finance that care. The urban model of health care delivery, including per capita health care insurance reimbursements, has been imposed upon the rural areas (Slifkin, 2002). Future policies responsive to geographical and other access barriers to health care among rural residents would look very different than the ones in place today. Accessible transportation; in-home supportive services; caregiver respite; emergency snow removal; trans-agency collaboration, coalition building, and planning; and home delivered meals would be funded.

Per capita budget allocations such as the Medi-Cal fee for adult day health care (ADHC) insure financial viability for urban ADHCs. For the rural center, it may take

three years to build to a daily census of 10 people. The fee is inadequate to sustain the professional staff required. And, extensive grant writing capabilities must be accessible to the administration. Since 1998, three ADHCs spread throughout 25,000 square miles have closed for lack of financial resources. Today there are only two ADHCs covering the entire area. In California, approximately 25% of the residents over 65 live in rural areas (Census 2002) yet examining the list of ADHCs on the Department of Aging website reveals that less than 15 out of 349 ADHCs are located in rural areas (roughly 4%). In a conversation with the ADHC Section Chief of the California Department of Aging (March 22, 2006), she suggested that a change in MediCal reimbursement policy for rural centers would definitely help to increase the number of rural ADHCs that could reach sustainability. She indicated that many rural ADHCs close due to lack of funds.

Medicare reimbursements in rural areas are typically lower than urban areas because urban-centric policy makers think it is less expensive to live in rural areas (Mueller & McBride, 2003; Stearns et al., 2000). The skilled nursing facility in Timbertown offers a salary to nursing assistants that will not retain them. Beds have been closed because the staff ratio is not sufficient. Meanwhile residents who desperately want to keep their loved ones in the community are forced to find facilities as far away. With for-profit nursing home chains closing Stone County facilities, rural elders' prospects of remaining in the community continue to diminish.

County home health care resources have been stretched to the limit. Staffs have received time cuts. The agency has been asked to do more with less. Trained and bonded home health aides are rare. (I don't know of one with those credentials). And, their services are not reimbursed by Medicare or MediCal for ongoing care. Typically, residents don't have the resources to pay for them.

Medicare has been the single largest factor in improving access to medical care for elderly people by providing a payment mechanism for care. It is especially important for rural America because, compared to urban areas, a higher proportion of the rural population is elderly (Mueller, Schoenman, & Dorosh, 1999). Rural elders comprise 18% in Stone County compared with 11-14% in metropolitan areas (Census, 2000).

Rurality and Separatism

The needs of rural elderly people are often invisible as happens with marginalized groups. The unique attributes of rural health and aging and the identity of this group have been largely ignored. Health care policy analysts use language that has, in their recommendations, assimilated this group into the dominant urban health culture. This construction of reality has created a separatism of rural people in general and elderly in particular from the mainstream recipients of state resources. Rural culture and the state of rural health and aging must be studied in their own right, escaping the hegemonic cast of urban culture. What would this recognition mean in terms of policy and practice? The Area Agencies on Aging (AAA) are currently designated geographic areas based on population numbers only. If rural culture were not held in separatist ideology by assimilation, the AAAs would be based on population with a factor accounting for wide expanses of land mass. This would preserve the ability of rural senior service agencies to network and form coalitions strong enough to effect change, or at least be given the resources, albeit more than an urban per capita population counterpart, to affect the same services.

Public Image of Health and Old Age in Rural Living

When rural culture is not invisible to the dominant group, it often takes on a romanticized stereotype of the peaceful rural life and a strong rural family providing a

safety net for older people. The evidence from this study supports a different reality. Families in rural areas are vulnerable to geographic disintegration as relocation of working age groups becomes imperative with the fluctuations of industrial presence. This becomes more evident in towns such as Timbertown, when there is no economic buffer provided when corporate flight results. Older adults who stay in their place of residence are often left without the necessary social and economic resources to secure their futures as they attempt to age in place.

Rural aging is an inseparable part of societal development and must be recognized for what it is (Hermanova et al., 2001). Yet, the seniors of Timbertown have been separated from their families who could not find work in the collapsed economy of the post corporate flight days. Charles Taylor (1997) in his treatise on the politics of recognition, summarizes, "In the case of the politics of difference, we might also say that a universal potential is at its basis, namely, the potential for forming and defining one's own identity, as an individual and also as a culture" (p.236). For seniors who have spent much, if not all of their lives living and working by the company town whistle, it may be difficult to form one's own identity independent of the company.

Identity of a People

Age and identity are described in terms of the relationship between fluidity and stability as described here (Estes, Biggs, & Phillipson, 2003). In their explanation, stability means "...the degree to which identities are set as being fixed and unchanging" and "Fluidity refers to the degree to which identity is changeable, a subject of choice and desire but also of uncertainty and risk" (p.26). For the purposes of this study, this work of Estes and colleagues can be applied to the study community by focusing on the effects

of industrial decision-making and the unbuffered social consequences on the identity of individuals and the broader community in which they live.

The character of this research has some similarities to an archeological dig unearthing an economically and socially robust community in contrast to present day circumstances of local post timber industrial fall. Timbertown went from being an economically realized society to a community with potential. Being a senior citizen in Timbertown today, and having lived in the area for over 30 years, represents a trajectory of significant personal and societal identity shifts. Dependency on the company as an identified company worker, the shift to unemployed or suddenly retired, coupled with a collapsed economy, forged a community that 40 years later has not recovered a societal identity.

Today, the town with its vacant storefronts, automated mill, and high percentage of older retired residents, sits in stark contrast to the cohesive society and boom town economy of former days. Earlier, it was a destination town for many seeking to reap the employment benefits of the timber industry. Presently, it is a town used by travelers as a benchmark on their way to another destination. Government/Civic leaders recognized Timbertown's scenic and geographical potential of a viable economy as a tourist hub. But they quickly recognized that it remains a ghostown of more prosperous times.

This generation of former mill workers lived in a highly structured company town where everyone "lived by the whistle" and then suddenly shifted to an excessively fluid identity status in older years. This fluidity yields few options for maintaining in their homes and uncertainty about their social and economic futures. For any older adult, the risks of not being able to care for oneself in old age may be high and vary according to personal access to social and material capital.

Various attempts are made at preserving a sense of community identity. Perhaps the regular community dinners and annual events such as parades and carnivals, and the many venues for reminiscing about the 'good ole days' where residents strengthen their social networks are attempts to bring balance between the reality of a structured, dependable existence of the past and the uncertainty of the future of the town and the individuals in it. In this way people use customary events to maintain group identity reminiscent of more prosperous times. So permanent are the seasonal gatherings of this community that they are professionally painted on a fixed structure outside the chamber of commerce.

The point about having a voice and organizing for change could be daunting to a community where infrastructure to insure coordinated local, regional and statewide planning for their long term care is fractured, the insurance of a sustained voice in that process is missing, and the educational status of many occupants who are most affected is limited.

Interviews with government/civic leaders as well as health providers reveal a lack of collaboration and planning. For example three out of five of the civic leaders and none of the health providers had read the area plan filed with the State by the local Area Agency on Aging. This lack of planning could waste money by resulting in a duplication of some services and a gap in others. It could also affect the quality of health and human services care received by the elder residents by perpetuating a system that does not examine, plan for, and address their needs.

One government official providing money for senior programs, calls long-term planning issues "a luxury" or "icing on the cake" while another contends you cannot keep elderly people in the area without a long-term care plan. One official, who disagreed with

himself, said during his interview a year ago that assisted living is not the way to go in this area—rather home and community based services are. A year later, in a telephone conversation, he spoke about a new idea he was developing with a service provider to build a center that would include assisted living. While people have a right to change their minds, there is a difference between chasing an idea and methodically planning for the future including all constituencies and especially the community residents who know what they want and need.

Collaboration among senior services groups in the study area rarely included senior residents as representatives. Residents found it difficult to get release time from work for organizational Board of Directors activities and had to leave those volunteer positions.

One official, who worked in Stone County years ago, said that this lack of planning is not unique to the community of the study area. He said, "This is exactly the discussion that we had last week (at the federal level), is that there is no coordination between the State plan, The Area Agencies on Aging plan, and the local plans." He is aware of the lack of long term care planning at his federal level what this study reveals at the community and individual levels.

In addition to the lack of leadership on the federal, state, and local levels in planning for long term care, individual lack of planning could be reflective of the doubt and uncertainty produced by the absence of livable options for the future.

An Ideology of Aging and Interdependence

As referred to earlier, an ideology of interdependence would lend logic to the creation of policies to provide the requisite resources to level the health and human services playing field. Rural elders would be recognized for the work they have

contributed to society and their health and well-being in old age would have equal value as that of their counterparts in urban areas. In rural areas, a national ideology of aging and interdependence would provide adequate health care services with reimbursement rates structured to guarantee their sustainability. For example, given that rural communities are more dependent on Medicare and Medicaid revenue than their urban counterparts, reducing rates based on the belief that it is cheaper to live in rural areas would be untenable as would physicians refusing to care for these patients. American society holds some public institutions with an ideological framework of interdependence. These institutions provide services to all citizens regardless of the communities' ability to sustain them. They are often subsidized because of the belief that all people have a right to their access surpasses the particularities of economic resources. In reality, supply of these institutions' services is shared by all. The fire fighting industry and the postal service in the United States are two such examples. The state is willing to spend money on these services so that they will be available when needed regardless of the geographic area in which they are defined. Health services to the elderly in this country in general and in rural areas in particular do not enjoy the benefits of the same ideological importance. Elders would enjoy more individual agency in their choice of health care resources, ultimately facilitating their being able to age in the place of their choosing, making "forced relocation" unacceptable.

Federal disparities on rural health research expenditures were reported for AHRQ in the National Advisory Committee on Rural Health and Human Services to the Secretary of Health and Human Services (2003) as follows: "Current investments for minority and vulnerable populations:

Minorities - $60 million
Low Income - $20 million

Children - $14 million
Special Health Care Needs - $14 million
Urban - $11 million
Women - $7 million
Elderly - $5 million
Rural - $3 million (p. 21)

Based on this listing and the fact that the combined rural health research federal investments have "barely begun to address the larger resource needs facing rural health providers," the Committee recommended that rural health providers sit at the research planning table with AHRQ (p. 23).

Summary

This study has shown that historical constructs of state and private industrial relationships as well as current policies have conspired to make it difficult for these rural seniors to age in their home community. Some of these characteristics include, but are not limited to: cuts in rural healthcare budgets; health care reimbursement based on urban characteristics of densely populated geographic areas; the closure of for-profit skilled nursing facilities without backup plan for service provision; underpaid and under-trained home support care staff; an inadequate caregiver respite plan; lack of economic job development plan for keeping youth in the area; lack of proximal specialty services; lack of geriatric preparation of health care providers; and continued economic instability subsequent to the timber industry corporate flight to more profitable global sites; a missing economic floor in the health and human services provision; and disjointed federal to local long term care planning processes.

CHAPTER TWELVE: IMPLICATIONS FOR NURSING AND RECOMMENDATIONS

Implications for Nursing

Nursing care of rural elders dictates knowledge about historical, political, cultural, social, and economic context of the meaning of community, health care seeking behaviors, and caregiver issues specific to aging in place and relocation factors. Rural nursing is more than a geographic practice setting. It includes factors such as perception of health status (Brown, Gubrium, & Ogbonna-Hicks, 2004), scarce resources and issues related to the threat of anonymity and confidentiality (Bushy, 2004).

This study has emphasized the need for nurses to know and respect the culture of the community being served. This is obviously true regardless of the geographic setting. In this study, rural perception of wellness is defined as "able to get along." Recall Mrs. Clement, active at 94 years old, who does not go to see the doctor unless she has a problem. When asked about her seeing the doctor now, she said she would go if she broke her leg because she trusts her doctor. She told the story of going to the local senior exercise program recently and found that her blood pressure was high. She subsequently had another reading at doctor's office and was put on medication. Rural seniors in this study defined their own level of health according to functionality rather illness. For them, if they avoided "going to the doctor" that was a measure of health. Therefore, it is important for nurses to know how people in a community define their health so elders who do not frequent health care providers can be counseled in a venue outside the clinic about silent diseases and be consented for necessary screenings such as blood pressure and diabetes.

Nurses should become familiar with the meaning and practices of caregiving of a particular community. Recognize the stigma and reluctance of people to turn the caregiving function over to an agency or government service such as in home supportive services. One highly visible County official was quoted in the local newspaper as saying that he would never imagine getting paid for taking care of a family member (referring to In Home Supportive Services-IHSS). Nurses must recognize the perceived and actual costs of obtaining help. Local MediCal workers told a family member that they would put a lien on their property if they applied for coverage for their elderly mother. Nurses must recognize thatvthe process of "spending down" a bank account, in order to qualify for benefits, is demoralizing for many and so they do not apply for health coverage for which they are entitled. The process of obtaining monies for caregiving (IHSS) is stigmatizing and arduous (providing bank statements, proof of need, physician statements). In addition embarrassment in the application results when the intake worker, to whom financial and personal information is divulged, is probably known to the person in need.

Nurses must recognize the complexities of family situations and that the elder's caregiver may be a son addicted to methamphetamine with a co-occurring mental illness. The nurse must also recognize that this son is the slender thread that allows that elder to remain in her home. Such is the case with two known local elders.

Nurses must recognize the historical constructs of the particular rural area and the effects of that history on the health systems and the health practices of the people in that area. Identification of available health services including "alternative" practitioners and how people use them is important.

One of the most important lessons of this study is that what nurses hold to be important factors for aging in place may not be important to the rural elders, such as a multi-layered clinical approach. Therefore, listening to the will of the people in one-on-one conversations and by inclusion on planning boards is crucial.

By becoming knowledgeable about the complex facets of rural health and aging, nurses will be positioned to understand the characteristics of the political, economic, and other forces shaping aging-in-place decisions. Further they will have the necessary background to be advocates for policy changes on behalf of rural elders and their families.

Nursing education must reflect the obligation of training nurse leaders to think critically and to advocate vociferously for policy and systems changes that foster the health and well being of members of society. Experts in Sociology, Anthropology and Political Science must be readily available to nursing students of all academic levels as faculty within schools of nursing; and, curriculum must routinely reflect courses in such disciplines.

Recommendations

Transportation

It is recommended that transportation be provided to every elder resident regardless of functional ability and financial resources. Programs developed in other parts of the Country that are self-sustaining should be used as best practice models.

Home and Community Based Programs

Home maintenance programs addressing tasks like changing ceiling light bulbs, yard work, and other light maintenance and repair, such as the one funded by the Area Agency on Aging in Anderson, California should be instituted in Timbertown. This

would allow seniors to remain in their homes regardless of their physical inability to perform such household tasks.

Reimbursement policies should fund the needed home and community based services expressed by seniors as necessary for them to age in place. At a minimum, Medicare, not just MediCal, must insure funding for Adult Day Health Services for people who would otherwise be eligible for skilled nursing home care. In addition, home assistance should be funded for people at risk of relocation because they cannot maintain their activities of daily living by themselves such as bathing, dressing, toileting and transferring. This home assistance must include programs to address household maintenance that would otherwise cause a decision to relocate such as indoor and outdoor repair, snow removal, and light maintenance.

For those seniors whose children left the area, some may relocate to be near their families. For those who wish to age in the area, a service delivery model, born of stakeholder collaboration to address those needs expressed by constituencies in this study, in the form of a senior health center providing primary care and other services as listed below, is recommended. Services to individuals and families would provide for enough basic health and human services to allow for seniors to age in place if they choose. Access to services would account for the financial, linguistic, and cultural diversity in the population of Timbertown, where there will be senior health and social services with a board certified geriatrician, nurses, social workers, and mental health professionals trained in the care of geriatric patients. In consultation with a registered dietician, the center would provide one nutritious hot meal everyday with dietary provisions for people with hypertension, diabetes, and chewing and swallowing difficulties. The center would also provide dental, podiatry, hearing and vision services. Other specialties would

include the services of a cardiologist and psychiatrist/psychologist. These specialty services will be available either through in-person or tele-medicine care depending on the services needed by the patients.

Local Nursing Home Quality Care and Sustainability

It is recommended that all initial and routine medical care of skilled nursing facility residents in Timbertown be provided by board certified geriatrician(s) and gerontological nurse practitioner(s). Since the future of the skilled nursing facility is at risk, it is recommended that the County float a bond to purchase the facility and that the facility include an expansion of beds that would cover the needs of the residents of the County including beds designated for people with HIV/AIDS, alcohol and other drug users, and 24 hour hold for mental health patients to avoid future week-end holds in the County jail. It is further recommended that this skilled nursing facility and the senior health center (mentioned above) become a model program for the clinical rotation of medical, nursing, social work and mental health students from the College of the Stones Rural Health Institute, University of California Centers for Geriatric Nursing and Medical Excellence and the Oregon Health and Science University Center for Geriatric Nursing Excellence. Alliances with other Medical Centers such as University of California Davis tele-medicine and tele-psychiatry are recommended.

Health Care Provider Training

Health care providers must be trained to care for older adults through paid leave time to attend continuing education programs. Medical and nursing training programs, generally in urban academic medical centers with little experience or interest in rural medicine, have not met national needs (Rosenblatt, 2004). It is recommended that urban

medical and nursing programs develop competency-based curricula to represent clinical, research, and policy realities of rural-based best practices.

Long Term Care Planning

Long-term care planning on all levels—federal, state, local, and individual is needed. Leadership at the federal level must model a planning process that includes major stakeholder representatives of at least rural elders, government and private funding officials, health care providers, and researchers. Such planning efforts must recognize the pockets of racial and ethnic diversity as well as geographically separated family generations, not often considered part of rural societies, and the interlocking systems of oppression affecting poor health outcomes of rural older adults.

Leadership at the state level would raise a consciousness of the scope and presence of rurality particularly in a State such as California where most people live in urban centers. Such a consciousness would include a common understanding that most of the land mass of the state is rural and that the percentage of older adults in rural areas is higher than that of urban areas. An inquiry based on those two facts alone would yield more meaningful planning and outcomes processes. On the local County level, as in the federal and state, officials would carefully include local residents who are representative of the racial/ethnic, gender, social class, able-bodiedness of the service population for long-term care planning. Such processes would recognize and build programs that address the cumulative disadvantages experienced by individuals and groups who have experienced years of oppressive poverty, racism, unemployment, disrupted family geographic integrity and other losses of social and financial capital and the health sequelae of such disadvantages.

Deep Rooted Reimbursement Policy Changes

A deep rooted change in reimbursement policy of Medicare and Medi-Cal is needed. It would effectively be one that recognizes the characteristics of rural human services delivery in order to insure the survival of the population who chooses to age in their home communities. Reimbursement policies would recognize the need to level the playing field by factoring sparse population base and other characteristics of rurality in the formula. Such other characteristics would include a recognition that wage index is not an accurate basis for reimbursement amounts in rural areas because the cost of living (rapidly rising housing costs, higher than urban gas prices coupled with the distance to procure goods and services, higher cost of food and other household goods, when available) increases before commensurate wages.

Equal worth and dignity for rural elders will have to be preceded by a leveling of the playing field with policy addressing the inequities of income, health access, affordable adequate housing and in-home care, as well as job opportunities for working generations.

Community Care Safety Net

And finally, the establishment of the following is recommended: an equitable mechanism for the taxation of private industry that would fund the long term care infrastructure and services delivery to rural elders who have given their very lives to their profit making activities. This taxation would fund, for the purpose of elder care, a state administered safety net program including the voluntary reunification of families geographically separated by loss of jobs, taking into account the layered, cumulative results of racial prejudice on the disenfranchisement of subsequent generations. The mechanism for the taxation of corporation and administration of safety-net programs

could be modeled on a trust fund approach. The taxes would be received by the federal government and untouchable by any branch for use other than the funding of these programs. The formula for the taxation could be based upon the worth of unpaid caregiving through the life course of the individuals who are likely to be served. This "corporate taxation for long term care" (CT-LTC) program would be separate from any programs funded by federal income tax or corporate pension plans because the program is based on the ideology of interdependence through the life course and not on the labor market participation and property accumulation of individuals. Overall, such a long term care infrastructure would provide a safety net to fill continuum of care gaps identified in this and other studies, respecting self-determination of the place of aging as a right and recognizing that "life chances" of individual members of society that have dictated their caregiving and/or labor contributions is adequate rationale for a corporate funded, state administered safety net long term care program. Such a program would equilibrate the social and financial resources required by them as elders with the contribution these senior residents of Timbertown (and residents of other rural and urban areas) have made to the wealth of corporate enterprises.

Summary Statement of Most Immediate Need

In the short term, and based on the data from this study, it is recommended that policies governing funds administered at the local level by county, state, and federal levels to senior benefit programs, recognize the residents' clearly voiced need for affordable personal care assistance and light home maintenance and repair as their first choice of services needed – followed closely by transportation – in order for them to remain in their homes. The short term plan must reflect this stated need by amending resources allocation policies. It is further recommended that a local long term planning

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APPENDICES

Appendix A: Rural California Facts

(Referenced on page 12)

The California State Rural Health Association published a fact sheet about rural California. While it is not specific to seniors, it serves as useful background and comparison data with the area under study. It is summarized here:

Rural Geography and Population

- Rural areas makeup approximately 80% of the total land mass of 156,000 square miles. *-2000 Census data*
- 1.1 million California residents live in rural areas of Southern California, 2.3 million live in Central, and 1.5 million live in Northern. *-2000 Census data*
- The rural population at the 1990 Census was 3,232,000 and the 2000 Census reported 3,896,000. An increase of 664,000 or 20% (the total State population increase was 12%). *–Department of Finance 2005*
- Fewer residents of rural counties are college graduates compared to residents of non-rural counties (16.5% vs. 23.1% respectively). – *Behavioral Risk factors Survey 2004*
- Fewer residents of rural counties have completed post-graduate degrees compared to residents of non-rural counties (10.7% vs. 15.9% respectively). *–Behavioral Risk Factors Survey 2004*
- Rural persons are over represented among those who have served in the U.S. Armed Forces. *–Behavioral Risk Factors Survey 2004*

Socioeconomic Indicators

- A greater proportion of residents of rural counties compared to residents of non-rural counties are between 100% and 200% of the Federal poverty level (21.5% vs. 16.9%). - *Behavioral Risk Factors Survey 2004*

Health Conditions

- A greater proportion of residents of rural counties have been told by a health professional that they have diabetes (7.9% vs. 6.8% respectively) and/or high blood pressure (7.9% vs. 6.8% respectively) compared to residents of non-rural counties. And of those approximately 65.7% are taking blood pressure medication. - *Behavioral Risk Factors Survey 2004*
- Postponing or foregoing dental cleaning is markedly over-represented in rural counties. *-Behavioral Risk Factors Survey 2004*

Health Insurance Utilization

- Of the 6.5 million residents of California who were beneficiaries of Medi-Cal services in fiscal year 2004-05, 1.9 million, or 29.0% live in rural areas. *Department of Health Services—Medical Care Statistics Section 2004*
- Among the rural residents who have health insurance the proportion of those with Medicare is greater in rural counties than in urban counties (18.1% vs. 15.7% respectively). - *Behavioral Risk Factors Survey 2004*
- There are a greater proportion of rural residents covered by Medi-Cal compared to urban residents (13.8% vs. 10.4% respectively). *Behavioral Risk Factors Survey 2004*

Appendix B: Study Participant Demographics

(Referenced on page 19)

N=27: Residents (N=13); Health Providers (N=9); Government/Civic Leaders (N=5)

	n	%
Ethnicity		
African-American	3	11
Hispanic	6	22
Caucasian	17	63
East Indian	1	4
Sex		
Female	18	67
Male	9	33

Age of Residents
- Distribution: 65-93 years
- Mean: 76.15 years
- Median: 79 years

Age of Health Providers
- Distribution: 43-73 years
- Mean: 53.8 years
- Median: 58 years

Age of Government/Civic Leaders
- Distribution: 42-69 years
- Mean: 52.6 years
- Median: 53 years

Time Lived in the Area

Residents
- Distribution: 36-93 years
- Mean: 60 years
- Median: 64.5 years

Health Providers
- Distribution: 2-45 years
- Mean: 15.4 years
- Median: 23.5 years

Government/Civic Leaders (Not all live in area)

Appendix C: Timbertown Timeline: Pre-Mill Days to Closing of the Plant

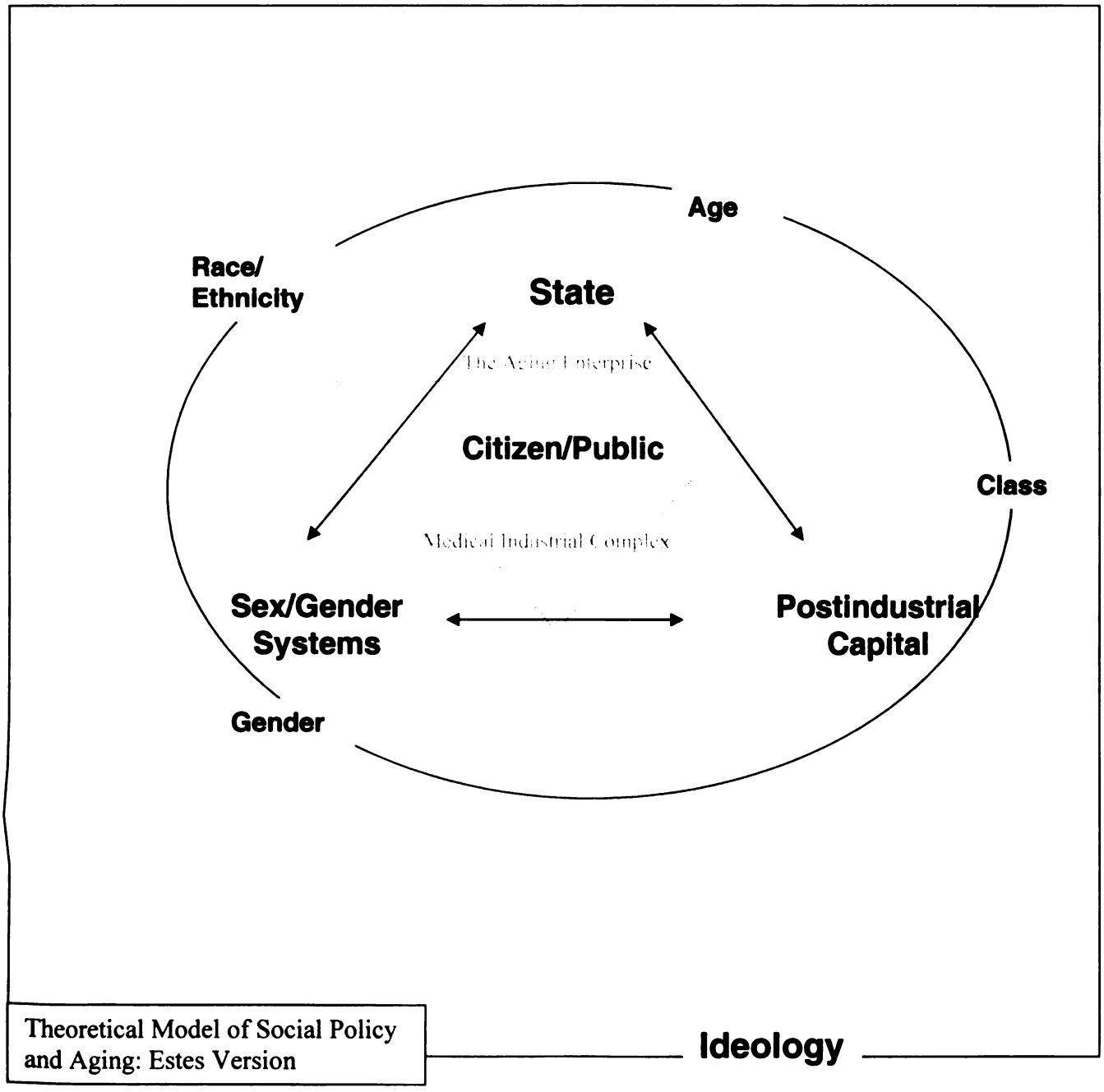
(Referenced on page 38)

1880 Thickly forested with pines, firs, and cedars. Theis area was called Shastina. The population consisted of a few farm families, whose trading centers were two or three day journey away by wagon team.
1891 Abner Timbertown who had come from Maine, his first venture was a small mill on the eastern slope of Mt. Eddy due west of Igerna
1987 Abner sold his mill to a man by the name of Durney and bought the Stone Lumber and Mercantile Mill plus 280 acres of land in what is now the town of Timbertown, for the sum of $400.
1901 Abner built mill in Timbertown
1903 Abner procured two heavy locomotives for his railroad serving the timber region of Timbertown. The local Journal described the locomotives as monsters with eight wheels.
1905 Timbertown had grown to include hotels, grocery stores, restaurants, saloons and a hospital. Company offices are now City Hall. In March Abner Timbertown sold the Timbertown Lumber Company to Long-Bell Lumber Company for $2,000,000.
1906 The first church was built. 1909: A grade school was built on Schoolhouse Hill. 1920: The first high school was built.
1919 Union successfully organized in Timbertown: International Union of Timber Workers, Local #114 (Linville, 2000a).
1920 All the mills were working two shifts. Southern Pacific was building a railroad on the east side of Timbertown. Dwinelle Dam was also being built north of town. Saturday night when all those men came to town, it really came alive.
1922 Union Strike failed—attributed to lack of interracial solidarity (Linville, 2000a).
1935 National Labor Relations Act (Wagner Act). Gave workers right to organize and join labor unions, to bargain collectively and to strike. No provision in the Act allowing government to delay or block a strike that threatened national interests (Wagner, 2002).
1940 Timbertown was the "Sodom and Gomorrah" of Stone County. Because of isolation, the law was loosely enforced. Conductors on passenger trains that stopped here advised all of the passengers not to go into town. Ladies and children were cautioned to stay off the streets. Gambling, prostitution, and liquor were some of the main attractions. Main Street had it's "respectable" west side and "seamy" east side. There was even a tunnel used for clandestine meetings. (Timbertown Museum)

1941 Successful strike getting everything asked for (except full Union shop)—attributed in part to interracial solidarity which was lacking in the 1922 strike. Plant was completely shut down until December 15th. The Union and the Company agreed to federal arbitration due to the entry of the United States into WW II. The Company recognized the Union for the first time in Timbertown (Linville, 2002a). There were nearly 4,300 strikes called by union officials across the Country that same year.
1942 National War Labor Board created. Gave president power to issue directive orders to settle labor-management disputes that "might interrupt work contributing to the effective prosecution of the war. Designed to encourage a strike-free "labor peace," it did not stop the escalating number of strikes across the Country (Kendrick, 1942).
1946 Wave of strikes in many industries across the US continued.
1947 Congress passed Taft-Hartley Labor Act. Gov't was empowered to obtain an 80-day injunction against any strike it deemed a peril to national health and security. Viewed as "new guarantee of industrial slavery" by 28 Democratic members of Congress (Wagner, 2002). Still in place today.
1954 Last Union strike at the mill. Union became a "full union shop" whereby every worker had to join the Union. (Linville, 2000a)
1956 Long-Bell Lumber Co. sold to International Paper company.
1959 International Paper Co. started selling the company houses to their employees. This is considered by many to be the turning point in the modernization of Timbertown.
1961 Timbertown was incorporated in January and became a City.
1981 International Paper Company closed Timbertown Plant on December 10th.

Appendix D: Theoretical Model of Social Policy and Aging: Estes Version

(Referenced on page 106)



Theoretical Model of Social Policy and Aging: Estes Version

Appendix E: Interview Guides

Demographic Interview Guide
(Researcher will complete while talking with study participant)

(Code) Study Code Number:
(Date) Date of Interview

(Age) Age:
(Sex) M☐F☐

(Ethn) Ethnicity:
- ☐White
- ☐Black
- ☐Filipino
- ☐Chinese
- ☐Japanese
- ☐Russian-American
- ☐Hispanic
- ☐Other:

(Mar) Marital Status
- ☐Married
- ☐Divorced
- ☐Widowed
- ☐Single
- ☐Never Married
- ☐Domestic Partner

(Kin) Next of Kin
- ☐Spouse
- ☐Son
- ☐Daughter
- ☐Niece
- ☐Nephew
- ☐Grandson
- ☐Granddaughter
- ☐Friend
- ☐Legal Guardian
- ☐Other:

(Pay) Source of Payment for Care:
- ☐Private
- ☐Medicare
- ☐Medi-Cal
- ☐VA
- ☐Private Insurance
- ☐Other

(Rel) Religion
- ☐Organized Religion.
- ☐Spiritual Following
- ☐None

Education
- ☐1-6 yrs.
- ☐1-12 yrs
- ☐AA
- ☐BA
- ☐MA
- ☐PhD

Time lived in (Timbertown)

Interview Questions (Person over 65 living in Timbertown)

(Code) Study Code Number: Date of Interview

Could you please tell me a bit about yourself?

Could you tell me about a typical day?

What brought you or your family here?
Probes: What was life like when Long Bell was here?
How is the town different today?

Describe your life here in (Timbertown).

Describe your living situation.

Are you able to be as independent as you would like?

Do you have family or friends who live nearby?

What places do you frequent i.e. coffee places, pubs, gathering places?

Describe your social circle. Has it changed in the last few years?

Do you have family or friends who have left the area?

Are there special places that you like to go?

Do you have photos that you might want to show me? Can you describe the importance of the people and the places in them?

Probes: How would you describe your health? Your husbands/wife's/partners health.

How would you describe your ability to care of yourself? Other's health?

How do you picture your life 15 years from now?

Would you like to live in (Timbertown) for the rest of your life or do you think you might move?

What would be the reasons for moving?

If you stay in (Timbertown) and if you were ill or had to go to the hospital, where would you go?

Where do you picture living?

What kind of health care do you envision needing? Who or where will you get that care?

What do you think your housing needs will be as you age? Do you think you will require assisted living? How will those needs be met financially? Do you think you will have to move out of (Timbertown) to get those needs met?

If you need in home caregiver services, how will you go about getting them? How will you pay for them?

If you felt that you would need to move to get your health needs met, but decided to stay in (Timbertown), what would be the reasons for doing that?

Interview Questions for Health Care Provider

Study Code number:
Date of Interview
License type of Provider
What year were you born?
I am researching the needs of seniors as they age in place here in (Timbertown).
Could you describe the health care system for older adult residents who live in (Timbertown)?

How do you feel about the services that are available for older people?

- Proximity of services
- Technology, i.e. local diagnostic equipment
- Expertise with care of older people
  1. physical
  2. psychological
  3. social service network, i.e. social workers to facilitate needed services

Have you taken care of older adults who have moved away from (Timbertown) in order to secure health care services including assisted living or other housing/caregiver supports? Could you tell me about them?

Do you recognize a particular "tipping point" such as "one last straw" that is a determining factor of when people relocate?

What do you view as the future needs of the elderly population here in (Timbertown)?

Can you see yourself aging herein (Timbertown) or in the general area?
What would you need to remain in (Timbertown) as you become older?

Interview Guide for Political and Civic Leaders

Study Code number:
Date of Interview
Position Held:
Length of Time in position
Approximate Age:

1. I am interested in talking about seniors would like to remain living in (Timbertown) as they get older. Can you tell me what services are here to facilitate that?

2. Are any additional services needed right now?

3. What services will be needed in the near future for elderly people here in (Stone) County? How about in (Timbertown)?

4. Can you tell me about the demographic characteristics of (Timbertown)? Are they changing? If so, how? What percentage of the population is over 65 years old?

5. What is your feeling about the recent influx of retirees, particularly the very quick and steady migration to (intentionally suppressed identity of place). How will that influx effect resource allocations to seniors?

6. Do you see yourself staying here in (Stone) County as you get older?
What additional services do you see yourself in order to do that?

For reference

Not to be taken from the room.