Elder Health in Rural America

The composition of rural America today is predominantly elderly. Individuals 65 years and over constitute approximately 13.1% of the American population; however, 20% of the elderly live in non-metropolitan designated areas.[1] In many of the non-metropolitan areas individuals over 65 years constitute greater than 13% of the population[2]. All states have areas designated as rural using government classifications, with many states in the Midwest and west having large geographic areas designated as non-metropolitan. Two-thirds of the 3,142 counties in the United States are rural. In localities which are economically dependent on agriculture, the elderly continue to work the crops on their farms. Today, rural communities are experiencing farm consolidation, loss of forest land, shrinking population, lack of access to services and transportation, and limited planning capacity.[3] The focus of this paper is 1)to provide an overview and brief analysis of the current status of rural communities, rural elder health, policy, and practice, and further 2)to suggest guidance/recommendations for future policy based on a systems approach which incorporates sustainability, best practice, quality, efficiency, effectiveness, with a conceptual basis for care within the context of people and place which constitutes rural America.

Rural communities look different based on their geographic location, and population; however, they also share similarities that extend beyond available and accessible health care. The classification that a community is assigned impacts the resources that are available to the elderly who reside in the community, since the designation is frequently the basis for determining program need and finances. For many elders with chronic health care conditions having locally accessible health care and social service resources may compel family members who serve as primary caregivers to remain in their rural communities. Health risks for individuals in rural communities and may be grouped into occupational, behavioral and environmental factors. Occupations, such as farming, fishing, and the acquisition of natural resources (coal, lumber and natural gas, etc.) are specific to rural communities. Health risks associated with these occupations have immediate manifestations for poor health, such as farm accidents resulting in loss of limb, while others have long latency periods, such as black lung. Individual behaviors also have immediate and longer-term effects. Examples of behavioral factors include: alcohol consumption, tobacco and sedentary lifestyles. Health risks associated with environmental factors are frequently seen as beyond the choice of individuals and include weather conditions, natural terrain and presence of wild animals in addition to access to adequate housing, clean water and healthy food. Each of these three categories of risk factors for poor heath may be a contributing factor to chronic health conditions.

The health of rural elders is further impacted by limited access to health care for prevention, management and treatment of chronic conditions and social services. Access to health care is

[1] A copy of the full report may be found at: http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2011/3.aspx.
[2] Ibid.
[3] Mishkovsky, N., Dalbey, M., & Bertaina, S. (2010). Putting Smart Growth to Work in Rural Communities (Washington, D.C.: International City/County Management Association), 2-5.

further limited for elderly who need assistance with activities of daily living (ADLS) such as bathing, cooking, etc, and instrumental activities of daily living (IADLS) such as transportation.[4]

In addition, elder health needs to be considered within the changing context of multicultural and racial diversity of rural America. Further, it is pertinent to consider minority aging in rural areas in terms of both the "collective effects" resulting from the concentration of persons with certain characteristics, and the "contextual effects" which address the broader political, cultural, or institutional context.[5] According to the U.S. Census 2010, between 2000 and 2010, the minority population, which includes all persons other than non-Hispanic whites, accounted for 82.7% of the nonmetropolitan population gain, even though minorities represented only 21% of the rural population. Patterns of racial diversity are uneven. Many rural counties remain largely non-Hispanic white, yet diversity is substantial in certain pockets of rural America. For example, Hispanics are spreading from the Southwest into the Southeast and Midwest. The large concentrations of African Americans in the Southeast have seen a recent influx of black migrants from other areas.[6] Native Americans are the only ethnic group with greater representation in rural than in urban counties with high concentrations in the Great Plains, parts of the West, Alaska and Hawaii. Asian Americans have the smallest rural share of the four groups.[7] While children are the vanguard of this growing diversity in rural America, (nearly 28% of the child population is rural/minority compared with 18% of the adult rural/ minority population), the collective and contextual effects of diversity impact the healthy aging of minority populations in rural areas and their access to health care.[8] For example, 65% of rural counties are whole or partial health professional shortage areas (HPSAs). In general, shortages are more common in counties where racial/ethnic minorities represent more than half the population. Four of every 5 rural counties (81%) in which Hispanics are the majority population are HPSAs, as are 83% of counties with African American majority, and 92% of counties with an American Indian/Alaska Native majority.[9]

Access to health care for prevention, identification, treatment, and management of chronic diseases such as cardiac artery disease, chronic respiratory disease and type two diabetes is necessary for elders to lead productive independent lives. The ability for rural elders to access a primary care provider in the community they identify as home is important. The focus of primary care is on the prevention of illness, chronic disease exacerbations and maintenance through effective management by using appropriate treatment modalities that the elder finds acceptable and affordable. Frequently primary care providers needs assistance in treating and managing an

[4] ADLs indicate functional ability and are frequently used as a measure for nursing care, IADLs are activities that individuals need to be independent.

[5] Probst, et.al. (2004). Person and place: The compounding effects of race/ethnicity and rurality on health. American Journal of Public Health 94:10, 1695-1703.

[6] Glasgow, N. & Berry, E.H. (Eds). Rural Aging in 21st Century America. New York: Springer.
Johnson, K.M. (Winter, 2012). Rural Demographic Change in the New Century: Slower Growth, Increased Diversity. Carsey Institute. Issue Brief No. 44.

[7] Jones, C., Kandel, W. & Parker, T. (2007). Population dynamics are changing the profile of rural areas. Economic Research Service. USDA. Amberwaves, 5:2, 31-35.

[8] Glasgow, N. & Berry, E.H. (Eds). Rural Aging in 21st Century America. New York: Springer.
Johnson, K.M. (Winter, 2012). Rural Demographic Change in the New Century: Slower Growth, Increased Diversity. Carsey Institute. Issue Brief No. 44.

[9] Probst, et.al. (2004). Person and place: The compounding effects of race/ethnicity and rurality on health. American Journal of Public Health 94:10, 1695-1703.

elder's health condition, particularly when an exacerbation of a chronic disease occurs or when the chronic condition first presents itself, such as in the case of a myocardial infarction. Many elderly need assistance with ADLs and IADLs due to their chronic health conditions. Long term care is necessary for many elderly due to limitations in their ability to carry out ADLs and IADLs. Unlike acute care, which usually requires hospitalization, long term care can be provided in the elder's rural community home or in a facility which assists or provides the elder with the identified care.

Rural elders deserve the highest level of quality care by health care providers providing safe effective care while meeting the needs of the elder. While differences exist among states in the specific roles which health care providers are licensed to perform, differences in professional standards of practice do not exist within individual health care professions.[10]. In addition for many health care professions what they actually do on a daily basis in providing care share similarities. The professional standards of practice among health care professional groups differentiate what the provider is educationally prepared to do. Professional licensure is determined by individual states, and does not consistently reflect the professional standards of practice for the health care provider. Elders benefit with the best care possible when congruency exists between standards of practice and licensure. When congruency does not exist between standards of practice, and licensure it is not clear that the elder receives quality care and financial inefficiencies exist. Addressing professional roles that are congruent with professional standards is beneficial for the rural elder by having the health care professional provide care that is accessible, acceptable and appropriate. As the elder requires care that is beyond the role of the health care provider it is paramount that the provider collaborate with the professional who is qualified through professional standards of practice and licensure to meet the needs of the elder. As the elder receives care from a different health care professional, both providers are accountable not only to the elder but also to their profession for delivery of care which meets their standards of practice, and roles which are sanctioned by state licensure.[11,12] When care is required the elder expects and deserves the provider to meet their needs, they do not ask to see the provider's credentials, instead they trust that they have the knowledge, skills and abilities to meet their needs. Rural elders have similar needs as urban elders when you address their functional abilities such as the ADL's and IADL's, as well as other areas of interest such as health literacy and access to care. In the provision of care it is important that the provider, regardless of whether they are a physician, a nurse practioner, a physician assistant, a registered nurse (RN) or an emergency medical technician (EMT) that they provide care in conjunction with their professional standards of practice, that embraces their scope of practice. It is important that the provider is not limited in their practice due to regulations which do not embrace professional standards of practice and scope of practice. Health care professionals must practice within their professional standards, and licensure while addressing what the elder needs.

[10] Standards of practice are determined by the professional group, while licensure is determined by individual states, licensure may or may not encompass professional standards of practice.

[11] Robert Wood Johnson Foundation and the IOM Future of Nursing both address collaborative practice. Robert Wood Johnson Foundation. (Nov. 2011). Implementing the Future of Nursing-Part II: The potential of interprofessional collaborative care to improve safety and quality. Charting Nursing's future, reports on policies that can transform patient care. 1-8. Available at www.rwjf.org/goto/cnf.

[12] IOM (Institute of Medicine). 2011. The Future of Nursing: Leading Change, Advancing Health. Washington DC: The National Academies Press

Federal involvement with rural elders may be viewed through policies focused on social services and health care. The Older Americans Act provides a comprehensive approach to policies and community services. Since the act was first instituted in 1965, the focus has remained constant in addressing services such as transportation, nutrition and social organizations, which promote health. Additionally, the act has expanded its focus to include elder rights, elder abuse, individuals with disabilities and family caregivers, which are the largest group of individuals providing community, based long-term care. Local Area Agencies on Aging provide social services for elders and are generally administered through state offices of elder services. Medicare, Veterans Affairs and Indian Health Services provide much of the financing for health care for elderly in this country. Medicaid programs provide much of the financing for health care for the elderly who need assistance with ADLs and IADLs, whether the care is delivered in home, through community-based services or in an institution such as a nursing home. While the payment for services vary, the federal government is responsible for setting policy, while the states are responsible for o staffing, financing and monitoring the health care organizations adherence to policy. State government through Medicaid is the largest payment source for long term care in this country, while unpaid family caregivers provide the majority of care to community dwelling elders. Rural elders are frequently at a disadvantage regarding social service and health care availability due to lack of financial resources in rural jurisdictions.

In 2011, the National Advisory Committee on Rural Health and Human Services began to focus on the rural health implications of key provisions of the Patient Protection and Affordable Care Act (ACA) through a series of policy briefs with recommendations for the Department of Health and Human Services.[13] The ACA includes a number of program that focus on elderly health and human service needs. They include: 1) The Community First Choice Option (Section 2401); 2) The Removal of Barriers to Providing Home and Community-Based Services (Section 2402); 3) The Money Follows the Person Rebalancing Demonstration (Section 2403); 4) The Funding to Expand State Aging and Disability Resource Centers (ADRCs) (Section 2405); 5) The Community-Based Transitions Program (Section 3026); 6) Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes (Section 10202); 7) Payment Adjustment for Conditions Acquired in Hospitals (Section 3008); and 8) Hospital Readmissions Reduction Program (Section 3025).[14]

The Committee sought to focus on Sections 2405 and 3026 because they are still being implemented and speak to particular challenges facing rural seniors. The first is helping rural seniors understand what services are available and how to take advantage of them and the ADRCs are an important tool in that regard. The second is the need to revisit some past work by the Committee on the Community-Based Care Transitions grant program in order to ensure rural participation in the program. The committee concluded that the ADRCs can play an important role in connecting rural seniors, particularly isolated rural seniors and their caregivers, with the range of resources that may be available. The challenge for the ADRCs will be in understanding the unique challenges that face a rural senior, such as the lack of transportation and lack of direct health services. In addition, ADRCs may also be required to coordinate access to elderly support programs such as congregate and home-delivered meal programs that are financially limited

[13] Available at: http://www.hrsa.gov/advisorycommittees/rural/publications/elderly.pdf
[14] Ibid.

given the higher per unit cost of delivering services to large geographic areas. Thus, ADRCs will need to tailor their services to the geographic reality of the senior taking into account lack of access to other health services such as hospice care. The committee also recommended training for ADRCs on key aspects of the rural health delivery system. Secondly, the Committee explored the Community-based Care Transitions Program (CTTP), which is designed to improve the quality of care transitions, reduce readmissions for high risk Medicare beneficiaries, and document measurable savings. It recommended that Centers for Medicare and Medicaid Services (CMS) give careful attention to rural-based models and ensure that rural providers are part of the overall award pool.[15]

Elder services among states vary. A closer look at a Midwest state which is predominantly rural provides insight into how states assist rural communities and their elder residents. Kansas is predominantly rural with greater than 90% of the 105 counties designated as rural. Kansas has created elder policy that incorporates a comprehensive view of community, which identifies six broad areas: Government, Community Service, Business, Housing, Transportation and Health Care.[16] Communities are encouraged to create a community steering committee which involves local government, the aging network, business, community leaders and volunteers. Within the health care area they identify PACE programming for the delivery of community and facility based long-term care services. This comprehensive view of community promotes a holistic approach to individual health and encourages a population approach to elder policy and services.

Health in its broadest definition is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[17] Communities need to promote healthy living for their elderly residents. A community approach to healthy lifestyles has resources that extend beyond health care and incorporates all aspects of the community. Using a community model such as the elder-friendly community,[18] incorporates numerous factors and organizes them around four central components. Each of the four components addresses basic needs, promotes social and civic engagement, optimizes physical health and well-being, maximizes independence for frail and disabled and encourages the elderly individual to meet their maximum health status. The component to maximize independence for frail and disabled has a central focus related to long term care needs, regardless of whether they are community or institutionally based. The component optimizes physical health and well-being has a central focus related to health promotion/prevention and acute care services such as hospital based and chronic care services such as Dialysis. The remaining two components (address basic needs and promotes social and civic engagement) have a central focus related to community level variables such as safety, transportation and infrastructure such as taxes.

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[15] Ibid.

[16] Available at: http://www.kdads.ks.gov/index.html

[17] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[18] The elder-friendly community model was developed by conducting focus groups of elders in rural, urban and suburban communities throughout the USA. Feldman, P. H., & Oberlink, M. R., (2003). The AdvantAge Initiative Developing Community Indicators to Promote the Health and Well-Being of Older People. Family & Community Health, 26:4, 268-274.

The basic needs component of the elder-friendly model addresses elders' access to food, which relates to their nutritional status. The lack of grocery access for Americans in isolated rural areas is a phenomenon, known as a "food desert" and particularly affects rural elderly. Food deserts are defined as a "community or neighborhood where residents are unable to purchase nutritious food easily due to distance from a market, price, lack of transportation, and/or absence of healthy options".[19] Residents in 418 counties in the nation do not have a grocery outlet within 10 miles of home. These counties typically have a higher percentage of older residents. Research also indicates that residents of these areas where there are no vendors of healthy foods are more likely to be obese and have diabetes.[20] Some examples of state policies addressing this issue include Pennsylvania's enactment of the 2004 Fresh Food Financing Initiative to leverage private and state funds to help finance retail food outlets. Funding can be used not only for construction, but also for workforce training and marketing research. A main aspect of the program is that the stores fit the community needs and culture. As of 2009, Pennsylvania's Fresh Food Financing Initiative had helped 83 stores in 34 rural and urban counties and created 5,000 jobs. States have also worked to ensure that public assistance recipients have access to farmers' markets; Illinois, Indiana, Vermont and Washington passed legislation in the past two years to allow seniors to use their public food benefits (such as SNAP) at these markets. These measures have typically provided technical assistance, health information, and funding to ensure the public assistance recipients can use their electronic benefit transfer card at farmers' markets, This can be helpful to elders who receive benefits from different public assistance programs.[21]

In addition, the basic needs component also takes into account mobility and transportation issues of rural elderly. A 2011 survey conducted by the National Center for Frontier Communities resulted in 518 counties designated by State Offices of Rural Health as frontier with approximately 5.6 million people (http://www.frontierus.org). Mobility for persons living in these highly rural counties means having access to urban centers with banking, commerce, law, engineering, medical and other specialized services. With limited options and long distances, providing access for elderly who cannot drive is a challenge. Intercity bus companies that formerly helped meet this need have dropped routes because they are no longer profitable. According to the Department of Transportation Bureau of Statistics, "between 2005 and 2010, 3.5 million rural resident lost access to scheduled intercity transportation, increasing the percent of rural residents without access to intercity transportation from 7 to 11 percent.[22] To accommodate elderly in isolated communities, nonprofit and for-profit companies are attempting to fill the void, though they face multiple hurdles related to liability and lack of funding. One example of state policy addressing the mobility of seniors in rural areas occurred in Washington State. In 2007, many private intercity bus operators were pulling out the state, leaving 22 communities without bus service to major transportation hubs or other rural towns. In response, the Washington Department of Transportation created a robust intercity bus program using the Federal Transit Administration's (FTA) Formula Grants for Other than Urbanized Areas

[19] Shinkle, D. (2010). Growing Groceries in Food Deserts. Denver: NCSL.
[20] Morton, L.W., & Blanchard, T.C. (2007). Starved for Access: Life in Rural America's Food Deserts. Provo: Rural Sociological Society, 3.
[21] Farber, N. & Shinkle, D. (2011). Aging in place: A state survey of livability policies and practices. Denver: National Conference of State Legislatures (NCSL).
[22] Firestine, T. (2011). The U.S. Rural Population and Scheduled Intercity Transportation in 2010: A Five-Year Decline in Transportation Access. Washington, D.C.: U.S. Department of Transportation, 1.

Intercity Bus grant program. The FTA provides half the program costs, and the state can raise the remaining 50 percent through in-kind matches from private operators. Providers are also allowed to contract with other transportation providers. For example, some bus lines have agreements with airlines so that, if a local airport is closed due to inclement weather, the intercity bus can take them to another terminal.[23]

Rural elders view health as the ability to be productive and many elders in rural farm communities continue to work well past retirement age of 65. Another group of elder retirees choose to move to rural communities where they participate in recreation activities which are not present in urban areas. Challenges for elders in rural areas vary; the native rural community elder may be limited by financial considerations, however, they are connected to the community through kinships and lifelong relationships. The non-native retiree may not have financial challenges but they will probably be limited by their lack of local kinships and connectivity to the area due to lack of local lifelong relationships. Regardless of the reason why elders live in rural areas, the community has the responsibility to provide them with direct and indirect resources which promote physiological, psychological, emotional and spiritual health. Having government facilities which are physically accessible to all individuals is a must. Providing roads, buildings and green spaces which promote health and enhance elder safety through incorporating translational research is important.

Rural elders need to voice their concerns and be active participants in the life of their community. Both the rural elder and the community will benefit when partnerships are created to promote programs based on research, which benefit both the rural community and the elder. Communities need to embrace the elder in their communities. National elder organizations such as the American Association of Retired Persons (AARP) will embrace states to promote elders in rural areas to be active in their communities, while educating state and national leaders in concerns of rural elders. In addition, national, state and local elected officials need to involve rural elders in policies which impact their health. Elected officials, planners and business leaders in communities with large elder populations need to ensure local access to essential health services for the elderly along with adequate elder housing, transportation and social support. The health care delivery system should also consider how to formally link with other communities to allow for easy access to and transition of care when it is necessary to seek health services outside of the community. National policies related to health care need to take into account the distribution of elderly in rural areas. Incentives for health care providers who specialize in elders, such as nurse practitioners, Gerontologist and Geriatric Psychiatrists/psychologists need to include long term incentives, which extend beyond the payment of school loans. Additionally policies need to extend beyond the immediacy of health care shortage areas, to include areas of risk based on components of the elder-friendly community.

[23] Farber, N. & Shinkle, D. (2011). Aging in place: A state survey of livability policies and practices. Denver: National Conference of State Legislatures (NCSL).

References

Farber, N. & Shinkle, D. (2011). Aging in place: A state survey of livability policies and practices. Denver: National Conference of State Legislatures (NCSL).

Feldman, P. H., & Oberlink, M. R., (2003). The AdvantAge Initiative Developing Community Indicators to Promote the Health and Well-Being of Older People. Family & Community Health, 26:4, 268-274.

Firestine, T. (2011). The U.S. Rural Population and Scheduled Intercity Transportation in 2010: A Five-Year Decline in Transportation Access. Washington, D.C.: U.S. Department of Transportation, 1.

Glasgow, N. & Berry, E.H. (Eds). Rural Aging in 21st Century America. New York: Springer.
Johnson, K.M. (Winter, 2012). Rural Demographic Change in the New Century: Slower Growth, Increased Diversity. Carsey Institute. Issue Brief No. 44.

IOM (Institute of Medicine). 2011. The Future of Nursing: Leading Change, Advancing Health. Washington DC: The National Academies Press.

Jones, C., Kandel, W. & Parker, T. (2007). Population dynamics are changing the profile of rural areas. Economic Research Service. USDA. Amberwaves, 5:2, 31-35.

Mishkovsky, N., Dalbey, M., & Bertaina, S. (2010). Putting Smart Growth to Work in Rural Communities (Washington, D.C.: International City/County Management Association), 2-5.

Morton, L.W., & Blanchard, T.C. (2007). Starved for Access: Life in Rural America's Food Deserts. Provo: Rural Sociological Society, 3.

Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

Probst, et.al. (2004). Person and place: The compounding effects of race/ethnicity and rurality on health. American Journal of Public Health 94:10, 1695-1703.

http://www.kdads.ks.gov/index.html

Robert Wood Johnson Foundation. (Nov. 2011). Implementing the Future of Nursing-Part II: The potential of interprofessional collaborative care to improve safety and quality. Charting Nursing's future, reports on policies that can transform patient care. 1-8. www.rwjf.org/goto/cnf.

Shinkle, D. (2010). Growing Groceries in Food Deserts. Denver: NCSL.

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