Rural Aging Teaching Module
Social Work Practice and Competency with Rural Elders

[Introduction 1](#_Toc438048328)

[Objectives 1](#_Toc438048329)

[Definitions of “Rural” and the Key Demographics of the Population 3](#_Toc438048330)

[The Unique Challenges Faced by Rural Elders and the Professionals Who Work with Them 5](#_Toc438048331)

[Poverty 5](#_Toc438048332)

[Health Disparities 5](#_Toc438048333)

[Access to Health and Human Services 5](#_Toc438048334)

[Special Challenges for Diverse Populations in Rural Communities 7](#_Toc438048335)

[The Advantages of Aging and Working in Rural Communities 9](#_Toc438048336)

[Gero Competencies and Rural Practice 10](#_Toc438048337)

[Interdisciplinary Practice in Rural Communities 12](#_Toc438048338)

[Health and Aging Policies Impacting Rural Elders 14](#_Toc438048339)

[Social Security 14](#_Toc438048340)

[The Older Americans Act (OAA) 14](#_Toc438048341)

[The Americans with Disabilities Act 14](#_Toc438048342)

[Medicare 15](#_Toc438048343)

[Medicaid 15](#_Toc438048344)

[Affordable Care Act 15](#_Toc438048345)

[Rural Aging Bibliography 16](#_Toc438048346)

[Books 16](#_Toc438048347)

[Journal Articles 16](#_Toc438048348)

[Health and Mental Health Issues 16](#_Toc438048349)

[Social and Health Care Services 18](#_Toc438048350)

[General/Other 23](#_Toc438048351)

[Stories from Students Working with Rural Elders 25](#_Toc438048352)

[Mrs. Netting and the Johnsons: Case Study 25](#_Toc438048353)

[Frank and Ida Rogers: Case Study 26](#_Toc438048354)

[Web-based Resources 28](#_Toc438048355)

[References 29](#_Toc438048356)

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Introduction

Objectives

1. Define “rural” and identify key demographics of rural areas and residents
2. Describe the unique challenges facing older adults, their informal supports, and service providers in rural areas
3. Discuss the advantages of aging in rural areas and working with this population
4. Identify unique competencies for working with older adults and their families in small towns and rural areas
5. Identify the issues involved in interdisciplinary practice with rural elders
6. Examine the impact of major health and aging policies and programs on rural areas and their older residents

\*\*Note: This module was designed using information and exercises from the book and instructors guide by Hash, K. M., Jurkowski, E. T., & Krout, J. A. (2015). *Aging in rural places: Programs, policies, and professional practice.* New York, NY: Springer Publishing (<http://www.springerpub.com/aging-in-rural-places.html>), as well as from a for-credit and continuing education-based course, *Rural Gerontology*, offered by West Virginia University (<http://academicinnovation.wvu.edu>).

Peaceful…scenic…tight-knit…neighborly…a great place to grow old. That is the picture that many envision when imagining life in a rural community. Small towns and rural areas can offer this reality to many who age in place or relocate to these locales. And, although these communities and their residents have a multitude of strengths, they also present many challenges to older adults, their families, and the professionals that work with them. This module explores the unique experience of aging in small towns and rural areas. The content can be included in a variety of courses but may fit particularly well with human behavior in the social environment (HBSE), diversity and social justice, and courses focused on aging or rural practice. Topics in this module include:

* Definitions of rural and key demographics of the population
* Unique challenges faced by rural elders and the professionals who work with them
* Special challenges for diverse populations in rural communities
* Advantages of aging and working in rural communities
* Gero competencies and rural practice
* Interdisciplinary practice in rural communities
* Health and aging policies impacting rural elders

This module contains or links to materials that may be incorporated into lectures or presentations to help students understand how to work with older adults living in rural communities. It includes the following components:

* PowerPoint Lecture: [Social Work Practice and Competency with Rural Elders](http://www.cswe.org/File.aspx?id=84002)
* [Advanced Rural Gerontology Syllabus](http://www.cswe.org/File.aspx?id=84000)
* Rural Aging Bibliography
* Stories from Students Working with Rural Elders
* Case Exercises
* Web-based Resources

Definitions of “Rural” and the Key Demographics of the Population

To begin to understand the lives of older adults and the challenges and opportunities that they face as they age in rural communities, a definition of “rural” must be established. Unfortunately, it is a difficult concept to define.

Before looking at several definitions that have been put forward, take a moment and write down *5 words* that come to mind when you hear the word “rural” and *describe (in 50 words or less) what you think comprises a rural area.*

One approach to defining rural is to consider the *dimensions* of rural areas and their residents. These include:

* Behavioral: Normative behavior around health such as exercise, diet, and drug and alcohol use; social relationships including family and friends; and service utilization.
* Compositional: Socio-demographic characteristics of the younger and older population in the area, such as age, gender, education, race, ethnicity, and economic status.
* Cultural: Generally shared values and beliefs that influence attitudes and behaviors of a population. These can impact interpersonal relationships, expectations of kin care, and health and service seeking behaviors.
* Ecological: A place’s population size and density, natural environment, and location vis a vis other communities (e.g., proximity to larger city).
* Organizational: Structure of formal activities related to government, economics, health and social services, recreation, and religion;.
* Social and Economic Resources: Economic, physical and organizational infrastructure available to sustain and improve a population’s health and social needs.

(Krout & Hash, 2015, pg. 8-9)

In defining “rural” the ecological dimension is most often considered. However, there is still no uniform definition of the term or one that is agreed upon by federal agencies and other decision-making bodies. Instead, definitions are often used interchangeably when they have different units of measurement, such as the interchangeable use of the terms “rural” and “nonmetropolitan” and “urban” and “metropolitan.” Unfortunately, this inconsistency affects research and public policy.

By defining “rural” using a definition of “nonmetro” from the U.S. Census Bureau, a basic, demographic understanding of older rural residents can be attained. The following figures provide a snapshot of the key features of the population:

* Rural, or nonmetro, areas are home to 50 million people of all ages, or 16% of the population of the United States.
* Those aged 65 years and older make up 16% of the rural compared to 13% of the urban population.
* Persons 85 years and older represent 2.1% of the rural versus 1.7% of the urban population and 1.8% of the U.S. population.
* Rural areas have more older persons than do urban areas; they have a higher median age (40 years compared to 37 years).
* In terms of gender differences, women 65 and older make up a larger proportion of rural areas than men do (18% compared to 14%).
* Rural residents 65 and older are more likely to be married (i.e., heterosexual marriages) than are their urban counterparts (31% versus 29%) but are just as likely to be widowed (29%).
* Older rural residents have lower levels of educational attainment than do their urban counterparts:
	+ 13% have less than a high school diploma, compared to 11% of urban elders
	+ 16% hold a bachelor’s or higher degree, compared to 23% of urban elders.

(Krout & Hash, 2015; U.S. Census Bureau, 2008-2012)

To conclude this section, take a few minutes and determine if where you currently live or where you are from is considered “rural” (<http://www.raconline.org/amirural/>).

The Unique Challenges Faced by Rural Elders
and the Professionals Who Work with Them

In addition to the definitions and demographics that describe rural areas and their older residents, data also exists on the many challenges that they face, including poverty, health disparities, and poor access to needed services. These topics will be discussed in detail below.

Poverty

The definition of poverty has varied by the country and the time period in which people live. Rural residents are often thought to be poorer than their urban counterparts. Before looking more closely at rural poverty, it may be helpful to take a few minutes and review the definitions of poverty and how prevalent it is in the United States by following the links below:

<http://npc.umich.edu/poverty/>

<http://nclej.org/poverty-in-the-us.php>

Rural areas have higher rates than do urban of both individual- (individuals of all ages) and community-level poverty. This is thought to be the result of higher rates of unemployment and lower paying jobs in these areas. These communities also have less adequate access to health care and other community resources (USDHHS, 2008). In addition, persons 65+ in rural areas are at more risk for food insecurity (or not having consistent access to food) and are more likely to defer needed health care due to inadequate health insurance coverage (Bennett, Olatosi, & Probst, 2008; Ziliak & Gunderson, 2009).

Health Disparities

Health disparities is a growing area of concern in this country and has been the subject of many reports and funding to combat the problem. As defined by the U.S. Department of Health and Human Services (USDHHS, 2010), health disparities are:

“a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.”

Older adults in rural communities experience significant health disparities, including:

* increased prevalence of obesity
* more activity limitations
* more years living with physical disabilities
* greater prevalence of chronic (long-term and ongoing) health conditions
* increased reporting of “poor” health
* less likely to engage in health activities

Access to Health and Human Services

One of the greatest challenges facing older adults and persons of all ages in rural areas is limited access to needed services, both health and social services. This includes sufficient numbers of health and human services and the professionals available to provide needed preventative and management care. In particular, rural elders have difficulty accessing:

* Respite and homemaker services
* Affordable and physically accessible housing
* \*Transportation
* Primary care physicians
* Medical specialists
* Dental services
* Mental health services
* Social services

(Housing Assistance Council, 2013a; Li, 2006; Li, Kyrouac, McManus, Cranston, & Hughes, 2012; Virnig, Haijun, Hartman, Moscovice, & Carlin, 2006)

Transportation is “starred” in the list above because it is an area that is considered most problematic for rural elders. Aside from emergency medical services (ambulances), very few transportation options exist in rural areas. Public transportation (buses) does not often exist in small areas or only runs with limited hours and routes. If an older person cannot drive, has an unreliable car, and does not have family or friends to provide transportation, there are often very few options in the community. Options must also be accessible, affordable, and in many cases, adaptable (able to accommodate wheelchairs or other needed equipment). “Essential or life sustaining” (like medical care and grocery shopping) and “nonessential or life enriching” (like visiting friends and going to church) trips are both important for an individual’s well-being and quality of life (Kerschner, 2006).

To conclude this section, take a few minutes to research the services available and not available in a rural community that you are familiar with at

<http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx>

Also, explore the link below to learn more about the growing use of telehealth to bridge the distances between individuals in rural areas and health professionals. This technology is being used in place of or as a supplement to face-to-face medical and social service appointments. For rural elders, this means increased access to providers without the barriers of limited services and transportation options in their communities

<https://www.raconline.org/topics/telehealth>

Special Challenges for Diverse Populations in Rural Communities

Diverse populations residing in rural communities often face the challenges listed above to a greater degree and often deal with additional challenges. Ethnic minorities, gay lesbian, bisexual, and transgender (LGBT) persons, and women who age in these areas are at particular risk and will be discussed below.

In terms of ethnic diversity, many rural areas are predominantly White; 85% of the population of rural communities identify as White, compared with a 72% of urban areas and 74% of the overall U.S. population. Despite this statistic, many individual rural communities are quite diverse in terms of racial and ethnic makeup. Specifically:

* African Americans make up about 8% of the population of rural areas, and the majority live in the Southern United States.
* Rural Hispanics are now the largest and fastest growing ethnic minority group in rural areas, making up over 9% of the population. The majority live in the Southwest United States.
* Nearly half of all Native Americans live in rural areas, and the majority resides in the plains of the Midwest, the Southwest, and Alaska.
* Asian Americans and Pacific Islander population have also seen growth in rural areas despite only representing 2% of the population.

(Housing Assistance Council, 2012b; Hartman & Weierbach, 2013)

These ethnic minority elders often experience even greater challenges and disparities as they age in rural communities, including:

* Transportation
* Poverty
* Health status
* Housing

(Bennett et al., 2008; Housing Assistance Council, 2013b; Lee & Singelmann, 2013; Park et al., 2010; Probst, Moore, Glover, & Samuels, 2004)

Unfortunately, very little is known about gay, lesbian, bisexual, and transgender (LGBT) elders who reside in rural areas. The literature directed at LGBTs of all ages has shown that this population deals with discrimination from family as well as from professionals. This has been partly the result of the lack of universal marriage rights and protections in terms of policy (Cahill & South, 2002; Hash, 2006). This population also experiences higher rates of obesity, HIV, substance abuse, depression, loneliness, and suicide. Transgender elders experience even greater risk for health and mental health challenges (Fredriksen-Goldsen et al., 2011). As strengths, members of this population may have the benefit of built resilience and a strong social support network (Grossman, D’Augelli, & Harshberger, 2000; Metlife, 2010). Older LGBTs residing in rural areas may have the disadvantage of being socially isolated and the lack of specialized services and supports for LGBTs. They may also experience more homophobia and be more reluctant to reveal their sexual orientation or gender identity to professionals, family, and other community members (Comerford, Henson-Stroud, Sionainn, & Wheeler; 2004; King and Dabelko-Schoeny; 2009; Lee & Quam, 2013; Oswald & Culton, 2003).

Although representing the majority in terms of numbers and percentage of the older population, rural women experience unique challenges and disparities. In fact, adult women in rural areas are thought to face greater:

* Poverty
* Barriers to accessing needed health care services
* Prevalence of obesity, cervical cancer, stroke, depression, and mobility reducing chronic conditions
* Risk for intimate partner violence

Similar to other minorities in rural areas, older women often possess resilience that has been built over the years in response to challenges and barriers.

(Alkadry & Tower, 2010; Bennett, Lopes, Spencer, & van Hecke, 2013; Dorfman, Mendez, & Osterhaus, 2009; Housing Assistance Council, 2012b; Peek-Asa, Wallis, Harland, Beyer, Dickey, & Saftlas, 2011; Teaster, Roberto, & Dugar, 2003)

The Advantages of Aging and Working in Rural Communities

The previous section highlighted the challenges faced by rural elders, and there is an abundance of research focused on these disadvantages. Unfortunately, little has been written about the advantages of aging in these communities and working with rural elders. In fact, there are many strengths that older adults in rural areas possess and that rural communities offer. To begin, rural areas are often “tight-knit” and have strong social support networks. This support from family, friends, neighbors, and church members can contribute to increased life satisfaction and a sense of well-being among rural elders. Many rural residents also participate in church services and demonstrate faith-based coping. These beliefs and supports can help individuals cope with challenges such as family and health crises and also may lead to decreased depression and greater life satisfaction (Mair & Thivierge-Rikared, 2010; Yoon & Lee, 2007). Many professionals and students working in these communities with elders confirm these strengths and suggest that the informal support networks of family, friends, neighbors, and churches can fill in the gaps where formal support services are lacking (Hash, Damron-Rodiguez, and Thurman, 2015).

Gero Competencies and Rural Practice

Social work educators and scholars have identified areas of special consideration for effective practice in rural areas with persons of all ages. Many have noted the importance of rural social workers having a *“generalist” training and perspective*. This means that they can effectively work at multiple levels, including intervention with individuals, groups, organizations, and communities. A solid *understanding of rural culture* and its people are also important in facilitating relationships in these communities. This involves the knowledge of local traditions, customs, history, and institutions. Experts in this area have also identified *personal and professional traits* that can improve the effectiveness of social workers in these communities. Being able to handle professional isolation is an important quality because an individual may be the only geriatric social worker in a community. As such, professionals should be prepared to function with little supervision and support from peers, and professional development and continuing education may be even more important. As another helpful trait, social workers in these communities should also be committed to the community and its issues (Locke & Winthrop, 2005).

Finally, social workers practicing in small towns and rural areas should have the ability to *manage ethical issues*, especially dual relationships. The National Social Work Association (NASW, 2008) in its Code of Ethics states that social workers should not engage in what are called dual relationships, which involves having more than one relationship with a client. To manage dual relationships, it is suggested that social workers in small areas prepare for such situations and negotiate roles with clients at the very beginning of their work together. With each client social workers should set boundaries and carefully assess issues of potential harm, exploitation, and disempowerment of clients in various roles and relationships. Other ethical issues, such as confidentiality and self-disclosure, are also likely to be more difficult to manage while working in these communities (Bosch & Boisen, 2011; Galbreath, 2005).

Be sure to check out the website of the Rural Social Work Caucus to learn more about the challenges and opportunities of working in rural communities and to connect with others in the field:

<http://www.ruralsocialwork.org/>

Although not specific to rural practice, the Geriatric Social Work (GSW) Competencies (SWLI, n.d.) have outlined practice skills standards that every social worker working with older adults and their families should be prepared to meet. The competencies can be found at http://www.cswe.org/File.aspx?id=25445 and comprise the following domains of competence:

1. Values, ethics and theoretical perspectives
2. Assessment
3. Intervention
4. Aging services, programs and policies
5. Life-long Leadership

Students and professionals working in rural areas understand that practice in these communities involves special considerations in terms of competency (Hash, Damron-Rodriguez, & Thurman, 2015). In terms of the GSW competencies, social workers practicing in small towns and rural areas will have unique experiences and issues with those that fall under the domains of:

* Values & Ethics & Theoretical Perspectives (competencies 2, 3, & 5)

(2) Respect and promote older adult clients’ right to dignity and self-determination:

Elder residents of rural communities can be very proud, determined, and resilient.

(3) Apply ethical principles to decisions on behalf of all older clients with special attention to those who have limited decisional capacity:

Dual relationships, confidentiality, and self-disclosure can be difficult to manage in rural practice.

(5) Address the cultural, spiritual, and ethnic values and beliefs of older adults and families:

Social workers in rural areas should understand rural culture and the beliefs and traditions of its residents.

* Intervention (competency 6)

(6) Provide social work case management to link older adults and their families to resources and services:

Linking clients to needed resources in rural areas can be challenging as many of these communities lack a full continuum of services.

* Aging services, programs, and policies (competencies 1, 3, 8, 9, & 10)

(1) Provide outreach to older adults and their families to ensure appropriate use of the service continuum.

(3) Identify and develop strategies to address service gaps, fragmentation, discrimination, and barriers that impact older persons.

(8) Advocate and organize with the service providers, community organizations, policy makers, and the public to meet the needs and issues of a growing aging population.

(9) Identify the availability of resources and resource systems for older adults and their families.

(10) Assess and address any negative impacts of social and health care policies on practice with historically disadvantaged populations:

As with Intervention competency 6, linking clients to needed resources in rural areas can be challenging because many of these communities lack a full continuum of services. Identifying and addressing gaps and advocating for needed services and policy changes is even more critical for rural than for urban geriatric social workers.

* Leadership (competencies 6 & 7)

(6) Build collaborations across disciplines and the service spectrum to assess access and continuity and to reduce gaps in services for older adults.

(7) Manage individual (personal) and multi-stakeholder (interpersonal) processes at the community, interagency, and intra-agency levels in order to inspire, leverage power, and identify resources to optimize services for older adults:

Social workers in small towns and rural areas can build professional relationships and become leaders in their communities; leaders who optimize services for elders (Hash, Damron-Rodriguez, & Thurman, 2015).

Interdisciplinary Practice in Rural Communities

Many different disciplines, including social work, serve older adults and their families in small towns and rural areas. These professionals may also work for organizations in larger cities but have clients who reside in more rural areas and travel to receive specialty and other care and services that are not available where they reside. For this reason, we can say that sometimes “urban is rural” and that students and professionals should be trained in the unique aspects of rural living and aging in these areas (Hash, Damron-Rodriguez, & Thurman, 2015). To best serve rural elders, professionals from different disciplines should work collaboratively and communicate effectively. This is often described as “interdisciplinary teamwork” (Monroe, 2015).

Many interprofessional teams work with rural elders in health care settings. If we look at what we consider “health care professionals” that encounter elders in their practice, it may include (but may not be limited to) those working in the disciplines of:

* Dentistry
* Dietetics
* Medicine
* Nursing
* Pharmacy
* Psychology
* Social Work
* Therapies (Occupational, Speech, Physical, etc.)

It may be helpful to review the list above to identify those disciplines that you are not very familiar with and research the particular scope of practice, standard interventions, professional organizations, and special geriatric certification or training relevant to each discipline (Hash, Krout, & Jurkowski, 2015; Monroe, 2015).

The Institute of Medicine (IOM) (2008) report *Retooling for an Aging America* cited a shortage of professionals who are competently trained to work with the growing population of older adults. In response to the IOM report, a coalition of professional organizations was formed to work toward the development of core competencies across the health professions. Similar to the GSW Competencies discussed previously, the Partnership for Health in Aging developed multidisciplinary competencies for the care of older adults. The competencies are considered “essential skills” that professionals should master in order to work with older adults. The Six Domains of Multidisciplinary, Foundation Competencies are:

* Health Promotion & Safety
* Evaluation & Assessment
* Care Planning & Coordination Across the Care Spectrum
* Interdisciplinary & Team Care, Caregiver Support
* Healthcare Systems & Benefits

Take a few minutes to review the Partnership for Health in Aging (PHA) (2010) report on multidisciplinary competencies in the care of older adults at the completion of the entry-level health professional degrees and note the similarities and dissimilarities between the GSW and PHA competencies:

<http://www.americangeriatrics.org/files/documents/health_care_pros/PHA_Multidisc_Competencies.pdf>.

The area of interdisciplinary collaboration and teamwork is addressed in two of the domains:

Domain 3: Care Planning and Coordination Across the Care Spectrum (Including End-of-Life Care).

Domain 4: Interdisciplinary and Team Care.

In addition to professional competencies, many models of interdisciplinary collaboration exist. Freshman, Rubino, and Chassiakos (2010) define interprofessional collaboration as:

A complex process through which relationships are developed among healthcare professionals so that they can effectively interact and work together for the mutual goal of safe and quality patient care. (p. 110)

Team members must have certain skills in order for collaboration to be successful, including the ability to:

Listen actively, communicate non-defensively, share expertise openly, trust and respect members of the interdisciplinary team, problem-solve, and resolve conflicts
(Freshman, Rubino, & Chassiakos, 2010).

In rural areas this collaboration may difficult because professionals may not be working within large systems and may be geographically spread out. In addition, rural communities may face a shortage of medical and social services professionals to help meet the needs of their elders (Monroe, 2015).

Health and Aging Policies Impacting Rural Elders

Polices and programs constitute the larger structures that influence the health and well being of rural elders and the ways in which professionals are able to work with them. Although many health and public policies affect the lives of older adults in rural areas, a few have the most impact:

* Social Security
* The Older Americans Act
* The Americans with Disabilities Act
* Medicare
* Medicaid
* The Affordable Care Act

Social Security

The Social Security Act (1935) provides for income as well as other benefits to older adults and those not able to work. Supplemental security income (SSI) provides a supplement to Social Security for those who fall below a certain income level. The Social Security Act makes possible food stamp and energy assistance programs. It also allows for benefits to WWII veterans as well as to individuals who are blind. Benefits provided through the Social Security Act provide vital assistance to rural elders because they often have low incomes. (Jurkowski, 2015).

The Older Americans Act (OAA)

The Older Americans Act was enacted in 1965; however, it has been expanded through re-authorization amendments. It applies to adults age 60 years and older and also covers grandparents raising grandchildren who are 50 years of age and older. The OAA is administered by the U.S. Department of Health and Human Services (USDHHS) through the Administration on Aging (AOA). From the AOA, money is allocated to states, often through Departments on Aging. Departments on Aging work with local Area Agencies on Aging (AAAs) to offer services at local levels. The AOA offers the Eldercare Locater service, the National Administration on Aging website, and the National Aging Information Center. State-level Area Agencies on Aging administer services including case management, hotlines, referral, insurance, legal, and pension counseling, and long-term care ombudsmen. Unfortunately, rural elders do not always benefit from the full continuum of OAA programs; their communities have significant gaps in many of the services (Jurkowski, 2015).

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) (1990) covers a range of services and opportunities for community inclusion, including the areas of employment, public services, public accommodations, and telecommunications. The ADA applies to individuals of all ages, regardless of location (urban or rural). It was enacted to protect people with disabilities from discrimination in various settings and in all communities (Jurkowski, 2015).

Medicare

Medicare is a medical insurance program for older adults. To qualify, an individual must have worked for forty quarters over their lifetime, which means about ten years of employment contributions paid into Medicare. The Medicare Program is divided into these parts:

* Part A covers hospital, rehabilitation, and long-term care stays.
* Part B is a voluntary supplemental insurance that covers some services that are not included in Part A.
* Part C is also a supplemental insurance programm which helps cover the additional costs to the individual not included in Parts A & B.
* Medicare Part D covers prescription drug expenses.

Like with the OAA programs, rural elders are often at a disadvantage in terms of Medicare benefits. This disadvantage is often the result of covered services or plans not being available in a rural community (Brown & Blancato, 2006; Jurkowski, 2015).

Medicaid

It may be helpful to begin with explaining the difference between Medicare and Medicaid. Both programs provide medical coverage and began in 1965 under the Social Security Act. Medicare is a federal insurance program administered by USDHHS. Persons over 65 and disabled individuals who are eligible through their lifetime work contributions are entitled to its benefits.

Medicaid is also a federal program; however it is administered by the states. Medicaid does not have an age eligibility requirement and provides coverage for low-income adults and children. Rural elders rely heavily on and benefit greatly from both of these programs. As such, recent "cuts" in these programs have had an especially detrimental impact of service delivery in rural areas, an impact that will be worsened by expected future cuts (Brown & Blancato, 2006; Jurkowski, 2008).

Affordable Care Act

The Affordable Care Act (2010) was designed to provide affordable health insurance to persons of all ages in the United States. For older adults in particular, it offers greater accessibility to wellness and preventive care and health care specialists and more affordable prescription drug plans. Because they have lower incomes and may also receive fewer medical screenings and preventive care procedures, the ACA holds great promise for rural elders (Jurkowski, 2015).

To get a complete overview (including the ability to read the entire law) and stay up to date on the latest information on the ACA, visit:

<http://www.hhs.gov/healthcare/rights/index.html>

The Library of Congress has a useful website called “Thomas” where information about legislation can be searched. Take a few minutes and go to the Thomas website (http://thomas.loc.gov/home/thomas.php) and do a search for a rural gerontology-related policy issue.

Rural Aging Bibliography

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Stories from Students Working with Rural Elders

This module ends with a few experiences of students who engaged in field practica with older adults and their families in rural communities. These perspectives personalize the challenges as well as opportunities that exist for students and professionals working with elder residents of these communities, as is shown by these quotes from a recent study.

“There are places that I have visited where, to get to a patient’s house, you have to park at the end of a dirt road and walk across a field. There are places that are not accessible during the winter because of the dangerous terrain you have to drive on to reach an elderly client. Also, many elderly people do not drive, and they rely on family members or neighbors for transportation. If these people are not around, the elderly person does not get to go to their needed doctor’s appointment, for example…they may miss appointments and end up in the hospital.”

“As a part of traditional rural culture, family members take care of their loved ones in times of illness, birth, and death. It was not always possible to get a loved one to a doctor or have the doctor make home visits, so it was up to the family. Tragedy can strike at any time in the form of weather, death, illness, etc. Rural communities banded together to face these tragedies head-on and together. Many are very accustomed to working as a community or neighborhood to help someone overcome a hardship.”

“I think it provides a safe, home-like environment where we can get to know one another. Working with the same people in the same small town, you begin to get to really know the person, almost to the point that they become like family. Our clients become real people, not just another case number, and for the clients, we become a familiar face that they can come to rely on and trust.”

“The stories and the knowledge I have gained from the rural elders I have worked with are priceless. I think I have learned more from them than any textbook could have provided.”

(Hash, Damron-Rodriguez, & Thurman, 2015).

Mrs. Netting and the Johnsons: Case Study

Evelyn Netting is a widowed 85-year-old woman with the energy and spunk of someone decades younger. She still lives alone, drives a car, manages her own finances, and is very independent. She is in excellent health, and in fact, once a year she takes her roller-skates out of the closet, brushes the dust off, and goes for a spin around the dining room for old-time’s sake. She has provided childcare in her home in Downeast Maine for over fifty years and continues to do so up to the present day, though with fewer children in her care now. As one of the few child care providers in a small, rural town, Evelyn has cared for multiple generations of families and has a strong network of client-families and friends in the area. However, because she is working with children in her home all day, she has less time for other activities. The town she lives in offers few formal recreational, social, and educational opportunities, and has very few amenities. There is a small market, a post office, a coffee shop, a church, and a senior center that offers occasional transportation for meals and events, which Evelyn attends when her schedule allows. The nearest large community to access shopping and medical facilities is 30 miles away. If her car were to break down, or if she were no longer able to drive, Evelyn would have difficulty meeting her basic needs. The sidewalks in town are in disrepair, and in order to access any programs or services on foot, Evelyn would have to cross a rural but busy highway. Evelyn’s son had been living nearby and providing any assistance she might need, such as home repairs, snow shoveling, and grocery shopping, but he recently passed away. Her only other living family member is her younger son, who lives several states away and cannot travel long distances due to a chronic health condition.

In the same small Maine town live Ted and Sheila Johnson, a well-educated couple in their late 60s who are photographers in semi-retirement. They raised their children in the town, and they love the area for its natural, unspoiled beauty and its proximity to several lakes and mountains; however, due to Sheila being diagnosed with Raynaud’s Syndrome in her 40s, which causes the blood vessels in her fingers and toes to overreact to the cold, they travel frequently and spend a great part of the year in a warmer climate. When in town, they are quite engaged in the community. They have planned musical, educational, and cultural events for everyone in town to enjoy. Ted serves on a nonprofit advisory board, while Sheila volunteers in a program at a local nature preserve, teaching people how to grow and cultivate herbs. Both participate in the many informal recreational opportunities in the area, such as swimming and hiking. Although they are active and well known in the community, they feel the town is lacking enough social and educational opportunities, especially in terms of intergenerational activities. They could attend events at the senior center, but they do not feel like they have much in common with the people who regularly go there.

Questions for discussion:

* What are some of the uniquely rural features of this case?
* What challenges do Mrs. Netting and the Johnsons face as they age in place in their communities?
* In what ways could a social worker assist these individuals?
* What services might Ted and Sheila benefit from?

Sources for the exercise:

Kaye, L. W., & Harvey, S. A. (2015). Providing services to well older adults in rural areas. In K. M. Hash, E. T. Jurkowski, & J. A. Krout (Eds.), *Aging in rural places: Programs, policies, and professional practice* (pp. 135-159). New York, NY: Springer Publishing.

Hash, K. M., Jurkowski, E. T., & Krout, J. A. (2015). *Instructor’s manual, Aging in rural places: Programs, policies, and professional practice.* New York, NY: Springer Publishing.

Frank and Ida Rogers: Case Study

Frank and Ida Rogers live in a small home that Frank built in a quiet “hollow” in Kentucky. Frank is 85 years old and was a “lifer” in the U.S. Army. He worked in the coal mines for 10 years after leaving the Army to support his loving wife Ida. Ida is 84 years old and served her country as a member of the Women’s Army Corps (WAC) during WWII. She met Frank while serving in the WAC in 1944, and they married two years later. Frank continued his army career, and Ida stood by his side as he completed tours of duty in both Korea and Vietnam. Ida never worked outside the home but has always been actively involved in her faith community and charitable activities. Even now, in her advanced age, she knits blankets for newborns at the nearby critical access hospital and remains a leader in her church. Although their marriage has lasted for over 67 years, Frank and Ida were never able to have children.

Like many veterans coping with combat, Frank used alcohol to dull the nightmares and the images of war in his head. Frank’s alcoholism led to many physical complications including cirrhosis of the liver and pulmonary fibrosis, as well as problems in his marriage and work life. A recent diagnosis of diabetes explains his recent significant weight loss and complications with his eyesight. Pain and numbness (neuropathy) in his feet has resulted in an unsteady gait limiting his ability to walk comfortably for any distance outside the home. Ida has been his primary caregiver up to this point, but there has been a recent change in her as well. She experiences chronic arthritis in her knees and hands, has recently developed hypertension, and has been complaining of frequent fatigue, requiring long naps each afternoon. Neighbors and friends have also reported short-term memory loss, forgetting church meetings, and mistakes in her job as treasurer at the church.

Frank and Ida both require trips to a physician—the closest of which is over 60 miles away. Frank and Ida still drive but neither is comfortable enough to make the long trip alone. Frank and Ida live mainly on Social Security and a small pension from his years in the mines. Frank refused to apply for Medicare when he was eligible because he believes that the Veterans Administration (VA) owes him his medical care. This means that all of his care must come through the VA or it is not covered at all. He is too proud to apply for Medicaid or food stamps, refuses to use the food pantry at the church, and will not allow Ida to accept “charity” from anyone.

Questions for discussion:

* What are some of the uniquely rural features of this case?
* What challenges do the Rogers’ face as they age in place in their community?
* Would you consider Frank and Ida to be “frail” elders? Why or why not?
* In what ways could a social worker assist the Rogers?
* What services would Frank and Ida possibly benefit from?

Sources for the exercise:

Gammonley, D., Hash, K. M., & Sonntag, L. (2015). Providing services to frail rural elders. In K. M. Hash, E. T. Jurkowski, & J. A. Krout (Eds.), *Aging in rural places: Programs, policies, and professional practice* (pp. 161-185). New York, NY: Springer Publishing.

Hash, K. M., Jurkowski, E. T., & Krout, J. A. (2015). *Instructor’s manual, Aging in rural places: Programs, policies, and professional practice.* New York, NY: Springer Publishing.

Web-based Resources

Center for Rural Affairs: <http://www.cfra.org>

Gerontological Society of America (GSA) Rural Aging Interest Group: [https://www.geron.org/stay-connected/interest-groups#rural](https://www.geron.org/stay-connected/interest-groups%23rural)

HRSA Rural Health Policy: <http://www.ruralhealth.hrsa.gov/>

National Association for Rural Mental Health: <http://www.narmh.org/>

National Association of Rural Health Clinics: <http://www.narhc.org>

National Organization of State Offices of Rural Health: <http://www.nosorh.org/>

National Rural Health Association: <http://www.ruralhealthweb.org/>

Rural Assistance Center--Aging: <http://www.raconline.org/topics/aging>

Rural Policy Research Institute: <http://www.rupri.org/>

Rural Social Work Caucus: <http://www.ruralsocialwork.org/>

USDA Rural Information Center: <http://www.nal.usda.gov>

Veterans Administration Office of Rural Health: <http://www.ruralhealth.va.gov>

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