

SERVING OLDER ADULTS IN RURAL NORTH CAROLINA: MEETING THE CHALLENGE

A REPORT FROM THE
NORTH CAROLINA GOVERNOR'S
ADVISORY COUNCIL ON AGING
SYMPOSIUM ON RURAL AGING

Editor:
Lucille B. Bearon, Ph.D.

A publication of the:

*Institute on
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NC Cooperative Extension Service
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North Carolina State University

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December 6, 2000

The Honorable James B. Hunt Jr.
Governor, State of North Carolina
116 West Jones Street
Raleigh, NC 27603-8001

Dear Governor Hunt:

The Symposium on Rural Aging was the culmination of the work of the Committee on the Concerns of the Rural Elderly created in 1998 by the Governor's Advisory Council on Aging. The Committee was formed in recognition of the fact that nearly half of North Carolina's seniors live in rural communities as do at least four in ten "Baby Boomers". In addition, a significant number of the Council members live in such communities.

The Committee on the Concerns of the Rural Elderly was actively working before Hurricane Floyd and the tragic flooding occurred. The symposium was structured to address issues in a broader statewide geographic area than was affected by the flood and an historically longer period of problem development. Despite this basic plan, the problems emerging after the disaster were reflected in the presentations and in the recommendations. It was a timely attention to a population which is sometimes left behind as younger people leave rural areas to seek employment when economic trends take a downward path.

Attended by over 100 people, this was the third symposium designed to educate Council members about important issues affecting the state's older adults and their caregivers. Each symposium aimed to make recommendations of how best to address these problems through new state programs and improved coordination among state agencies.

This publication includes the Council's recommendations with suggestions for implementation as well as details of the material presented by a diverse group of researchers, service providers and other advocates for older adults. The acknowledgments and the listing of brief sketches of those presenting expresses gratitude to the many who made the event so successful. The willingness of the UNC Institute on Aging to publish these proceedings edited by Dr. Luci Bearon is especially appreciated.

You will recall that we submitted to you the recommendations which emerged from this symposium, and we feel honored that you immediately transmitted recommendations to appropriate departments. We shall follow up to see how we may be of further assistance.

Sincerely,

Ann B. Johnson
Chair



In August 1996, the North Carolina General Assembly approved funding for the creation of an Institute on Aging which was placed under the umbrella of the University of North Carolina 16-campus system and based at the University of North Carolina at Chapel Hill. The mission of the Institute is to enhance the well-being of older people in North Carolina by fostering state-wide collaboration in research, education and service. More information about the Institute on Aging is available on our website: <http://www.aging.unc.edu>

The Institute's Aging Information Center is a central source of aging-related information in North Carolina, with resources available to researchers, health and social professionals, government officials, and others across the state. The Information Center library is located in the IOA main offices but can also be accessed via the internet.

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Governor's Advisory Council on Aging

The Governor's Advisory Council on Aging is authorized by state legislation to carry out the following functions and duties:

- To make recommendations to the Governor and the Secretary of Health and Human Services aimed at improving human services to the elderly;
- To study ways and means to promote public understanding of the problems of the aging, to consider the need for new State programs in the field of aging, and to make recommendations to and advise the Governor and Secretary on these matters;
- To advise the Department of Health and Human Services in the preparation of a plan describing the quality, extent and scope of services currently provided to elderly persons in North Carolina;
- To study the programs of all State agencies that provide services for elderly persons and to advise the Governor and the Secretary of Health and Human Services on the coordination of programs to prevent duplication and overlapping of such services; and,
- To advise the Governor and the Secretary of Health and Human Services upon any matter referred to the Council by them.

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Dr. Clare Sanchez (North Carolina Medical
Society)

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- The North Carolina Division of Aging and its staff for assistance with the symposium, including Director Karen Gottovi, Dennis Streets, Mary Bethel, Shawnette Eagleton and Amy Zimmerman.
- The University of North Carolina Institute on Aging for co-sponsoring the symposium and producing the conference proceedings, especially Director Dr. Victor Marshall and Diane Wurzinger.
- The North Carolina Cooperative Extension Service for providing me the time to work on this report.
- Bob White, Chair of the Committee on the Concerns of the Rural Elderly of the Governor's Advisory Council on Aging for his leadership in chairing that committee and in bringing the concerns of the rural elderly to the attention of the full Council.
- All the speakers for sharing their expertise in informative and often compelling presentations and for suggesting ways in which public and private sectors can address the challenges facing rural older adults.
- The Penick Episcopal Home for providing financial support.
- John Frank of the Kate B. Reynolds Trust and Inez Myles of the North Carolina Senior Citizens Federation, for materials appearing in Appendix D.
- Ann Johnson, whose extraordinary vision, leadership and energy have guided this project and all the work of the Council in its efforts to improve the lives of older citizens in our state.

On behalf of everyone who attended the symposium or who learns from this report, I offer my appreciation for these efforts and contributions.

Luci Bearon, PhD
Editor, Conference Proceedings
Chair, Aging Issues Dissemination Committee, Governor's Advisory Council on Aging
Adult Development/Aging Specialist, North Carolina Cooperative Extension Service

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REPORT FROM THE SYMPOSIUM

Outline

- Overview of Rural Development Issues
- The Graying of Rural North Carolina
- Meeting the Special Challenges of Rural Counties

Overview of Rural Development Issues

Nearly one-half of North Carolina's older adults live in rural communities.

The future of rural areas will very much influence the future of many of our elderly and the strengths of older rural households will very much affect the future prosperity of their communities.

Ms. Ann Johnson, the Chair of the Governor's Advisory Council on Aging, opened the conference with basic facts: nearly one-half of North Carolina's older adults live in rural communities, as do at least 4 in 10 Baby Boomers. The Governor's Advisory Council is charged with the responsibility of making recommendations for improving human services to the elderly. This symposium on rural aging was conducted to inform the Council about important issues affecting a significant portion of the older population in our state.

Ms. Johnson noted that the condition of rural older adults is related to the economy of the communities in which they live: "The future of rural areas will very much influence the future of many of our elderly and the strengths of older rural households will very much affect the future prosperity of their communities."

Mr. Leslie Boney, Staff Director of the Rural Prosperity Task Force, expanded upon this theme. The Task Force was established in

1999 by Governor Jim Hunt to identify issues needing to be addressed to improve the economic status of rural counties in the state. Mr. Boney outlined the major economic issues and trends in rural North Carolina which impact on citizens *of all ages*.

The Task Force found that, although rural North Carolina has many assets, some things were broken and in need of repair. When the Task Force was launched, three major trends converged to weaken the economies of rural areas:

- a steep decline in commodity prices
- devastation of the tobacco industry
- a sharp decrease in jobs in the manufacturing sector, especially in rural counties.

Shortly thereafter, North Carolina was hit by Hurricane Floyd which became the worst natural disaster in the state's history, and a major blow to Eastern North Carolina which is largely rural.

Mr. Boney stated that North Carolina is in danger of becoming two states, one urban and prosperous, the other rural and lagging substantially behind. **Ms. Rosi Derka**, a colleague from the Department of Commerce, offered an illustration from the Task Force's findings regarding information technology. Rural counties are handicapped by the lack of available high-speed broad-band Internet capabilities, the high costs of securing available Internet services and the shortage of

High-speed access to the Internet will be critical for the provision of human services in both rural and urban areas.

We need to find some way to stop North Carolina from becoming two states.

opportunities for training people in the skills most in demand in the workplace, including computer science, computer engineering and systems analysis. North Carolina is ranked 46th in computer ownership and 47th in Internet access. Enhancing access to technology in rural areas would allow rural businesses to compete in a global marketplace based on E-commerce and rural citizens to participate in distance learning, electronic voting and other activities spawned by the growth of information technology.

Ms. Derka stated that high-speed access to the Internet will be critical for the provision of human services in both rural and urban areas. She also noted that senior adults are now the fastest growing group of computer users, and need access in order to maintain family ties, get needed information and participate in enrichment activities.

Mr. Boney presented some recommendations for strengthening the rural economy, including creating new ways of financing small businesses, increasing the capacity of local citizens for leadership roles, improving training and retraining for workers, increasing funding for rural schools and community colleges, and building affordable housing. Mr. Boney also pointed out the critical need for improvements to infrastructure such as water, sewer and roads to increase the capacity of rural communities to expand business and residential opportunities.

Mr. Boney concluded with lines from a well-known verse: "North Carolina is a place where the weak grow strong and the strong

grow great.” He added that North Carolina has tremendous assets but is reeling from a combination of factors, and that if we succeeded in “lifting up” the rural portions of our state, “everybody in all of the boats regardless of age” could consider staying in their rural communities.

The Graying of Rural North Carolina

Older adults and immigrants are the fastest growing segments of the rural population in North Carolina.

Although North Carolina is one of the states with the highest proportion of its older citizens living in rural areas, it ranks below the median in the number of clients being served by programs funded by the Older Americans Act.

Dr. Vira Kivett, Professor Emerita from the University of North Carolina at Greensboro, reported that older adults and immigrants are the fastest growing segments of the rural population in North Carolina¹. From an economic perspective, these population changes create new opportunities for growth and community development. But at the present time services for older adults in rural areas and education for self-care that would lead to productive aging are sorely lacking. Although North Carolina is one of the states with the highest proportion of its older citizens living in rural areas, it ranks below the median in the number of clients being served by programs funded by the Older Americans Act.

According to Dr. Kivett, North Carolina ranks 9th among states in the percentage of older adults living below the poverty level. Rural elders experience a higher rate of poverty than do urban elders. Some rural subgroups, including older black women, have poverty rates of 80% or more. A profile of the oldest rural residents (age 85 +) shows that about half are poor or near poor, over one-third have completed high school, and just under

The trends point to an increasingly large population of impaired and vulnerable older persons likely to require additional services, and a more racially and ethnically diverse population likely to require more thoughtfully designed, culturally-sensitive services.

one-half own their own homes. This profile is more optimistic for younger cohorts of older adults, with only one-fourth of those age 60-64 in poverty. Also, most in this younger age group have completed high school and a significant majority own their own homes.

Dr. Kivett focused on five population changes and projected trends that have implication for the design of programs and services:

- an increase in the number of older adults and a change in population characteristics as the Baby Boomers reach their senior years;
- a dramatic increase in the number of persons age 85 and older;
- continued poverty in old age, especially among the oldest-old and those living alone;
- significant increases in the number of older persons who are racial and ethnic minorities;
- continued rapid growth of rural retirement communities in the state.

She also noted that responses to the challenges of the graying population would vary depending on whether a county is a farming or manufacturing county, a retirement destination county, a Federal land county or a persistent poverty county. These categories are not mutually exclusive.

The trends point to an increasingly large population of impaired and vulnerable older persons likely to require additional services, and a more racially and ethnically diverse

The findings were that the rural elderly have higher rates of disability, lower incomes, less education and lower reading ability than their counterparts in small and larger towns.... This casts doubt on the assumption that older people in rural areas are self-sufficient and not likely to need services.

population likely to require more thoughtfully designed, culturally-sensitive services. She suggested that planners should use multiple models, or specify target groups, in designing services appropriate for the diversity of need. She noted that lifelong community residents with strong informal networks would differ from those without informal supports, such as those whose families have moved out of the area as well as new migrants and retirees. She also added that planners need to prepare for future cohorts of older adults who will bring different challenges.

Dr. Jim Mitchell, Director of the Center on Aging at East Carolina University, presented data from his research to elaborate on the special needs of rural elders². His findings dispel the stereotype that older people in rural areas are so robust, self-sufficient, and independent that they are not likely to need services. His study compared the most rural residents (i.e., people residing in areas with no place names or at a rural crossroads) with residents of small towns with up to 10,000 residents, and larger towns of 10,000 or more. He found that the rural elderly have higher rates of disability, lower incomes, less education and lower reading ability than their counterparts in small and larger towns. Each of these “disadvantages” impacts on the need for and ability to access needed services. Dr. Mitchell found, however, that there were few differences by residence in knowledge and use of primary care health services, publicly-funded home and community care services, or Medicare/Medicaid-supported home health services. He pointed out that rural elders are

accustomed to getting to the doctor, even if it means a 100-mile trip with friends or neighbors (often for pay) or with family members.

Some services for older adults simply do not exist in rural areas, such as:

- services that delay or eliminate the need for institutionalization (e.g., long-term coordination of care)
- mental health care
- specialty and subspecialty medical care.

These gaps in service exist for a variety of interconnected reasons, including restrictive federal regulations, the lack of incentives for professionals to reside in rural areas, the lack of a critical mass of service providers and organizations to coordinate the delivery of complex services, and the lack of leadership in rural counties to give priority to innovations in human services. The result: overburdened families and premature or unnecessary institutionalization of older adults.

About 1 in 5 rural elders live alone.

Dr. Karen Roberto, Director of the Center for Gerontology at Virginia Polytechnic Institute and State University added some important facts to the profile of the rural elderly and emphasized the social context in which older rural adults live their everyday lives³. She noted that rural residents have a higher age-adjusted rate for most chronic conditions than their urban counterparts. She also emphasized the increasing population of the very old and pointed out that among rural residents age 85 and over, women outnumber

Family caregiving is not a one-way street. Elders do not just receive assistance, they also support their families.

men more than two to one. About 1 in 5 rural elders live alone, a fact that may have implications for service needs, because people who live alone are more likely to be in poor health and less likely to have access to family members for assistance.

Dr. Roberto spoke of the tendency of older adults to rely on informal caregivers, who are predominantly middle-aged women, many of whom are caring simultaneously for children and adolescents and parents. The demands on family caregivers will likely increase as our elderly population continues to grow, while at the same time the supply of family caregivers is decreasing. She added, however, that family caregiving is not a one-way street. Elders do not just *receive* assistance, they also *support* their families, in roles such as grandparent and sometimes as caregivers and surrogate parents to their grandchildren.

For people planning services for older adults, it is important to note that service use among rural adults is relatively low. A variety of factors contribute to the likelihood of service use including the client's education, awareness, need, accessibility, and cost. Rural elders hold strong values of self-reliance, conservatism, distrust of outsiders, family and work orientation and individualism. Dr. Roberto contends that what is needed is a better understanding of rural elders and their families so service providers can allocate limited resources in the most innovative, appropriate and efficient manner possible.

Meeting the Special Challenges of Rural Counties

There should be a core set of long-term care options and services available in every county.

Long-Term Care. **Ms. Kim Dawkins Berry**, Director of The Area Agency on Aging for the Piedmont Triad Council of Governments, described current issues in long-term care policy affecting the rural elderly, by focusing on the work of the Institute of Medicine's Task Force on Long-Term Care Policy⁴. This task force, constituted in 1999 has been charged with presenting recommendations for a comprehensive, equitable, consumer-friendly system of long-term care for all elderly and disabled North Carolinians. Ms. Dawkins Berry described the preliminary recommendations of the task force, including the idea that there should be a core set of long-term care options and services available in every county. Some of these services are respite, home-delivered meals, housing and home repair, adult day care and day health. She illustrated many issues facing long-term care policy-makers and planners such as developing systems for information-and-assistance that are at once standardized, efficient and protective of confidentiality, and the shortage of aides to provide in-home services. Ms. Dawkins Berry noted the disparities in access to and quality of care for people who can afford services on a private-pay basis versus people requiring public assistance. The Institute of Medicine Task Force is working to assure that everyone has access to the services they need and that the quality of the services is the same for everybody in the state of North Carolina. Of particular relevance to people in rural

In an urban county you might have 50 different agencies for care management and in a rural county you might have nobody.

communities is the absence of some services or the higher cost of available services than found in urban counties, as well as inconsistencies between adjacent rural counties. "In an urban county you might have 50 different agencies for care management and in a rural county you might have nobody." Ms. Dawkins Berry stated that some rural counties lack the stable and committed professional leadership, knowledge of how to use public funds and private resources for maximum effectiveness, and a trained work force to provide needed services. Also, the rural elderly tend to have fewer resources for securing those services that are available.

Ms. Dawkins Berry called attention to the special needs of older women whose life in rural communities was enmeshed in farming and family roles which left little economic security for their later years. Citing historical issues such as irregular work patterns, sex discrimination, family caregiving, limited education and divorce, she pointed out the vulnerabilities of these women in obtaining long-term care for themselves, and suggested that priority be given to identify women at risk to inform them of available assistance before they reach the point of crisis. She also mentioned the need to involve the large numbers of older in-migrants in community service. She urged support for federal legislation to support family caregivers and to provide Medicare coverage for prescription drugs, and suggested that money from the tobacco settlement be directed to assist the rural elderly, many of whom spent most of

their lives in tobacco farming and related occupations.

Transportation. **Ms. Donna Creech**, Director of the Johnston County Council on Aging described the challenges of providing non-emergency transportation to elders in rural counties. She noted several common concerns:

The vehicles and the regulations are not tolerant of frailty. For instance we do curb-to-curb service. If you have vision problems, if you have difficulty with mobility, it's difficult for you to get out of your house to the vehicle.

- the lack of public and private transportation options (for example, a reservation may require 2-3 days lead time; also, taxis do not go out into some areas)
- a shortage of vehicles equipped for disabled persons
- insufficient numbers of people trained or available to accompany frail persons who cannot ride unassisted on a van
- regulations which limit accessibility of vehicles (for example, "The vehicles and the regulations are not tolerant of frailty...We do curb-to-curb service. If you have vision problems, if you have difficulty with mobility, it's difficult for you to get out of your house to the vehicle.")
- the long distances and high costs of mileage in large geographic areas
- problems with scheduling rides and appointments to maximize resources
- problems with billing for canceled trips, and some client abuse (for

Local governments need to give transportation a higher priority and fund public transportation above the minimum level needed to get state funding.

example, people call their doctors to change their appointment but forget to call the transportation provider and change their appointment)

- a mountain of paperwork with low-tech record-keeping systems which have a high capacity for error.

Additionally, Ms. Creech noted the reluctance among rural residents to accept van transportation, including concerns about traveling with strangers and/or without personal assistance. She pointed out that in her county there are few family members available during the day to assist their elders in getting to appointments.

Ms. Creech suggested that the public needs to be educated about using the available systems and that health care providers need to be made aware of the importance of working with transportation providers in scheduling appointments. She also noted that local governments need to give transportation a higher priority and fund public transportation above the minimum level needed to get state funding. Policy changes should include funding for enhanced technology to schedule appointments, track travel routes and keep more reliable records.

Housing and Supportive Services. **Ms. Cynthia Davis**, Assistant Director of the Area Agency for the Mideast Commission addressed the special challenges of housing for older rural adults. She described several

different housing options for older adults:

- independent apartments for the elderly, disabled or handicapped (services not provided)
- congregate housing with supportive services such as transportation, meals, recreation
- continuing care retirement communities (which include a menu of services and either a nursing home or an adult care/assisted living facility)
- shared housing
- multi-unit assisted housing with services, a form of assisted living which includes personal care and other services for semi-dependent elderly people

Some of these important housing types are not available in rural settings and many only cater to private pay markets.

In describing the challenges of providing such housing in a rural area, Ms. Davis said:

“Some of these important housing types are *not* available in rural settings and also many of those only cater to private pay markets.... We have the challenge to produce housing-with-services types in rural settings in order to give our seniors choices that enable them to remain in their communities.” Ms. Davis cited the need to build the capacity of developers to produce and manage these kinds of housing in a cost-effective manner (especially with the smaller economy of scale), the need for more flexible funding options, and the improvement of infrastructure in Eastern counties, especially those hit by the flood. She provided a number of examples of shared group housing and housing with services built in the 1990s

Issues of concern to rural elders include isolation, safety, lack of choices, distance, and lack of education.

or in development in rural counties. She also provided information on federal, state and local funding and support sources, such as the federal Rural Development funds, Rural Rental Assistance, the North Carolina Housing Finance Agency, the North Carolina Housing Trust Fund, and county councils on aging. She applauded the partnership between the North Carolina Housing Finance Agency and the Division on Aging: "These efforts and partnerships must continue and must grow. As we allocate money for services and as we fund housing, rural factors must be taken more into account in order to overcome the disparity that exists."

Mr. Bob White, Chair of the Governor's Advisory Council's Committee on the Concerns of the Rural Elderly, opened the second day of the symposium with a review of the work done by the committee. He highlighted issues of concern to rural elders, including isolation, safety, lack of choices, distance, lack of education, and urged individual and group advocacy to bring about changes.

The Role of Foundations and Faith Communities. **Dr. Valerie Rosenquist**, Associate Director of the Rural Church Division of the Duke Endowment addressed how one foundation is making a difference in the lives of rural seniors⁵. The Duke Endowment was established in 1924 to support selected colleges and universities, children's homes, non-profit hospitals, and rural United Methodist churches. The Endowment's Health Care Division supports

(1) programs that attempt to provide community coordination of care and services; (2) programs that attempt to coordinate and provide extensive care to patients in nursing homes; (3) statewide planning for the needs of the elderly; (4) efforts to determine how best to utilize nurse practitioners in long-term care facilities; and (5) projects providing care and support services explicitly geared to the needs at the end of life. The Rural Church Division supports building projects and outreach ministries. The two divisions have worked jointly in developing parish nursing programs to extend health care in rural communities and on issues of prescription drug assistance.

Communities have not figured out how to use retirees to provide needed leadership.

The Rural Health Division has as one of its major goals the integration of care for seniors into the lives of rural churches; in rural areas the major portion of church members are senior citizens. Dr. Rosenquist stated that retirees who move to rural communities bring a wealth of experience and ability but that communities have not figured out how to use them to provide needed leadership. She added that those who have lived a long time in rural communities are a great resource, providing transportation, getting groceries, and doing intergenerational outreach. "They carry the history of the locale, they know the ropes, they know who can be counted on to do what, when. They are dedicated to the community." Dr. Rosenquist described the extreme isolation and poverty of some rural elders, and their need for advocates. She also pointed out the needs of caregivers who are exhausted, lack resources and

alternatives. She suggested that all of these challenges are opportunities for churches to provide leadership.

Health and Health Care. **Mr. Jim Bernstein** of the North Carolina Department of Health and Human Services' Office of Research, Demonstrations and Rural Health Development, addressed issues of health care for rural adults, describing the vast increase in the numbers of rural health centers and providers in rural communities since the early 1970s. He also described in some detail the trend away from small hospitals and doctor's offices toward big systems of care. All health care in the state may eventually be organized into six systems, each responsible for the people in a large geographic area, and accountable for population-based outcomes in that area. Although getting providers distributed to all areas is still difficult, the situation is very much improved over the way it was.

The health issue of the 21st century is care for seniors.

He gave several examples of programs, planned or in the demonstration phase, which address access, quality and cost issues in health care, prescription drug access for the indigent, and coordination of care in long-term care. He described the emerging challenges of monitoring and evaluating managed care plans and programs, and speculated on how the trend toward fee-for-service arrangements, the aging of the Baby Boomers, innovations in medical technology and information technology, an emphasis on wellness, and treatment of the mentally ill will

affect the health care and health of North Carolinians.

He predicted a widening gap between poor and rich, such that in 2010 the disparity between the bottom 25% and the top 25% will have increased significantly from what it is today. He stated that the health issue of the 21st century is care for seniors and warned of the need to develop strong networks to be a countervailing force in the expected competition between children and the elderly and between public and private providers for the finite resources available.

Employment and Training. **Ms. Margie DeWoskin**, Director of Employment and Training for the Triangle J Council of Governments, noted the special challenges of employment and training for older adults in rural areas, where economic security is often a struggle, especially in an economic downturn. Barriers to opportunities are “location, location, location” and “transportation, transportation, transportation.” Often the jobs that become available are not desirable or appropriate for older workers, especially for those people without computer skills. She added “One of our biggest challenges is having the skills and the abilities and the educational level of older adults match the job opportunities, and if they don’t, we need to ask what can we do to bring that match closer together.”

The Title V program is the federal program under the Older Americans Act that helps

Barriers to employment opportunities in rural areas are ‘location, location, location’ and ‘transportation, transportation, transportation’.

What we discovered is that whenever we promote the value of hiring older workers we get many calls from the service industry. But these are not always the kinds of jobs older workers want.

low-income people 55 and older obtain employment and training. Additional opportunities have been created in recent years, especially in response to the 1996 report of the Governor's Older Worker Task Force which stressed that older workers were critical to work force and economy. The report made 50 recommendations for enhancing employment opportunities for older workers in North Carolina. That report, along with national initiatives, has created an interest in older workers. "What we discovered is that whenever we promote the value of hiring older workers we get many calls from the service industry. But these are not always the kinds of jobs older workers want." There have been other changes in the last four years, including the Workforce Investment Act which is a Federal attempt to consolidate all the numerous employment and training programs. There are 71 JobLink Centers in North Carolina, and there are efforts underway to make sure that older adults are referred to older worker employment and training programs, such as the Title V program, where available. Also, training has been given to all employment and training specialists to raise their awareness about the benefits of employing older workers.

Ms. DeWoskin urged participants to find out what is going on in their own communities, and to make sure that the employment and training professionals are working in coordinated efforts across agencies and organizations to facilitate services for older workers. She included in that list of potential

We assume that in a rural area in a tiny little town or crossroads that everyone knows everyone and everything and that's not really true. They may know the people that live around them but they don't really know the system and the institutional pathways that they might be able to access. They also don't consider themselves in need of the institutional services.

partners, senior centers, which now include job-related skills such as computer training as part of their programs.

Information and Assistance. **Ms. Janet Bradbury**, Coordinator of Information, Assessment and Case Assistance for the Pitt County Council on Aging defined "information and assistance" as services designed to link people with resources available in their geographical area. The information task is rather straightforward, consisting of telling people about a service, giving out a phone number or connecting them to the service provider. Assistance is more intensive. It includes helping people figure out what they need, planning and coordination, follow-up, and advocacy: "We get a lot of calls from people who just know it's not working. They don't know what they need. They need a little help figuring that out."

Bradbury explained that many rural residents do not consider themselves as needing formal services, and seek out natural advice-givers in the community, or call professionals in the evening to talk about their problems in a more personal manner. She noted that it is hard to get the word out about available services in the more remote areas. Additionally, staffing for information and assistance is often a low priority, assigned to the least trained member of an agency's staff. She urged cross-training for staff in the use of information resources, whether high-tech or low-tech. She also emphasized the growing need for computer databases that include services over a wide geographical area and

Advocacy starts locally, at the ground level where programs are delivered.

standardized software that allows data-sharing across counties and agencies.

Senior Empowerment and Community Action⁶. **Ms. Karen Gottovi**, Director of the North Carolina Division of Aging, provided information on how to engage in effective advocacy on behalf of older adults in rural areas. She noted that advocacy starts at the local level (city, county, or town) where programs are delivered. She pointed out, for example, that decisions as to how to use Home and Community Care Block Grant funds are made by county planning councils or county commissioners. Advocacy could be enhanced by developing local coalitions and seeking support from local nonprofits and foundations. Discussing advocacy at the state level, Ms. Gottovi pointed out that senior advocates have been quite successful in recent years in increasing allocations for the Division of Aging and raising the eligibility level for Medicaid services so as to serve an additional 35,000 people. She urged continued advocacy to influence how tobacco settlement monies are spent, how the long-term care continuum is reformed, how information and assistance is delivered, among other issues. At the national level, advocacy challenges include gaining prescription drug coverage, strengthening Medicaid and Medicare and Social Security, and reauthorizing the Older Americans Act. She cited steps needed to be an effective advocate, including getting the facts on what the proposed program will or will not do, joining with other nonpartisan groups and individuals who share the same goals,

We know the benefit of networking, of cooperative and complementary activity among many voices.

connecting with local county commissioners and state legislators, putting together bills and finding someone in power to support the issue.

Council Chair **Ann Johnson** closed the conference with a charge to the Governor's Advisory Council to prepare recommendations that address remedial activity needed to alleviate conditions related to the older adult in rural counties. The recommendations are to be transmitted to the Governor and Secretary of Health and Human Services. She ended with this statement: "If we have learned anything as North Carolina advocates for the elderly, we know the benefit of networking, of cooperative and complementary activity among many voices. We hope that the many organizations this audience represents will hear from you and you choose to become participants today in promoting obvious change."

Endnotes:

¹ A more detailed report by Dr. Kivett begins on page 26.

² A more detailed report by Dr. Mitchell begins on page 36.

³ A more detailed report by Dr. Roberto begins on page 46.

⁴ The report of the Task Force can be obtained from the North Carolina Institute of Medicine, Woodcroft Professional Center, 5501 Fortunes Ridge Drive, Suite E, Durham, NC 27713, (919)401-6599; Fax: (919)401-6899.

⁵ Information about an additional foundation's efforts on behalf of rural elders can be found in Appendix D.

⁶ For more on the subject of senior empowerment and advocacy, see Appendix D.

**RECOMMENDATIONS TO THE GOVERNOR
TO SUPPORT AGING SERVICES
IN RURAL AREAS**

The Council supports the recommendations of the North Carolina Rural Prosperity Task Force designed to bring economic prosperity to rural North Carolina. Of particular importance is the emphasis on increasing the availability of high speed, reliable and affordable Internet access; improving education, training, and retraining of students and workers; retooling the farming industry to assure a viable future; strengthening the infrastructure for transportation, housing, jobs and human services; and boosting community and economic development.

The Council recommends that:

- A. Future deliberations and initiatives stemming from the work of the North Carolina Rural Prosperity Task Force consider the significant presence of seniors in rural areas and include senior representation in all related state-level activities. Specifically, the Council wants to assure that:
- Seniors and the agencies that serve them are among those enjoying greater Internet access.
 - Older workers have equal access to appropriate opportunities for education (including literacy), training and retraining.
 - Agencies serving older adults are among those benefiting from efforts to support rural businesses and community development.
 - The interests and circumstances of older farmers and their families are included in the move to equip North Carolina for the future.
 - The needs and interests of seniors and the agencies that serve them are addressed in decisions about where and how to improve the rural infrastructure.

- The knowledge, skills and experience of seniors are respected and used in leadership and decision making roles in the efforts designed to build the capacity of rural communities.
- B. The Division of Aging, in collaboration with the Area Agencies on Aging, undertake steps to further help rural counties ascertain their capacity to address the needs of their older citizens and to assist them in their efforts to develop a comprehensive coordinated system of services that is responsive to community needs. This should include:
- Analyzing how funds are being used in relation to service needs,
 - Identifying gaps in service,
 - Analyzing use of volunteers and barriers to effective use,
 - Strengthening the availability and capability of the aging services workforce,
 - Examining the presence and needs of local leadership in aging,
 - Determining the preparedness of rural areas to respond to recommendations for long-term care reform,
 - Identifying the health disparities that exist in rural communities, and
 - Strengthening the role of senior centers in rural areas and seeking support for increased funding.
- C. The Task Force on Aging Information and Assistance (a previous recommendation of the Council) to be established by the Division of Aging give special attention to the circumstances of rural areas. Minimally, these include: (1) a lack of resources (e.g., technology, trained personnel), and (2) the constraints of long distances.
- D. The position of Assistant Secretary for Aging in the North Carolina Department of Health and Human Services be reactivated by appropriating the necessary funds to support

- this position on a full-time basis. The Council believes that this position is important in the State's efforts to improve the system of long-term care and is also vital in assuring that our state avoids for seniors the trend that Governor Hunt labeled as "becoming two North Carolinas. . . (One) urban and thriving; the (other) rural and struggling."
- E. The federal legislative proposal to establish a National Family Caregiver Support Program be supported. This program includes: (1) a tax credit for people with long-term care needs or their caregivers; (2) funding for services which support family caregivers of older persons; (3) improved equity in Medicaid eligibility for people in home and community-based settings; and (4) encouragement of partnerships between low-income housing for the elderly and Medicaid. While the Council sees this as important for all older adults, it is particularly timely for rural seniors and their caregivers.
- F. A portion of the Hurricane Floyd Disaster Funds be earmarked for housing with services for older adults, and support for the Housing Trust Fund be increased with a part of this new funding directed to housing for older adults in rural areas.
- G. Transportation services in rural areas be expanded. Specifically, the Council:
- Encourages the Division of Aging to reevaluate reimbursement policies for transportation services to allow for the calculation of reimbursement rates based on mileage rather than trips.
 - Asks that the North Carolina General Assembly study liability issues related to the provision of transportation services and that steps be undertaken to address the liability concerns of those who provide transportation assistance.

- Asks that the Department of Transportation protect the legislative intent of North Carolina General Statute 136-44.27 which established a state-funded elderly and disabled transportation assistance program (EDTAP) by retaining current basic requirements for use of the EDTAP funding at the county level. Where EDTAP funds are not being utilized efficiently at the local level, the Department of Transportation should consider other options including redistributing funds to sparsely populated rural areas where the costs of transportation services are higher.
- Supports the development and strengthening of rural transportation resources. The Department of Transportation and its Human Services Transportation Advisory Council should study:
 1. The needs of public transportation systems for better resources, including technology, to increase mobility options for people who cannot or should not drive;
 2. Options for updating transportation policies and procedures to ensure that human services transportation can be delivered; and
 3. Existing model rural transportation programs with exceptional services to older adults and younger adults with disabilities (i.e., services for people who need more than a ride in order to be able to access the transportation service).

**CURRENT PROFILE OF NORTH CAROLINA'S
RURAL OLDER ADULTS: PART I
Vira R. Kivett**

The importance of this symposium on rural aging was underscored by Governor Jim Hunt, July 1999, in his announcement of the formation of the North Carolina Rural Prosperity Task Force, saying: "We are on the verge of becoming two North Carolinas...One is urban and thriving. The other is rural and struggling" (North Carolina Department of Commerce, February 21, 2000). The Task Force studied reports which showed older adults and immigrants as the fastest growing segments of the rural population (Rubin & Ort, 1999). Rather than seeing this as a liability, members of the Rural Prosperity Task Force were asked to see this trend in population change as offering new opportunities for economic and community development.

Presenters to the Task Force set forth the challenges: ... "To help rural communities prosper, we must ensure that (1) immigrants are integrated into communities and work places; (2) aging workers remain productive; and (3) elders have access to the services they need and opportunities to contribute to the life of their communities...(Rubin & Ort, 1999, p. 1). Not surprisingly, the Task Force on Rural Prosperity found strong evidence of the continuing inadequacy of accessible, affordable services for older rural North Carolinians. Education for adults of all ages for self-care and productive aging was also found to be sorely lacking. As we have just heard, the Task Force pointed out numerous factors that stand in the way of the quality of life in rural North Carolina (Boney, April 2, 2000). All of these factors either directly or indirectly affect rural older adults and their support systems. This climate is the rural context in which we must plan and provide services.

My remarks today will be based upon the United States Census Bureau's definition of rural areas of less than 2,500 population and not located in a metro area (U. S. Census, 1995a). I would like to present the information in the content of the rural environment in which rural

older North Carolinians are aging, suggest service models, and pose several important questions surrounding rural aging that are increasingly being asked. Given population shifts and urbanization that occurred during the last century, a primary question of interest to this group and others making funding decisions is:

Question 1: How rural is North Carolina and should “rural” areas be justifiably considered for special funding for older residents?

Overall, approximately 13% of adults in North Carolina are 65 years or older (U.S. Bureau of the Census, 1999). This percentage approximates the national figure and is expected to increase between 1996 and 2020 to approximately 18% (Center for Aging Research and Education Services, 1998). In 1999, 49% or approximately 3.9 million people in North Carolina, were rural residents (Economic Research Service, 2000). This number represents a 16% increase since 1990. Although the percentage of people living in rural areas at the turn of the 20th century was almost double that of the current percentage, the rural population in North Carolina declined by only 11% in the last 40 years (U. S. Bureau of the Census, 1995b).

North Carolina holds several rural distinctions among the states. Currently, about 47% of North Carolina’s older population lives in rural areas. This percentage can be compared to 31% of the elderly in the United States (Rubin & Ort, 1999). North Carolina is expected to maintain this lead over the general population of the elderly for about the next 30 years. Among those states receiving Older Americans Act funds, North Carolina ranks third in the number of persons 60 years or older living in rural areas. However, it ranks 28th in the number of rural clients being served by such funds (Administration on Aging, 2000).

Most economic, health and social indicators support the argument that rural North Carolina can justifiably be considered for special funding and attention. The results of research studies show higher rates of poverty and chronic health problems, more substandard housing and social and health service needs among rural than urban elders (Bull, 1998; Economic Research Service, 1997a; Rubin & Ort, 1999).

Approximately 13% of adults 65 years or older, statewide, fall below the poverty level (Administration on Aging, 1999). Rural minorities represent a disproportionate share of the disadvantaged segment of the rural population (Cook, 1999). My own research in rural areas of the state shows poverty rates to balloon to 80% or more among certain rural subgroups such as older black women (Kivett, 1997).

Question 2: What is the current profile of rural older North Carolinians?

North Carolina ranks third among the states receiving Administration on Aging funds in the number of persons 60 years or older living in rural areas (Administration on Aging, 2000). North Carolina also has several other distinctions among the states. It ranks seventh with minority older adults aged 60 years or older. Approximately one in five persons 60 years or older is a minority. The State ranks ninth among states in the number of persons 60 years or older below the poverty level. Given limited demographics on rural older adults in North Carolina, national data occasionally must be extrapolated to the State. Nationally, the median age for the rural population in 1998 was 36 years, approximately two years older than for the urban population.

As among urban groups, rural women have a greater survival rate than men at all ages (Clifford & Lilley, 1993; Rogers, 1999). Women constitute 55% of adults 65 years and older in rural areas. They make up 63% of the population 85 years and older. By age 85, women make up 4.7% of the rural population compared to .7% of men (Bull, 1998). It is expected that the gender gap in longevity will narrow somewhat over the next two decades.

Economic well-being declines with age and rurality. In 1998, over one-half of rural persons 85 and over were poor or near poor, while one-quarter of those aged 60-64 fell into these categories (Rogers, 1999). Rural older persons living alone are considerably more likely to be poor than older married couples. Approximately 32% of rural older adults living alone are poor. Almost 82% of rural adults between the ages of 60-64 are high school graduates. About 39% of rural older adults 85

years or older have finished high school, a figure that changes significantly with level of rurality (Rogers, 1999).

My research shows the dramatic effects that a difference of 2-3 additional years of education can make in life expectancy among rural older adults (Kivett & McCulloch, 1992). Educational levels are increasing among this group. These increases are related to higher educational levels among the young-old and the in-migration of higher-educated retirees.

Home ownership remains high among elderly rural North Carolinians until very old age. The majority of adults age 65 to 80 years own their own homes. This number declines to about 41% by age 85. Despite numbers of rural persons 85 years or older living alone (51%), the majority of them need assistance with one or more activities of daily living (Kivett, Stevenson, Zwane, Cachaper & Moxley, 1997).

Rural older adults in North Carolina usually rate their health as good or fair, rating below that for the general population of rural older adults (Rogers, 1999). Ratings decrease with age. Despite health, economic and other challenges associated with age and residence, morale and life satisfaction are moderately high through very old age (Kivett & McCulloch, 1992; Kivett, Stevenson, & Zwane, 2000).

Question 3: What are the demographic trends among rural older North Carolinians?

The first trend is an increase in the sheer number of older adults, their distribution and socioeconomic status. In approximately 2010, there will be the beginning of a 2-million person cohort entering old age in North Carolina (Center for Aging Research and Education Services, 1998). Most of these Baby Boomers will be women; have fewer disabilities, be better educated, and have higher incomes than their parents at a comparable age. There will be smaller income gaps between racial groups, a greater diversity of family configurations and fewer married persons. The incoming old also will be less likely to live in intergenerational households, more likely to live alone, more

acculturated to lifelong learning and have higher expectations for services as a right and access to the latest technology in their health care. The down side is that they will have far fewer family resources to turn to in their old age than their predecessors. Additionally, they will contribute to higher dependency ratios.

The second trend is a dramatic increase in the number of persons 85 years and older. Projections vary on the number of adults 85 years and older. Modest estimates for the United States as a whole show a 402% increase in the number of adults 85 years or older between 1995 and 2050 when the last of the Baby Boomers enter this age group (Administration on Aging, 1997). Other population projections show a 754% increase.

The third trend is continued poverty in old age especially among the oldest old, and those living alone. It is anticipated that poverty will be perpetuated through increasing numbers of the very old and those living alone. Current trends in fewer marriages and continued low male-to-female ratios and marginal increases in longevity will contribute to larger single households in old age.

Fourth, there will be significant increases in the number of older ethnic minorities. It is anticipated that, nationally, approximately one in five elderly persons will be nonwhite by 2050 compared to one in 10 in 1994 (U. S. Bureau of the Census, 1995c). Given current trends, it might be expected that rural North Carolina will obtain even higher percentages of blacks and Hispanics than many less rural states.

Fifth, there will be continued rapid growth of rural retirement counties in the State. North Carolina has continued in an upward spiral in the attraction of retirees (Kivett, Dugan & Moxley, 1994; Longino & Haas, 1993). Given increasingly larger numbers of aging cohorts and tendencies not to age in place, in-migrants are expected to come to the state in increasing numbers. Retirees will continue to contribute to the economic well-being of these communities and hold high expectations for the latest in medical and social resources. They will continue to stimulate the economy and contribute to the development of better

medical care in rural areas (Reeder, 1998). At the same time, they maintain the potential for driving up rural living costs and dividing communities.

Question 4. What does the profile of rural counties suggest in the design of programs and services for older adults?

Each rural county in North Carolina faces various challenges and requires different solutions to meet them. The North Carolina Rural Prosperity Task Force concluded “North Carolina is a state of great dichotomy, with urban centers of tremendous prosperity surrounded by large distressed areas.”

Most counties fall into one or more of five types each with implications for the well-being of older adults and their families (Economic Research Service, 1997b). Historically, the first two county types have been mutually exclusive and characterized by their economic dependence on a particular industry. Their distinctions, however, are becoming more blurred, a trend that will continue. They are: (1) Farming counties; and (2) Manufacturing counties. In many cases, these two types are the rural areas most in current crises. The three remaining types of counties in North Carolina may or may not overlap with the two prior mentioned ones. They are: (3) Retirement-destination counties (15% net migration of persons 60+); (4) Federal lands counties, and (5) Persistent poverty counties. Service planners and providers in each of these county types have specific challenges.

Question 5. What does the profile of rural older North Carolinians suggest as major challenges to the aging network and to policy makers?

Trends among the rural elderly in North Carolina demand a different structure and orientation of services. There are demographic and socioeconomic changes occurring in the new century that will require careful consideration in planning for the rural elderly. A first challenge is meeting the needs of the growing numbers of rural older adults in general and the very old in particular.

Health and social services need to be designed to provide better and more effective care for the elderly with chronic conditions that impair their ability to function independently. Increasing numbers of some very vulnerable groups such as those 85 years and older living alone (approximately 50% in many rural areas), older women, elderly racial minorities living alone and with no children, and elderly unmarried persons living alone with no living children will require special services in housing, transportation, recreation and education as well as in health and nutrition.

The second major challenge in meeting the needs of rural older adults is their increasing diversity. Although the rural older population is predominantly white, it is becoming more racially and ethnically diverse. North Carolina's Hispanic population has doubled over the past seven years (Rubin & Ort, 1999). Current estimates range from 150,000 to 300,000, and their numbers continue to increase rapidly. Pockets of Hispanics have formed in a number of rural areas of the State. Contrary to earlier patterns, many Hispanics are now long-term residents, aging in place. There has been an increase in return migrants, particularly Blacks, to the rural South. Culturally-sensitive programs and services must be thoughtfully designed and implemented.

Question 6. What types of service models are suggested by the diverse profile of older adults in rural North Carolina?

Four models are suggested. The first model accommodates lifelong community residents who have maintained large kinship and informal networks. The second model services lifelong community residents whose informal support resources have been reduced as family members have moved away from the area. The third model addresses migrant elders who, because of their limited recent history in the area, have minimal access to informal support networks. The last model accommodates retirees who have moved from other areas with little or no previous history in the area and, as a result have limited informal social support. Socioeconomic status, race and ethnicity, and age level effect how and if these service models will be accessed.

Not all of the needs of rural older adults can be addressed through programs and services. In many cases, policies and legal barriers to rural service delivery must first be addressed. Further, government incentives are needed, such as those that foster additional community-based services and greater linkages between health care and existing social service agencies in an effort to increase independent living - a primary value. As importantly, plans for meeting the needs of increasing numbers of very old adults must take into consideration the influence of sociohistorical factors when examining aging status and needs. As a result, policies and programs need to reflect flexibility and sensitivity to future cohorts of older rural adults who, although experiencing some static processes of aging, will bring into old age very different challenges than those currently experienced by the rural elderly.

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**CURRENT PROFILE OF NORTH CAROLINA'S
RURAL OLDER ADULTS: PART II**
Jim Mitchell

This presentation has two objectives. The first is to describe differences in rural-urban residence among older adults living in eastern North Carolina that effect the likelihood that they will need assistance. Using information gathered from 2,178 older adults aged 60 and over living in their homes in eastern North Carolina, residential and other differences in disability, income, education, and literacy will be described. The second objective is to describe gaps in available services according to residence and to speculate about why such gaps exist.

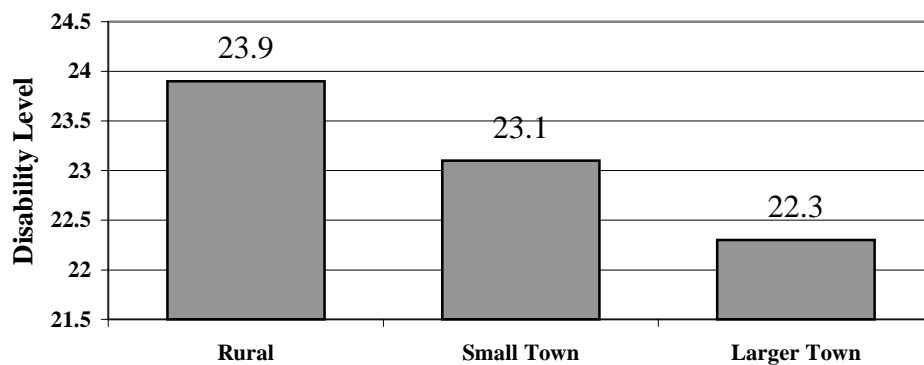
Data Summary

Information gathered from the study participants provides insight into differences by residence in the need for assistance. Stereotypical beliefs suggest that older people in rural areas are robust, self-sufficient, independent, and not likely to need services or other forms of assistance. The eight figures that are shown here suggest a different story, particularly among subgroups of the rural older adult population.

Figure 1 shows levels of disability by residence. To come up with a numerical score, interviewers asked about three kinds of abilities: (1) ability to perform activities of daily living (e.g., preparing meals, bathing, etc.); (2) limitations due to chronic health problems; and (3) mental health. People who needed no assistance were scored 0, those needing some help were scored 1, and those unable to function without help were scored 2. People with no limitations due to a chronic condition were scored 0, those whose abilities were compromised a little were scored 1, and those with significantly compromised abilities were scored 2. These scores were summed for 33 possible conditions to create a functional limitations score. Questions about 15 depressive symptoms were scored 1 if the symptom was present, and 0 if a symptom was absent, then added together with scores on 3 general questions to create a mental health score. Answers were summed across the three measures, yielding scores from 21.5 to 24.5.

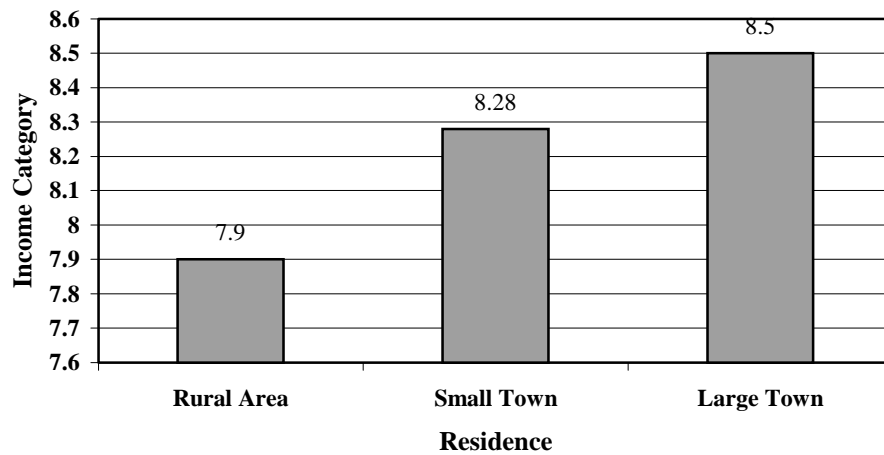
In this figure and those that follow, rural residence refers to people living in an area with no place name (e.g., in “Jones County”) or at a rural crossroads. Small town residence includes those living in “named” towns up to 10,000 inhabitants. Larger towns are residential locations with more than 10,000 people. Although the differences among the average disability values are not great, Figure 1 shows a clear tendency for disability to be highest in rural areas, followed by small towns,

Figure 1
Disability by Residence



followed by larger towns. This is contrary to our general belief that rural folk are more “robust” and less likely to be in need of assistance to live independently.

Figure 2.
Income Category by Residence

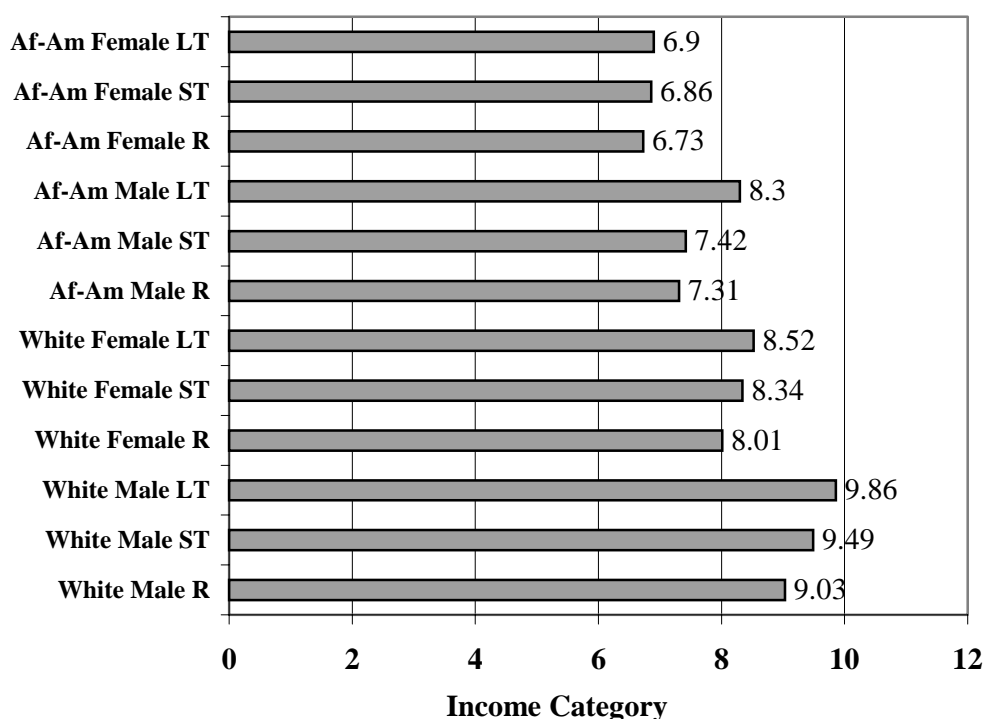


Household income among older adults can serve as a proxy measure of financial well-being or the ability to buffer potentially stressful life events.

Figure 2 shows differences in the self-reported average annual household incomes of the 2,178 older adults surveyed by residence. Responses on household income are categorical, from 1 to 15, offering respondents an opportunity to choose a monthly or annual category rather than divulge an actual dollar figure. Figure 2 shows a rather persistent tendency for household income to be higher among people living in the largest towns, followed by small town residents. Rural residents have the lowest incomes.

Figure 3 elaborates upon the pattern in Figure 2 by showing the difference in average household incomes among white and African-American males and females by residence. Examining the information closely shows that, first, white older adults have higher average categorical incomes than African Americans, regardless of sex or

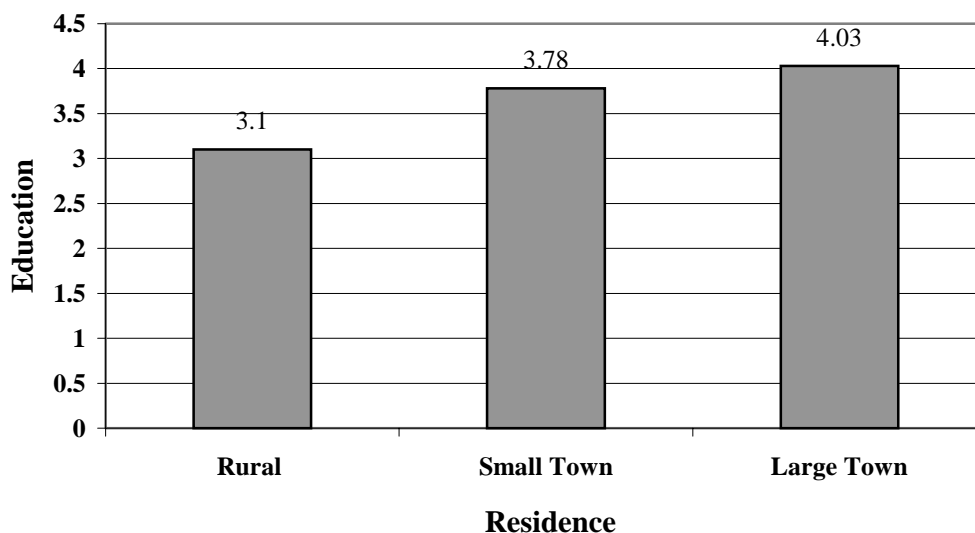
Figure 3.
Income by Race, Sex & Residence



residence. Secondly, males tend to have higher categorical incomes than females. Finally, the graph suggests that older African-American females are the most financially disadvantaged compared to other older adults regardless of residence. Small town and rural African-American males tend to have lower household categorical incomes than those living in larger towns. Finally, the figure suggests that rural residence compromises the household incomes of white males and females to a greater extent than among African Americans.

The educational attainment of older adults is perhaps more important for their life chances and general well-being than household income. Education indirectly affects income as well as the perception of

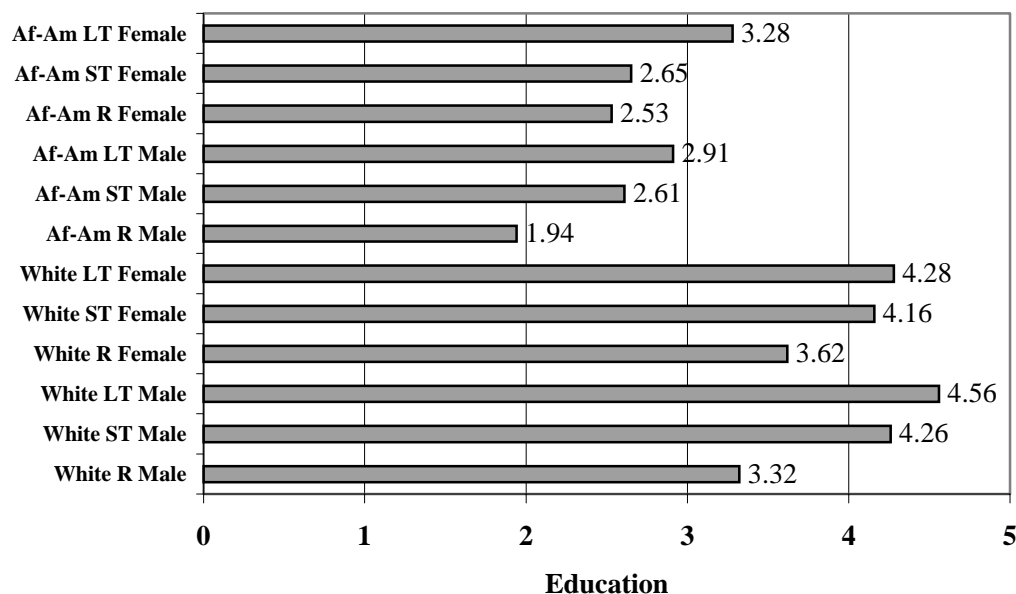
Figure 4.
Education by Residence



alternatives in the face of adversity. Although older adults likely obtained their formal education many years ago, the effects of education tend to be compounded over time. Figure 4 shows the now familiar pattern of lower average educational attainment among older people who live in rural areas compared to small towns or large towns. As used here, educational attainment includes nine categories from less than 4th grade (coded 1) to post graduate education (coded 9). As a reference, the number 4 refers to high school complete or the equivalent.

Figure 5 shows what happens to differences in educational attainment by residence when sex and race are taken into account. First, there is a clear tendency for older whites to have an educational advantage over older African Americans. Beyond the rather striking difference in educational attainment by race, residence consistently makes a difference in education and the pattern is the same as that in Figure 4. The most significant difference in Figure 5 is the difference in educational attainment between older rural African-American males and white males living in large towns.

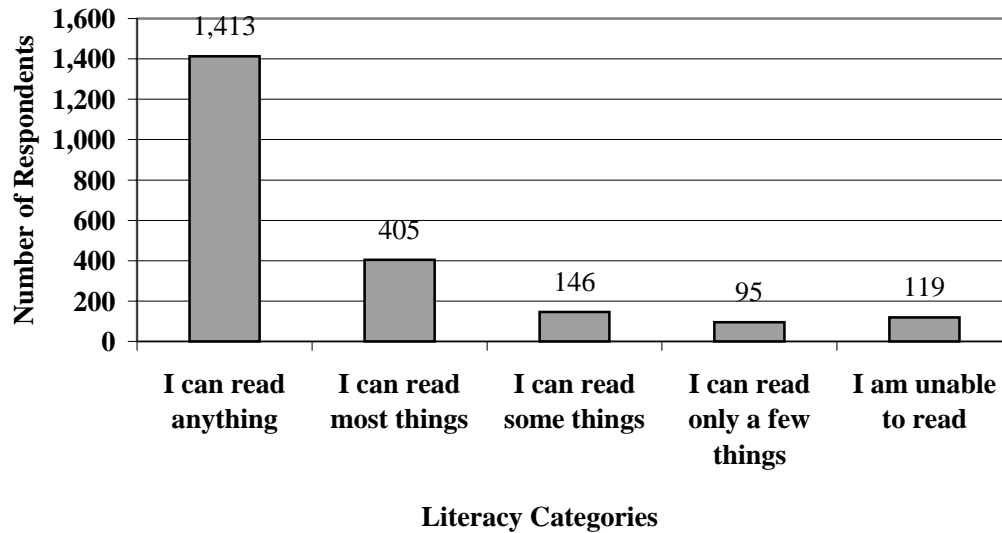
Figure 5.
Education by Race, Residence & Sex



The final characteristic to be considered as background information describing the need for services among older adults is literacy. The interview included a question about education sufficient to be able to read anything, most things, some things, only a few things, or reading inability.

Figure 6 offers a representation of reading ability among older adults in

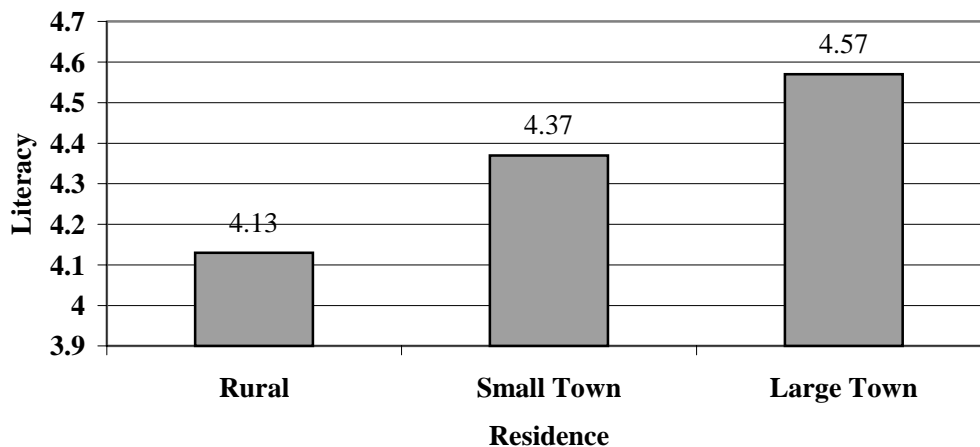
Figure 6.
Distribution by Literacy Categories



eastern NC. According to the numbers accompanying the bars in the graph, almost 17 percent of those interviewed have compromised reading ability or they are unable to read. Almost 19 percent report being able to read “most things.”

Although the numeric differences are not large, Figure 7, which

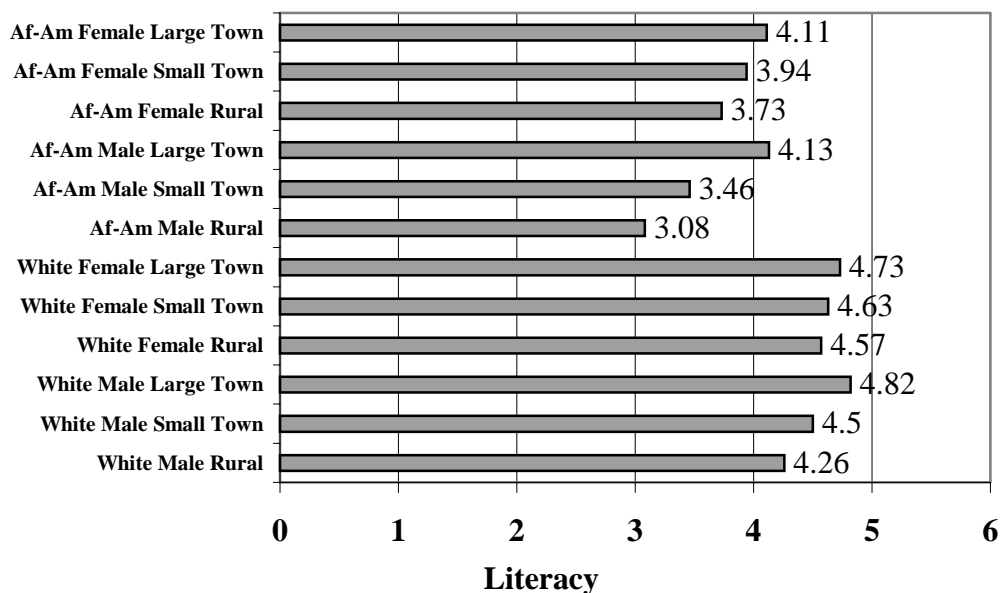
Figure 7.
Literacy by Residence



compares average literacy across residential categories, shows again that reported reading ability is highest among large town residents, followed by small town residents. Again, reading ability is lower among rural residents.

Figure 8 suggests that older whites have less difficulty reading than older African Americans. Similar to the pattern for educational attainment in Figure 5, those with the most reading difficulty are African-American males living in rural areas.

Figure 8.
Literacy by Race, Sex & Residence



These data help us think about groups of older adults who are more likely to need assistance, to have difficulty paying for assistance, and to have difficulty cognitively accessing sources of assistance. The information presented and discussed here suggests that older males and females who are African-American and living in rural areas are more likely to need assistance but they are also more likely than others to be unable to pay for assistance and to have difficulty accessing sources of assistance, particularly if assistance sources are complex (e.g., specialized medical care).

Gaps in Services Available in Rural Areas

Based upon multiple projects including personal interviews with some 8,000 older adults living in their homes in eastern North Carolina over the last 12 years (Mitchell, 1995; Mitchell, Mathews, and Griffin, 1997; Mitchell and Krout, 1998), I wish to offer, in outline form, some conclusions regarding the availability and the use of health and community-based services among older adults in this region and why gaps in services by residence exist.

- There are few differences by residence (*depending upon rural definition*) in knowledge and use of Home and Community Care Block Grant (HCCBG) funded services, with the caveat that a relatively small proportion of older adults use these services. We need to be cognizant, however, that rural penetration of HCCBG services is limited by their design (e.g., “one size fits all”) and funding.
- There are few differences among older adults by residence in the use of primary ambulatory health care or in Medicare- or Medicaid-supported home health care. Home health reimbursement is generally sufficient to get the service into homes and rural elders are accustomed to “getting to” the doctor, even if it means a 100-mile round trip.
- The kinds of services that are lacking in rural areas are: 1) those that delay or eliminate the need for institutionalization (e.g., care coordination or in-home care beyond Medicare’s post hospital discharge 20-day limit), 2) mental health care from trained providers, and 3) specialty and sub-specialty medical care, leaving institutional care as the only option. Institutional care is generally available in all counties due to the certificate of need process and motivation by the private sector to provide it. Recent implementation of a prospective payment system (PPS) for skilled nursing care may, however, limit its attractiveness for providers.

Why Do Gaps in Services Exist?

- The delivery of complex services (e.g., care coordination, skilled

nursing in-home care, specialty medical care) assumes an urban model based upon the *proximity* of skilled and specialized personnel.

- Even selected HCCBG services have an urban clientele because of federal regulations (e.g., volunteers delivering meals) limiting rural penetration or because of funding formulae underestimating transportation costs (mileage and time).
- Complex and innovative services, including care coordination, often happen through interaction among a larger “critical mass” of specialized providers. The whole can be greater than the sum of the parts. These providers working in larger towns generally know one another, they talk to one another, and they innovate or come up with ideas for improvement. The critical mass of providers in rural areas is much smaller, they are more isolated from one another, and they have little time for communication with each other.
- Those who deliver skilled or complex care tend to be better educated than those delivering less skilled care, they aspire to be upwardly mobile, and they are drawn to the diversity of urban environments--even if they were raised in a rural community.
- Rural county governments have fewer specialized staff and tighter budgets (poorer rural counties have lower tax bases, meaning higher millage rates) with basic needs (central water and sewer and police protection) that are the same as more urban locations. Fewer staff leads to micro-management by county commissioners who have limited or no human service background. Provider opportunities to educate commissioners are limited to 10 minutes on a crowded agenda. Therefore, requests for extra funds for service improvement or expansion are more likely to be denied.

Summary

Older adults living in rural areas generally meet their needs by traveling some distance with friends or neighbors (often for pay) or with family

members. With the onset of more serious limitations, they are often cared for, first, by a spouse with help from a daughter or female relative living close by. This arrangement continues as long as possible, with institutionalization often the only viable option when caregiving resources or caregivers become exhausted.

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**RURAL ELDERS: THE IMPORTANCE
OF RELATIONSHIPS**
Karen Roberto

In order to understand the needs of rural older adults, service providers and policy makers must keep in mind the importance of relationships in their daily lives. Members of the social networks of older adults influence every aspect of their lives. Relationships are interlocking; they represent a continuous intermingling of human beings. The family, where the development of personal relationships begins, provides the foundation for the formation of other informal and formal alliances.

As members of the aging and health care network, you will have many older individuals, either directly or indirectly, in your daily lives. Wherever you intersect the world of these older adults, remember they are not single individuals, although many may now be alone, but, they are persons with a history and collection of relationships.

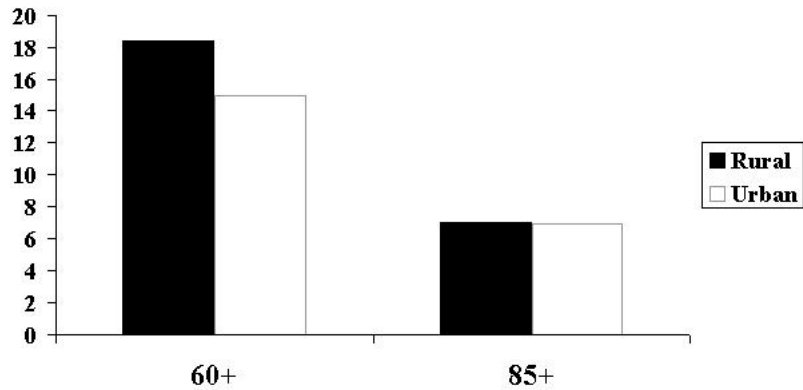
Older Adults Living in Rural Areas

The following is a brief description of the members of this generation of rural elders. Whenever possible, I provide information about rural elders in comparison to their urban counterparts. The majority of the statistical information was adapted from the work of Carolyn Rogers (1999).

Total Population

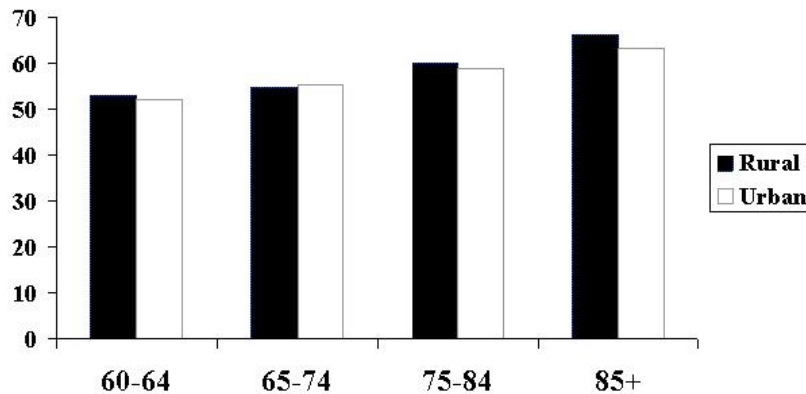
The population in the United States is aging. Within the aging population, individuals 85 years of age and older (i.e., the oldest-old) are the fastest growing segment and the most in need of community-based services (Figure 1).

Figure 1
Older Adults as a Percentage
of the Total Population
(1998)



Source: Rogers (1999). From Economic Research Service (ERS) data file, March 1998 Current Population Survey (CPS) data file, and 1980 and 1990 Census of Population, General Population Characteristics, U.S. Summary.

Figure 2
Percentage of Older Women
(1998)



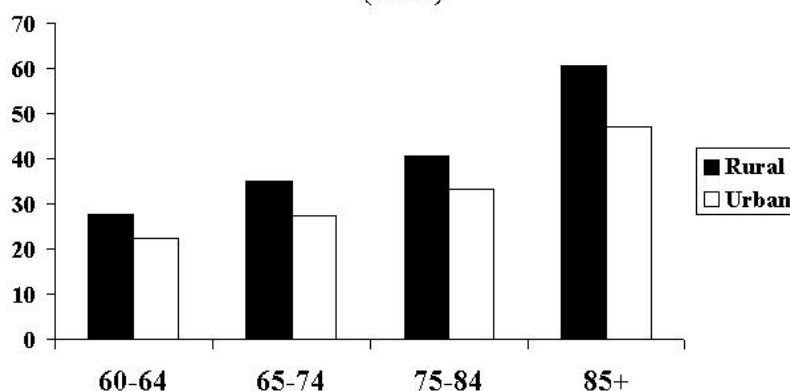
Source: Rogers (1999). March 1998 Current Population Survey (CPS) data file.

As interest in rural elders continues to grow, service providers cannot overlook the unique issues and needs facing rural older women (McCulloch & Kivett, 1998; McCulloch, 1998; Shenk, 1998). Although there is great diversity among these women, a characteristic they have in common and share with other women, is a higher survival rate than their male counterparts. For those over the age of 85, rural women outnumber rural men more than two to one (Figure 2).

Education Levels

As is shown in Figure 3, approximately 54% of rural older adults over the age of 65 have less than a high school education (Sigler, 1995). Although we are seeing a rise in educational levels, the educational gap within this cohort of elders contributed to financial disadvantages throughout their working careers and resulted in lower retirement income.

Figure 3
**Older Persons With Less Than A
High School Education**
(1998)

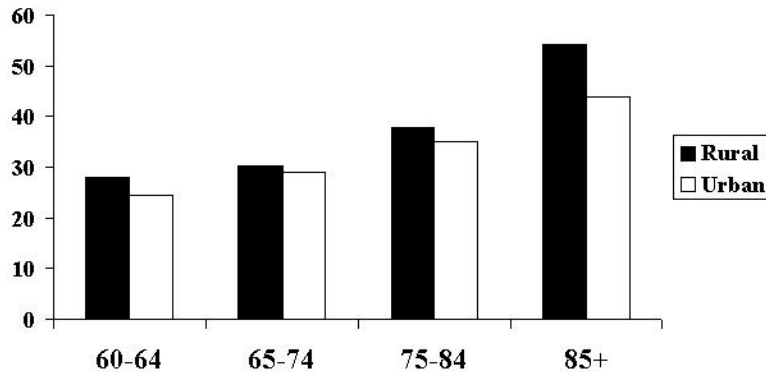


Source: Rogers (1999). March 1998 Current Population Survey (CPS) data file.

Income Levels

The median income for rural persons 60 years of age and older is \$9,159 (Sigler, 1995). With advancing age, increasing proportions of rural older adults reside in low-income households (Figure 4). Women

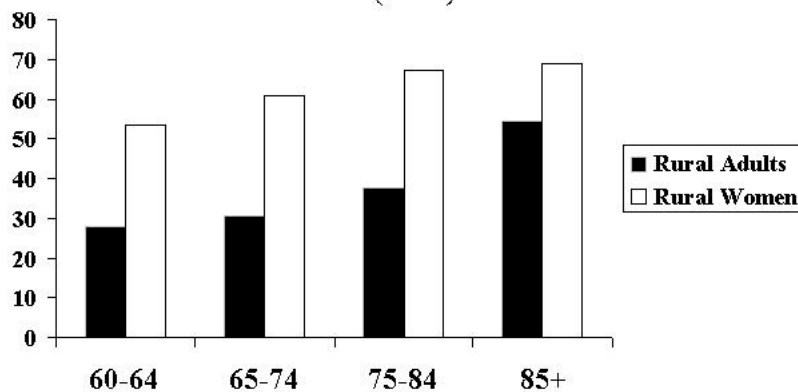
Figure 4
**Older Persons With Income
 Less Than \$10,000**
 (1997)



Source: Rogers (1999). March 1998 Current Population Survey (CPS) data file.

with low incomes are disproportionately represented in rural areas. Thus, poverty among older rural women, especially those in the older age groups, should be an increasing consideration for health and community service providers (Figure 5).

Figure 5
**Older Rural Women With Income
 Less Than \$10,000**
 (1997)

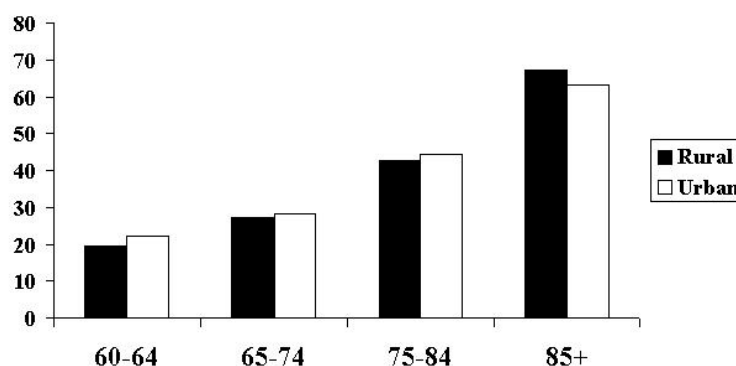


Source: Rogers (1999). March 1998 Current Population Survey (CPS) data file.

Living Arrangements

As shown in Figure 6, about one in five rural older adults live alone (Sigler, 1995). Living arrangements influence the well-being of older adults. Those living alone are more likely to lack social support networks and tend to report being in poor health.

Figure 6
Older Persons Living Alone
(1998)



Source: Rogers (1999). March 1998 Current Population Survey (CPS) data file.

Health and Social Support

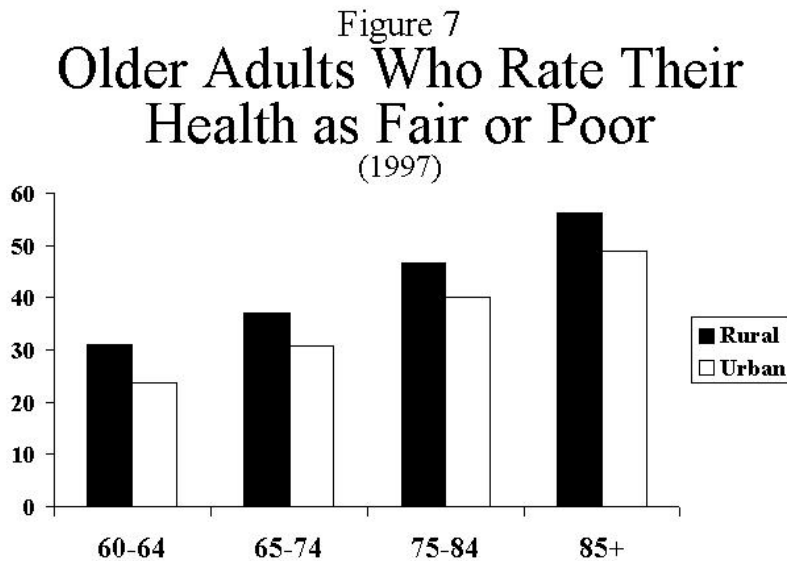
The findings of general population studies suggest that older residents of rural areas have a higher age-adjusted rate for most chronic conditions than their urban counterparts (National Center for Health Statistics, 1994; U.S. Senate Special Committee on Aging, 1992). The general pattern of rural excess for many chronic conditions may be related to differential environmental exposures, lower socioeconomic status, and lesser access to quality medical and rehabilitative care (Coward, McLaughlin, Duncan, & Bull, 1994; Kivett, 1997).

Practitioners need to understand how these chronic conditions, and changes in health status, influence the everyday lives and relationships of older women and men residing in rural areas.

Health Status

Personal assessment of one's health is a simple and informative measure of health. It is associated with mortality, life satisfaction, and

objective health-status measures such as physical exams and physician ratings (Van Nostrand, Furner, Bruelle, & Cohen, 1993). With advancing age, rural elders' personal assessment of their health status declines (Figure 7).

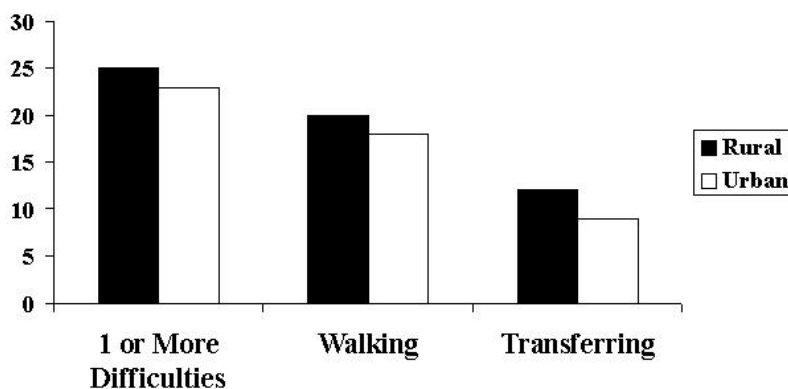


Source: Rogers (1999). March 1998 Current Population Survey (CPS) data file.

Activities of Daily Living

Difficulties in the ability to perform activities of daily living (ADL) or instrumental activities of daily living (IADL) are frequently used as indicators for the need for home and community-based services (Braden & Van Nostrand, 1993). About 25% of non-institutionalized rural adults 65 years of age and older report at least one problem or difficulty with conducting ADL's (Figure 8) and about 33% have difficulties with at least one IADL (Figure 9).

Figure 8
Activities of Daily Living



Source: In Braden & Van Nostrand (1993). Based on NCHS, National Health Interview Survey, 1986.

Figure 9
Instrumental Activities
of Daily Living

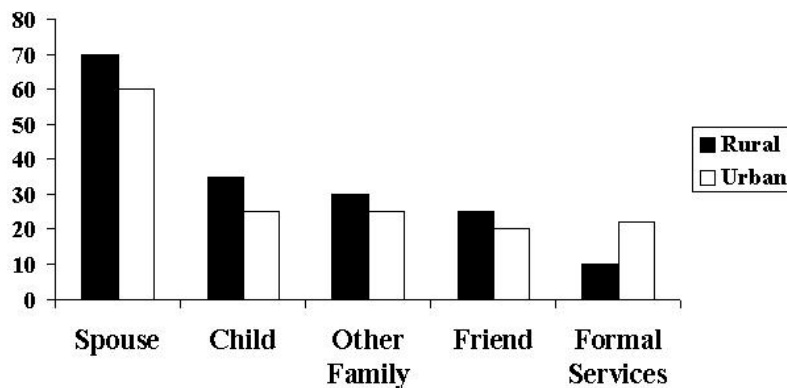


Source: In Braden & Van Nostrand (1993). Based on NCHS, National Health Interview Survey, 1986.

Family Support

Nearly three-fourths of persons over 65 who need assistance with daily activities rely exclusively on informal caregivers (Institute for Health & Aging, 1996). Most caregivers are middle-aged women, many of whom are caring simultaneously for children or adolescents and parents. Eighty percent of caregivers for elderly family members provide help seven days a week, spending an average of four hours daily providing care and emotional support. Housekeeping, meal preparation, and shopping are common tasks, and over 60% of caregivers also regularly help with feeding, bathing, dressing, and using the toilet (Stone, Cafferata, & Sangl, 1987) (Figure 10).

Figure 10
Sources of Support



Source: In Braden & Van Nostrand (1993). Based on NCHS, National Health Interview Survey, 1986.

The demands on family caregivers will likely increase as our elderly population continues to grow while at the same time the supply of family caregivers is decreasing. Among the factors that are at work shrinking the pool of possible caregivers are decreasing birth rates, family networks that are getting smaller and more top-heavy with more older than younger members, and the increasing number of dual-earner and single-parent households.

Recent changes in social policies support as well as challenge the family caregiving network of older rural adults, especially those with low income. For example, the *Family and Medical Leave Act* allows, among other things, individuals to take time away from work to provide care for older relatives. The question is, however, can family members afford to do so? Although the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* protects older recipients, their family members are required to work after two years of assistance. The law provides funding for child care to help more parents move into jobs; elder care, however, is not covered. Thus, the issue of the availability of low-income families to provide elder care comes into question.

Family caregiving *is not* a one-way street. Elders do not just receive assistance, they also support their families. A perfect example of this is the role of grandparents. The traditionally held view of the roles and responsibilities of a grandparent is as someone who passes on family traditions and values; someone with whom to have fun. Today, however, we see a growing number of grandparents raising their grandchildren. Approximately 5.4 million children live with their grandparents and more than one-third of these children are being raised solely by their grandparents or family member other than their parent (U.S. Bureau of the Census, 1998). Health and service providers need to be sure that community structures and programs are in place to support these family efforts.

Formal Services

When the needs of older adults exceed the capacity of their informal network, they tend to incorporate formal services as sources of assistance. However, researchers generally report low rates of health and community-based service use, particularly by rural elders (cf., Coward et al., 1994; Krout, 1994; Rowles, Beaulieu, & Myers, 1996). A variety of factors contributes to the likelihood of service use including awareness, need, accessibility, and cost. Use of services, especially those related to health care needs, is typically associated with education, knowledge and awareness, and respondents' perception of need (Andersen & Newman, 1972; Crawley, 1988).

A barrier to service use that researchers allude to and most rural service providers must contend with daily is rural culture (Bull, 1998; Roberto, Richter, Bottenberg, & MacCormack, 1992). Rural elders hold strong the values of self-reliance, conservatism, distrust of outsiders, family and work orientation, and individualism. These values influence their views of community and ultimately affect their willingness to accept formal services. What is needed is a better understanding of the disposition of rural elders and their family members to either supplement or substitute family care with formal care so that policymakers and service providers can allocate limited resources in the most *innovative, appropriate, and efficient* manner possible.

Future Planning

A clear understanding of informal and formal care for rural older adults requires recognition of the diversity of rural environments and rural people. Rural areas differ along a number of dimensions that might influence the configuration of care including population density, proximity to metropolitan areas, economic base, regional culture, and migration patterns (Stoller & Lee, 1994). Rural populations also vary on a number of sociodemographic variables (e.g., gender, race, ethnicity, social class, health), both within and among geographic regions. Each of these variables should be considered in the development and delivery of current and future programs and services for rural elders. For example, failing health and the consequent loss of the ability to take care of oneself may lead to increased needs in terms of health services, financial assistance, housing, and social, psychological, and family support (Rogers, 1999; Scott & Roberto, 1985). In addition, poverty in old age among certain subgroups of rural elders, especially women, the oldest-old, and those living alone, may require special programs to alleviate strained financial situations (Rogers, 1999).

Conclusions

To understand the issues and needs of rural older adults, policymakers and service providers must take into consideration the context in which they live – and one very important part of that context is their

relationship with others (Scott & Roberto, 1987). As individuals age, their relationships change. New relationships develop as individuals enter their lives (e.g., grandchildren) and others emerge as they expand or renegotiate existing relationships (e.g., caregiver). Some relationships are lost due to death, distance, or disagreement. The exchange of instrumental and emotional support is characteristic of most relationships. The type, frequency, and amount of support provided or received varies based on a variety of factors including individual needs and abilities, the type of relationship, personal resources, and cultural beliefs.

Relationships build upon one another, and when woven together provide important insight into the lives of older adults living in rural America. As professionals in aging, when working with or on behalf of older adults, be mindful of their relationships. For it is their present as well as past relationships with mothers and fathers, daughters and sons, sisters and brothers, grandmothers, grandfathers, extended kin, friends, and community that have sustained and will sustain their lives. My challenge to you as you continue your work with the rural elders living in North Carolina -- listen to them, respect them, advocate for them, empower them.

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**COMMENTARY: RURAL OLDER ADULTS -
MANY NEEDS, MANY STRENGTHS**
Luci Bearon

The picture presented by the speakers should sound a loud alarm for policymakers in North Carolina. The rural population of older adults is disadvantaged, has many unmet needs--and is growing. In fact, older adults are becoming a greater proportion of the residents of rural counties, making their needs all the more pressing and visible. We need both quick fixes *and* enduring solutions for the problems of health care delivery, transportation, housing, employment and training, long-term care, and social isolation which are prevalent and which so adversely affect the quality of life for older adults--and thus everyone--in a community.

But hidden in the picture is an overlooked and underestimated natural resource--the older people themselves. Most of today's rural older adults were born during the period from 1900 to 1935. They survived the Great Depression and World War II. They experienced major social changes with integration and the Civil Rights movement, and witnessed or helped parts of the South change from an agricultural economy to a haven for high technology in just a few decades. They have a strong stake in rural renewal--for themselves as they live out their projected longer lives--and as a legacy for their children, grandchildren and the larger society. And they continue to contribute as leaders, workers and volunteers, building onto a foundation of community formed through their own efforts and the collective efforts of their peers. Even retirees migrating from other locations energize communities with new ideas and ways of doing things.

An assets-based approach to community development illustrates ways in which a community can capitalize on the strengths of its individuals, organizations and institutions (Kretzmann and McKnight, 1993). Experts using this approach propose mapping community assets to identify the capacities of residents and workers, and the associations

and institutions and relationships which form the foundation of community life. This focus on “looking within” a community for resources, can be quite illuminating and useful, especially in times when a community cannot count on resources from outside. Not surprisingly, Kretzmann and McKnight contend that wise community developers can look at senior individuals and groups as being in the *center* of the community, as an economic force, as carriers of culture and tradition, as a source of experience, skills and time, and as an organized force for constructive action. These analysts provide an elaborate model for finding and utilizing existing and possible *reciprocal* relationships between seniors and community institutions such as libraries, parks, police, day care centers, hospitals, restaurants, merchants, religious institutions, schools and institutions of higher education, public agencies, non-profit organizations, and the broad array of community groups present in every community.

These ideas are not new or revolutionary. Over twenty years ago, a publication of the NC Agricultural Extension Service (now Cooperative Extension) (Hamilton & Buckley, 1979) explained how to tap into the talents and interests of potential senior leaders and volunteers, how to organize community groups, and how to recognize and reward the contributions of seniors. And as Inez Myles pointed out in her written contribution (Appendix D), rural older adults are already a powerful force to be acknowledged and encouraged, providing a great deal of leadership and advocacy in local communities. So as we in the field of aging earnestly attempt to meet the challenge of serving older adults in rural North Carolina, a challenge that will only grow in coming years, we need to remind ourselves to take the opportunity to learn from and partner with those who are already there serving their own communities from within.

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Appendix A. Conference Program

**Governor's Advisory Council on Aging
Symposium on Rural Aging
April 2-3, 2000**

Welcome

Ann B. Johnson
Council Chair

*Report on the Recommendations
of the Rural Prosperity Task Force*

Leslie Boney
Director, North Carolina Rural
Prosperity Task Force,
Department of Commerce

*Current Profile of North Carolina's
Rural Older Adults, Parts I and II*

Dr. Vira R. Kivett
Professor Emerita,
UNC-Greensboro

*Rural Elders: The Importance of
Relationships*

Dr. Jim Mitchell
Director, ECU Center on Aging

*Meeting the Special Challenges
of Rural Counties – Long Term Care*

Dr. Karen A. Roberto
Director, Gerontology Center,
Virginia Polytechnic Institute &
State University

*Meeting the Special Challenges
of Rural Counties – Transportation*

Kim Dawkins Berry
Director, Area Agency on Aging,
Piedmont Triad Council of
Governments

Donna Creech
Director, Johnston County
Council on Aging

Meeting the Special Challenges of Rural Counties – Housing and Supportive Services

Monday, April 3

Review of the Work of the Committee on the Concerns of the Rural Elderly, Governor’s Advisory Council on Aging

One Foundation’s Response to the Needs of Rural Communities and Their Seniors

Meeting the Special Challenges of Rural Counties – Health and Health Care

Meeting the Special Challenges of Rural Counties – Employment and Training

Meeting the Special Challenges of Rural Counties – Information and Assistance

Senior Empowerment and Community Action

Concluding Remarks – What’s Next?

Adjourn

Cynthia Davis

Assistant Director, Area Agency on Aging, Mid-East Commission

Bob White

Chair, Council’s Committee on the Concerns of the Rural Elderly

Dr. Valerie Rosenquist

Associate Director, Rural Church Division, Duke Endowment

Jim Bernstein

Director, Office of Research, Demonstrations and Rural Health Development

Margie DeWoskin

Director, Employment & Training Triangle J Council of Governments

Janet Bradbury

Coordinator, Information and Assistance, Pitt County Council on Aging

Karen Gottovi

Director, North Carolina Division of Aging

Ann Johnson

Appendix B. Profile of Presenters

Jim Bernstein is Director of the North Carolina Office of Research, Demonstrations and Rural Health Development. Since 1973, Mr. Bernstein has helped establish 79 community-owned health centers throughout the state and recruit more than 1700 health care providers to rural and urban underserved communities. The Office funds and supports community-based practices through grants and technical assistance, and has responsibility for Medicaid managed care demonstrations, the Long-Term Care demonstration and special programs for rural hospitals such as the Critical Access Hospital program. Mr. Bernstein has been President of the National Rural Health Association, a Commissioner on the Prospective Payment Assessment Commission and Chair of the Office of Technology Assessment Advisory Panel's Study on Rural Health Care. Currently he is the National Director of the Robert Wood Johnson Foundation program "Practice Sights: State Primary Care Development Strategies", President of the North Carolina Foundation for Advanced Health Programs and on the adjunct faculties of Duke and the UNC-Chapel Hill.

Leslie Boney is Staff Director of the North Carolina Rural Prosperity Task Force. Mr. Boney coordinated the 76-person team drafting recommendations for rural economic development in the state and wrote the Task Force's final report. Previously, Mr. Boney served as chief liaison between Governor Hunt's welfare reform effort and the business community, and gained commitments from businesses to hire 15,000 welfare recipients. He also led an interagency team in producing a successful application for North Carolina's \$50 million Welfare-to-Work grant.

Janet Bradbury is Coordinator of Information, Assessment and Case Assistance for the Pitt County Council on Aging, Inc., where she has worked since 1993. She was part of the Project Development Team that developed Pitt County's first information and referral plan and has supervised that service. She has served on various regional and

statewide work groups to help strengthen information and assistance services for seniors and their families.

Donna A. Creech is Executive Director of the Council on Aging in Johnston County, where she oversees congregate and home delivered meals, senior centers, in-home aides, subsidized elderly housing, personal emergency response systems, information and assistance volunteer development, and county-wide human services and transportation. With 28 years of work experience in human services, she is past president of the North Carolina Association on Aging and received its “Executive of the Year for Leadership Excellence” award in 1997. She is a former member of the North Carolina Legislative Study Commission on Aging and is on the Statewide Advisory Committee for the UNC Institute on Aging.

Cynthia Davis is Assistant Director of the Area Agency on Aging (AAA) for the Mid-East Commission. This region includes Beaufort, Bertie, Hertford, Martin and Pitt Counties. She has considerable experience in issues of housing for the elderly having focused on such issues for over 10 years. In her role as staff to the Mid-East Development Corporation, a non-profit arm of the Mid-East Commission, she has participated in developing senior apartments and shared group housing, and linking housing and community based services. She assists local agencies and consumers in gaining information and accessing programs on home modification, home repair, home ownership and reverse mortgages.

Kimberly “Kim” Dawkins Berry is Director of the Area Agency on Aging for the Piedmont Triad Council of Governments. This area includes Alamance, Caswell, Davidson, Guilford, Randolph and Rockingham Counties. Her previous experience includes serving as regional Long-Term Care Ombudsman for Piedmont Triad AAA, Planner for Region D AAA, Regional Program Coordinator for the Advocacy Assistance Center in Dallas, Texas and Economic Development Planner for the Coastal Plains Regional Commission in eastern North Carolina. Ms. Dawkins Berry has chaired the North Carolina Association of Area

Agencies on Aging, served on legislative study groups and is a member of the Long-Term Care Task Force of the North Carolina Institute of Medicine.

Rosaline “Rosi” S. Derka, Project Assistant in the North Carolina Department of Commerce, provided support for the North Carolina Rural Prosperity Task Force.

Margie DeWoskin is Director of Employment and Training for the Triangle J Council of Governments. Since 1983, Ms. DeWoskin has planned, coordinated, implemented and evaluated employment and training programs for Chatham, Durham, Johnston, Lee, Orange and Wake counties. In addition to her administrative duties, she has counseled older workers and conducted training events. She also has served as adjunct faculty at UNC School of Social Work and has been a member of the National Working Group of the National Council on the Aging. Her previous experience includes working as a supervisor of the Foster Grandparents Program in West Virginia and as a social worker for the Coordinating Council for Senior Citizens in Durham.

Karen E. Gottovi is Director of the Division of Aging in the North Carolina Department of Health and Human Services. Ms. Gottovi became director in October 1997 after a long career in public service. She was a state representative from Wilmington from 1991-1994, during which time she sponsored legislation to assist disabled persons with home modification, improve conditions in long-term care, and establish the Senior Tar Heel Legislature, among other contributions. From 1976-1984, Ms. Gottovi served on the New Hanover County Board of Commissioners, devoting much of her time to aging issues. She has also served on the North Carolina Commission for National and Community Service, was a member of the board of the New Hanover County Services for the Aging, the Region O Advisory Council on Aging and the Cape Fear Area United Way Board of Trustees.

Ann Johnson is Chair of the Governor’s Advisory Council on Aging, and Orange County Delegate to the NC Senior Tar Heel Legislature. Ms. Johnson served for 23 years as Executive Director of the Durham

Coordinating Council for Senior Citizens. She has served on the Governor's Advisory Council under three governors and is past President of the North Carolina Coalition on Aging and the North Carolina Senior Citizens Association. Selected as a delegate to the 1971, 1981, and 1995 White House Conferences on Aging, she also received the Geneva Mathiesen Award from the National Council on the Aging and the George Maddox Award from the North Carolina Division of Aging. Ms. Johnson co-authored the book *Serving Older Adults*.

Dr. Vira Rodgers Kivett is Elizabeth Rosenthal Excellence Professor Emerita, in the Department of Human Development and Family Studies, School of Human Environmental Sciences of the University of North Carolina at Greensboro. Dr. Kivett is well known for her studies on rural elderly, minority elderly, older migrants and later life family roles and relationships. She is the author of numerous articles, book chapters and reports, and has received many recognitions and high honors, including designation as Distinguished Academic Gerontologist from the Southern Gerontological Society. In 1996, she received the Oliver Max Gardner Award, the highest award given in the University of North Carolina system for scholarship and service to mankind.

Dr. James P. "Jim" Mitchell is Professor of Sociology and Family Medicine at East Carolina University and Director of the Center on Aging in the School of Medicine. He is also Associate Director for Public Service and Extended Education with the UNC Institute on Aging. He is a prolific researcher of issues facing rural older adults, including access to health and community-based services, and has published his research findings in all the major journals in gerontology. He has served as Convener of the Rural Aging Informal Interest Group of the Gerontological Society of America and is a US representative on the planning committee for the first international rural aging conference in June 2000. For his work in aging education, Dr. Mitchell was recently named a Founding Fellow of the Association for Gerontology in Higher Education.

Dr. Karen Roberto is Professor and Director of the Center for Gerontology at Virginia Polytechnic Institute and State University. She

is an expert on psychosocial aspects of aging, family gerontology and life-span development, and has done substantial research and writing about rural elders, especially about their health and social networks. Dr. Roberto received the “Outstanding Educator Award” from the Virginia Association on Aging and was recognized by the Region VII Office of the U.S. Administration on Aging for her contributions toward improving the lives of older Americans.

Dr. Valerie Rosenquist is Associate Director of the Rural Church Division of the Duke Endowment, which assists rural United Methodist churches through grants for building programs and outreach ministries. In this capacity, she has helped to initiate or expand several service and recreation programs for seniors. With a doctorate in American History, she also serves as Adjunct Assistant Professor in Christian Ministry at Duke Divinity School. Prior to assuming her present position, she was pastor of the White Memorial Presbyterian Church in Willow Springs, NC (1991-1996).

Bob White is the founding Board President of Seniors Call to Action Team, Inc. (SCAT) and chair of the Governor’s Advisory Council on Aging’s Committee on The Concerns of the Rural Elderly. He retired as a Lt. Colonel in the U.S. Army Medical Service Corps and became active in improving services for older adults in Cumberland County. He was a participant in Duke University’s Senior Leadership Enhancement Initiative and was catalyst for submission of two successful grant proposals to secure funds to organize volunteers to serve frail elders in his county. He also played a key role in organizing and hosting the 1999 North Carolina Summer Symposium on Aging in Fayetteville.

About the Editor:

Dr. Lucille “Luci” Bearon is Assistant Professor of Family and Consumer Sciences and Adult Development and Aging Specialist for the Cooperative Extension Service at North Carolina State University. She is also Chair of the Aging Issues Dissemination Committee of the Governor’s Advisory Council on Aging. Dr. Bearon is a sociologist with thirty years studying and working in the field of gerontology. In her work with Cooperative Extension Service, she co-chairs the Aging with

Gusto! program and develops and delivers educational programs on positive aging, eldercare, grandparents raising grandchildren and health promotion for older adults. She is co-author of *Quality of Life in Older Persons: Meaning and Measurement* as well as various book chapters, refereed journal articles and Extension publications.

Appendix C. A Word About Funding Formulas

Editor's Note: During the symposium, a number of speakers and participants mentioned "the funding formula" as a key factor in the distribution and delivery of services to elders in North Carolina. Symposium Chair Ann Johnson asked Mr. Bill Lamb, who was then working as a planner for the Division of Aging, to make a brief impromptu presentation explaining funding formulas. Here is his explanation:

Mr. Lamb: North Carolina's current Intrastate Funding Formula has been in place since 1989 and was adopted to address the revised targeting requirements of the Older Americans Act (OAA). OAA regulations require the state to develop a funding formula within the state that takes into account: *(i) the geographical distribution of older individuals in the State; and (ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals.*

North Carolina's funding formula for Home and Community Care Block Grant (HCCBG) funds is based on four factors: 50% is based on number of persons 60 years of age and older; 30% is based on the number of persons 60 years of age and older who live at or below poverty; 10% is based on the number of non-white persons 60 years of age and older; and 10% is based on the number of persons 60 years of age and older who live in rural areas. Two of these factors, 60 plus population and 60 plus/non-white are updated annually based on a revised population projection provided by the Office of State Planning. Poverty and rurality have remained constant since the 1990 Census. Both of these factors can potentially shift significantly based on data to be received from the 2000 Census. For purposes of the funding formula, the rural factor is based on the Census definition of rural—living outside a town or municipality, or living within a town or municipality of less than 2,500 persons. Given the growth and

annexations of a number of cities over the past ten years, there may be a number of older adults who will no longer be considered living in a rural area.

However, the effect of the funding formula does generally distribute funds to more rural counties in the state. Ten percent of funds allocated are distributed based on rurality alone. Persons living at or below poverty are also more likely to live in rural areas, and 30% of the HCCBG funds are allocated based on persons living at or below poverty. There is also a base amount of funds (\$4,293,000) distributed equally to each of the 18 planning and service areas. The base allocation favors Area Agencies on Aging (AAAs) without large urban centers because they generally have fewer older persons in their regions. In addition to these factors, North Carolina requires AAAs to target funding to a county level using the same factors. Each county is to receive a base allocation of \$429,300 with the remainder of the region's allocation distributed based on the funding formula factors.

Current statistics bear out the observation that funding for agencies serving the elderly is indeed more available in rural counties. Eight of the ten counties with the highest allocations under the SFY 2000-2001 HCCBG were 100% rural, and the county with the lowest per capita allocation was Mecklenburg, North Carolina's most urban county. Yet even with targeting, rural counties still struggle to meet the significant needs of their older citizens.

For additional information, contact Bill Lamb, Associate Director for Public Service, UNC Institute on Aging at bill_lamb@unc.edu or (919) 966-9444.

Appendix D. Supplemental Materials on Funding and Advocacy

Editor's Note: Both the Kate B. Reynolds Charitable Trust and the North Carolina Senior Citizens Federation (an advocacy organization) have contributed monetary and human resources to improving the lives of North Carolina's rural seniors. Mr. John Frank of the Reynolds Trust and Ms. Inez Myles of the North Carolina Senior Citizens Federation submitted the following materials to help participants get a broader picture of the role of foundations and advocates in bringing about social change.

Mr. Frank: The Health Care Division of the Kate B. Reynolds Charitable Trust provides grants to serve the health and medical needs of the people of North Carolina who may be in need of medical care or assistance for financial reasons. The Division's objectives are to: (1) increase the availability of health services to underserved groups; and (2) support other programs that have merit and are related to the division's goal. The underserved are defined as the frail elderly; persons with physical or mental disabilities; the uninsured or underinsured; Medicaid-eligible individuals; victims of family violence; substance abusers; persons with HIV/AIDS; maternal, infant, and child health populations; and persons with or at risk of chronic diseases, including cancer, diabetes, lung disease, and stroke.

The Division emphasizes rural areas; encourages health promotion and illness prevention, including early detection and intervention; and supports well conceived studies that clearly define health care problems in North Carolina and that will assist in the development of viable solutions to these problems. Examples of its 1999 grants include: Allied Churches of Alamance, Inc., Burlington (\$10,000) to provide medication assistance to needy elderly and disabled individuals; Ashe Services for Aging, Inc., West Jefferson (\$50,000) to expand the intergenerational day care center for low-income adults and children;

Asheville Buncombe Community Christian Ministry, Asheville (\$70,000 over two years) to expand services to meet the increasing medical and dental needs of low-income individuals; Bell House, Inc., Greensboro (\$87,500 over three years) to support and expand an educational project to train people with mental retardation to become certified nursing assistants; Black River Health Services, Inc, Burgaw (\$25,000) to purchase medical equipment to expand diagnostic services for low-income residents of rural Pender County; Charlotte/Mecklenburg Hospital Authority, Charlotte (\$77,429) to expand on-line communications services for disabled adults living in rural areas of North Carolina; Mountain Home Nursing Services, Inc., Hayesville (\$138,872 over three years) to purchase an automated office system to aid this agency as it provides home health care to needy elderly patients in Clay and Cherokee; and Pamlico County, Alliance (\$109,329 over three years) for the Senior Services Department to provide case/care management services for the indigent frail elderly who are not eligible for Medicaid. For more information see <http://www.kbr.org/health/1999grants.html> for a complete list.

John H. Frank is the Director of the Health Care Division for the Kate B. Reynolds Charitable Trust. You can contact him at 128 Reynolda Village, Winston-Salem, NC 27106-5123, (336) 723-1456.

Ms. Myles: Most North Carolinians realize that rural North Carolina is served uniquely in many ways, by its own community inhabitants. Often legislated services and resources found commonly in urban areas of our state are scarce and sometimes non-existent in our rural areas. Therefore, citizens volunteer to strengthen their communities. Volunteers most often exist among the elderly who have the time and take the time for active citizen participation. They are the ones who seek to understand their rights and push for their entitlements. I have come across many senior advocates in our rural counties. Often I see that seniors are assisting regulators in becoming more cognizant of their needs and even more responsive. To me, it does not matter what career choice a senior made, when engaged in community empowerment activities they are "paraprofessionals on the job," becoming issue experts!

Seniors in eastern North Carolina and in the mountains have developed transportation programs through the use of church vans and spearheaded garden projects that have yielded free vegetables to the community. They have effectively advocated for rural health services in areas where there were no doctors and where doctors were unwilling to accept Medicaid patients. In the early seventies, I recall seniors in a rural county who marshaled community support for reforming the food stamp application process, by eliminating the early morning long waiting lines. Many seniors in our state who were homeowners, from rural areas, were the power brokers behind Senator Ralph Scott, in the original passage of the Homestead Exemption. Today in rural communities, seniors are empowered and are tackling the deregulation of electricity. One cannot find a community that is making change that does not have a significant senior who is to be respected and called upon for assistance, unless it is a community void of elderly residents. Senior Power causes community responses. They indeed get things moving and shaking in a community. And, usually there is nothing that stops them! They are my most influential friends!

In tackling problems common to most rural communities seniors are organized. Their clubs become the source of power. So many times I have been invited to attend home meetings, or I have recommended a senior to sit on a board to improve transportation, or I have helped a senior prepare testimony in their communities' struggle for street lights and paved roads. Seniors in rural areas are in fact, a key ingredient of leadership. Begin to notice how seniors move and relate to each other through formal and informal networks. I have found that some of the most common networks in our rural counties are: friendships, neighborhoods, churches and the workplaces. Throughout these networks seniors are mainline informants. They are an empowerment zone alone! They collect, retain and transmit information all of the time. If change is to occur in a community, especially in rural communities, senior residents must be consulted. They are influential in most things.

Norms in rural areas seem to differ. Life appears to be somewhat more simplistic. Many seniors lack the tangible and personal assets that

many of us in urban areas may feel to be important. They value greatly their faith in God, in self, family and community. So they share much.

Ms. Myles is Founder and Executive Director of the North Carolina Senior Citizens Federation, a grass-roots advocacy organization that represents the interests of low-income elderly. Contact her at P. O. Drawer 1455, Henderson, NC 27536, (252) 492-6031, fax (252) 492-0821.

Appendix E. Selected Internet Resources For Aging in Rural North Carolina

NATIONAL PERSPECTIVES

Aging in the United States---Demographics/Statistics

Administration on Aging (1999). *Profile of older Americans: 1999.*

<http://www.aoa.dhhs.gov/aoa/stats/profile/default.htm>

Administration on Aging (2000). *Statistical information on older persons.*

<http://www.aoa.dhhs.gov/aoa/stats/statpage.html>

Federal Interagency Forum on Aging-Related Statistics (2000). *Older Americans 2000: Key indicators of well-being.*

<http://www.agingstats.gov/chartbook2000/default.htm>

Rural Aging

Administration on Aging (1999). *Internet information notes: Rural aging.*

<http://www.aoa.dhhs.gov/naic/Notes/ruralaging.html>

Rogers, C. C. (1999). *Changes in the older population and implications for rural areas.*

<http://151.121.66.126/epubs/pdf/rdr90/>

International Rural Aging Project (1999). *Shepherdstown report on rural aging.*

http://www.hsc.wvu.edu/rural_aging/113328%20COA.pdf

2000 Forum on Rural Aging (2000). *Policy recommendations.*

http://www.hsc.wvu.edu/rural_aging/Policy%20Recomendations%2010-3-00.htm

NORTH CAROLINA PERSPECTIVES

Rural Issues–General

North Carolina Department of Commerce (February 21, 2000). *North Carolina Rural Prosperity Task Force Report*.
<http://ruraltaskforce.state.nc.us>

U. S. Department of Agriculture (1999). *Development ideas that work*.
http://www.rurdev.usda.gov/ideas/idea_menu.html

Aging in North Carolina–Demographics/Statistics

Center for Aging Research and Education Services (1998). *Baby Boomers at midlife: The future of aging in North Carolina*.
<http://ssw.unc.edu/cares/boomteas.htm>

North Carolina Division on Aging (2000). *Demographics and planning data*.
<http://www.dhhs.state.nc.us/aging/demo.htm>

UNC Institute on Aging. *Miscellaneous reports and digital library on aging*. <http://www.aging.unc.edu>