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Chapter 1 : Meeting the Primary Care Needs of Rural America: Examining the Role of Non-Physician Provi

Aging in Place in Rural Communities. Rachelle Levitt, Director of PD&R's Research Utilization Division. The problems facing individuals struggling to age in place differ in magnitude in urban and rural settings.

Received Nov 21; Accepted Jun 5. This article has been cited by other articles in PMC. Abstract Background Lebanon is faced with a particular challenge because of large socioeconomic inequality and accelerated demographic transition. Rural residents seem more vulnerable because of limited access to transport, health and social services. No information is available regarding health, nutrition and living conditions of this specific population. The present paper will describe the gender specific characteristics of the study population. Methods AMEL is a cross-sectional population based study conducted between April and April including elderly individuals living in the 24 rural Caza districts of Lebanon. People aged greater than or equal to 65 y were randomly selected through multistage cluster sampling. Subjects were interviewed at their homes by trained interviewers. The questionnaire included the following measures: Results The sample included men Mean age was Regarding socio-demographic status, among women the level of illiteracy and poor income was significantly higher than in men. Moreover, chronic diseases, poor self perceived health, frailty, functional disability, depressive symptoms and cognitive impairment were particularly high and significantly more frequent in women than in men. Conclusion The present study provides unique information about nutritional status, health and living conditions of community dwelling rural residents of Lebanon. These findings may alert policy makers to plan appropriate intervention in order to improve the quality of life and increase successful aging. Malnutrition, Nutritional status, Elderly, Aging, Rural health Background With the growing number of elderly people, chronic diseases and disability become a public health challenge especially in developing countries, where the health care sector is less developed and suffering from limited resources [1]. This accelerated demographic transition does not give enough time to allow these countries to develop their health, economic and social infrastructures in order to deal with the emerging older population. Another concern is that population aging in the developing world is accompanied by persistent poverty [3]. Living in rural areas in developing countries may carry an additional disadvantage. Indeed, several studies reported that elderly people living in rural areas suffer from worse health conditions, are less educated and have lower incomes compared with those living in cities [5 - 7]. They face specific problems including limited access to transport, facilities and health or social services. Nevertheless, rural residents may receive more community support [8], have a healthier lifestyle, more physical activity as well as healthier food habits which may counterbalance some of the disadvantages otherwise mentioned [9]. Nutritional status of older people results from a complex interplay between dietary, socio-economic, physical and psychological factors [10]. In addition, malnutrition in form of under nutrition or overweight will limit the ability to move, perform daily activities, and worsen comorbidities. Thus, nutritional status is a key factor in maintaining health and autonomy, especially when resources and health care are sparse. This proportion may reach One of the major problems this growing population is faced with is the lack of policies and retirement pensions [11], the high cost of health insurances as well as health disparities [5 , 6]. These facts as well as high illiteracy [13] and poverty [14] mainly present in rural areas, may affect health status and contribute to the growing vulnerability of older individuals. Unfortunately, little is known about the characteristics and the needs of these elderly people. Most studies carried out among Lebanese older adults focused on nursing home populations [15 , 16] or on elderly people living in refugee camps and in underprivileged communities [17 , 18]. This article describes the gender specific characteristics of the study population including demographic, socio-economic conditions, health and functional status as well as nutritional assessment. Dietary habits were not presented in this paper, but will be the subject of a second paper in preparation, along with factors associated with nutritional status. To our knowledge, this is the first study investigating the living and health conditions of community dwelling elderly Lebanese living in rural areas. Sample size calculation The sample was selected through multistage cluster sampling. These results are based on a review of 48 studies including either healthy or frail elderly individuals [19] and a retrospective study of pooled data [20] based on the

Mini-Nutritional-Assessment MNA [21]. Although some of the study samples were of convenience nature and mainly focused on European population, we considered these results as the most appropriate for our sample calculation, as representative data from developing countries are lacking. Due to possible missing values in several items, a final sample size of elderly was chosen. Subjects and setting Lebanon is divided into eight Mohafazat governorates ; each of them consists of several districts Caza forming a total of 25 Caza. As our study included only rural elderly subjects, the Caza of Beirut urban area was excluded. In each of the remaining 24 Caza stratum , two villages were randomly selected from the list of villages provided by the Central Agency of Statistics in Lebanon, except for two Caza where only one large village was selected giving a total of 46 villages [22]. Within each village, a random sample of 25 elderly individuals was drawn from the small villages and 50 from the larger villages, based on the list of households provided by the municipality or other local authority. A replacement list was prepared in case of absence or refusal of participation. The inclusion criteria were: The study received the approval of the ethics committee of St Josephs University of Beirut. Questionnaire The study was based on a comprehensive multi-component questionnaire, administrated by trained interviewers, including the assessment tools as described below. The questionnaire was translated back and forth from French to Arabic by two persons fluent in both languages. People were questioned after oral consent at their place of residence. Written consent was not considered necessary because it was an observational study. Also, participants remained anonymous and individual results were kept confidential. A pilot study including individuals was performed previously in order to pretest the feasibility of the questionnaire. According to the results, some minor changes were made. If the participant was unable to answer, the help of a family member was required. Assessment tools Socio-demographic factors The variables recorded included demographic characteristics age, gender, marital status, village of residence and living conditions living alone or with others. Information about the financial situation was recorded by two questions: Information about educational level was obtained using the following categories: Regarding the main occupation, individuals were questioned about the longest occupation held, which was categorized into: The question about health insurance was categorized into three groups: Anthropometric measures and nutritional status Weight was taken in light indoor clothes without shoes by electronic digital scale to the nearest 0. Nutritional status was assessed by the MNA in its Arabic version [24]. The MNA, developed by Guigoz et al. It has been translated into more than 20 languages and is cited in nearly publications. The MNA includes 18 questions regarding anthropometric, general, dietetic, and subjective assessment. Based on the total score, subjects were classified into three categories: Health characteristics Health related characteristics were assessed by self related health status SRH based on a 5 item scale. This measure has shown to be a reliable indicator for overall health status [27] in developed countries but also in most Arabic countries [28]. Comorbidities were recorded by asking participants if they suffered from chronic physician-diagnosed conditions such as hypertension, diabetes, etc. Drug intake was estimated by the number of drugs taken daily on a regular basis as prescribed by a physician and checked with packages shown to the interviewer. Based on the original SOF frailty index, frailty status was defined as robust 0 component , pre-frail 1 component , and frail 2 or more components. Oral health assessment included three dichotomous questions about chewing problems, total or partial loss of dentition and wearing dental prosthesis. Continence was not considered in this scale because difficulties in bladder or bowel control reflect an abnormality in a particular physical system and should therefore be considered as impairment rather than a disability [32]. According to several authors [33 , 34], we defined three main groups: This 4 item IADL scale has been shown to be associated with cognitive impairment in community dwelling elderly subjects [35]. Individuals were considered as fully independent coded 0 if they could perform the IADL item without any help, otherwise they were considered partially dependent coded 1. The final score, ranging from 0 to 4, was computed by summing the number of IADL dependencies for these four items. Subjects were asked to stay on one leg without using their arms. Moreover, participants were asked if they experienced one or more falls during the past year. Psychosocial and cognitive status Mental status was assessed by the 5 item Geriatric Depression Scale GDS-5 , a dichotomized 5- item scale score ranges from 0â€”5 allowing to detect depressive disorder in elderly people [37]. Presence of depressive symptoms was defined as a score of two or above [37]. The 5-item WHO Well Being Index [38]

was used to assess the mood of our study sample, as this instrument had previously been validated in the Arabic version by Sibai et al. The WHO-5 Arabic version allows the detection of depression among Lebanese elderly at a cut-off point less than 13 [38]. Cognitive status was assessed by the Mini-mental-state MMS examination [39], the most commonly used screening tool for cognitive impairment worldwide. In order to take into account the high level of illiteracy, we constructed a modified version adapted to illiterate subjects MMS 2 , whereas the original MMS MMS 1 translated in Arabic language was used for literate elderly. Furthermore, regarding question 29, where the patient is required to write a sentence, the participant was asked to construct a sentence orally including a subject, a verb and an object. As no cut-off points were defined in Lebanese elderly, the results were divided into quartiles. This tool is an abbreviated version of the original LSNS scale [41], which was especially developed for elderly populations and has been shown to be associated with a wide range of health indicators. The LSNS 6 is based on 3 questions assessing the family network, as follows: How many relatives do you feel close to such that you could call on them for help? How many relatives do you feel at ease with that you can talk to about private matters? The answers were as follows: The total score is the sum of the 6 items, ranging from 0 to According to the author [40], at a score below 12, the person is considered as at risk for social isolation. Subjective loneliness was assessed by the modified version of the Jong- Gierveld Loneliness Scale as described by Wilson et al. This 5 item scale included the following: Cluster effect was taken into account when computing confidence intervals, according to Rumeau-Rouquette et al. Percentages were used to present nominal variables, while means and standard deviations were applied for presenting continuous variables. The Chi Square test was used for cross tabulation of qualitative variables in bivariate analysis, while the Student T test was used to compare the means between genders. Results A total number of participants were included in our survey. Among the selected individuals, 4.

Chapter 2 : Rural Aging in Place | Aging In Place

Aging In Rural Settings About this report giagingorg, about this report this report is one of two publications offered in connection with the beyond here & there rural mobility summit, co hosted.

Print Friendly The availability of accessible and efficient primary care in rural America is a substantial and growing concern that is heightened by a combination of demographic trends. Physician supply in rural areas is already low, compared to non-rural areas of the country. These areas may be substantially underserved by hospitals and other health care facilities. Demographic shifts, such as the aging rural physician workforce and the growth in the rural elderly and near-elderly population will increase demand for primary care services. One approach to meeting this increased demand that is under consideration in many state legislatures is a redefinition, and often expansion, of the scope and standards of practice for non-physician practitioners. A recent survey found that 41 percent of rural Medicare beneficiaries saw a physician assistant or nurse practitioner for all 17 percent or some 24 percent of their primary care in Scope of practice regulations vary by state. The American Academy of Physician Assistants defines a physician assistant as a graduate of an accredited PA educational program who is nationally certified and state-licensed to practice medicine with the supervision of a physician. Scope of practice is an important issue for all health professionals because it affects their revenue and potential client base. For example, state Medicaid programs pay providers based on the scope of practice standards for that profession. This brief examines the legislative role, provides an overview of existing research, and describes state activity relating to scope of practice. The Problem Estimates of the scope of the provider shortage in rural America vary, but what is generally agreed upon is that thousands of additional primary care providers PCPs are needed to meet the current demand in rural America and that, during the coming decade, tens of thousands of additional PCPs will be needed to meet the growing rural population. Those who obtain regular primary care receive more preventive services, are more likely to comply with their prescribed treatments, and have lower rates of illness and premature death, according to research. Research shows that financial, professional and cultural factors affect where young doctors choose to practice. Another factor compounding the shortage of physicians is that the number of medical graduates who choose to practice rural primary care is insufficient to replace the rural doctors who are retiring. A recent study found nearly 30 percent of rural primary care physicians are at or nearing retirement age, while younger doctors those under age 40 account for only 20 percent of the current workforce. The rural population of those ages 55 to 75 is estimated to grow 30 percent between and due, in part, to retiring baby boomers migrating from urban areas. In addition, the Patient Protection and Affordable Care Act requirement that most people have health insurance will increase demand for health care services, especially for primary care. Some estimates projected an additional 8 million to 9 million rural individuals would be eligible for coverage through Medicaid as a result of the expansion of coverage for those with incomes up to percent of the federal poverty guidelines. For these reasons, states have been working to find ways to increase the number of primary care providers in rural areas. One option under consideration is to expand the scopes of practice for certain non-physician practitioners, thereby permitting these professionals to furnish a greater array of diagnostic and therapeutic services to patients. The Research Studies suggest that access to and the quality of primary care services can be improved and certain costs can be reduced with targeted expansions of scope of practice for non-physician practitioners. However, research also identifies the need for increased educational and licensure standards for providers with expanded scopes of practice, as well as improved data collection in order to increase accountability and ensure quality of care. Here are some brief findings from the research. The IOM also found that nurses working as care coordinators and primary care clinicians can reduce hospitalization and rehospitalization rates for elderly patients. In certain studies, for example, nurse practitioners were found to spend more time in consultation with patients and generate greater overall levels of patient satisfaction. As rural and frontier areas increasingly rely on non-physician practitioners to deliver primary care services, research indicates that these providers need to attain higher levels of training and education over the course of their careers. In addition, the IOM recommends creating systems for collecting

and analyzing workforce data and that future decisions about the scope and standards of practice for non-physician practitioners be based upon the data collected. Physician Assistant Dispensing Authority State Actions Many states have taken steps to increase the procedures, treatments, actions, processes and authority that are permitted by law, regulation and licensure for non-physician primary care providers. For instance, physician assistants may prescribe medication in all 50 states and, according to the National Association of Boards of Pharmacy, 40 states have given physician assistants varying degrees of authority to dispense give or supply to a patient medications to patients; this can be helpful for people who live in rural areas where the closest pharmacist may be many miles away. Another eight states allow nurse practitioners to independently diagnose and treat patients, but not to prescribe medications. The remaining 27 states require either direct or indirect physician supervision of nurse practitioners to diagnose, treat and prescribe. In addition, according to the American Nurses Association, federal law requires that all 50 states provide payment for services furnished by pediatric nurse practitioners, family nurse practitioners and certified nurse midwives for medical services provided under their Medicaid fee-for-service or Medicaid managed care programs. Nurse Practitioner Scope of Practice Authority, Legislative Considerations For states with large rural and frontier areas, finding an appropriate balance between expanding scope of practice for non-physician practitioners while ensuring patient safety, the quality of care and provider accountability are a challenge. Physician groups generally support collaborative or supervisory arrangements with non-physician practitioners. However, these groups generally oppose efforts that allow non-physicians to practice independently. As policymakers grapple with increasing access to quality primary health care, they may wish to examine or re-examine the following issues. Can they practice without direct physician supervision, and under what circumstances? Should the requirements related to the distance between a supervisory physician and a non-physician practitioner be examined for providers practicing in rural areas? If so, what classes of prescription drugs should they be allowed to dispense? Should non-physician primary care providers in remote areas where there is no physician or pharmacist be given broader authority to dispense medications? Should educational and licensing standards for non-physician practitioners be increased in order to meet the growing demands placed upon these professionals in rural areas? Should non-physician practitioners receive lower payment than physicians for comparable services? Should rural providers be reimbursed differently for practicing in underserved areas? State Examples States have taken a number of actions in recent years to expand the scope and standards of practice for non-physician primary care providers, many of which are too recent to see results or properly evaluate. This section includes policy examples from Pennsylvania and Connecticut. Prescription for Pennsylvania Between and , the Pennsylvania General Assembly enacted a large package of health reforms, referred to as the Prescription for Pennsylvania, which included numerous provisions related to the scopes of practice for health professionals such as certified registered nurse practitioners, clinical nurse specialists, physician assistants, nurse midwives and independent dental hygienist practitioners. One law gave physician assistants working under the supervision of a physician the authority to order durable medical equipment and physical therapy, dietician, respiratory and occupational therapy referrals; perform disability assessments for the federal Temporary Assistance for Needy Families TANF program; issue homebound schooling certifications; and perform and sign for the assessment of methadone treatment evaluation. Walk-in clinics, which were then growing in numbers in Pennsylvania and often are operated by nurse practitioners, were the impetus for this expanded scope. This can make legislative decisions very difficult, even for the most informed legislator. Five scope-of-practice changes were reviewed under the new process for the legislative session and one, eliminating a face-to-face supervision requirement for physician assistants, became law. Consequently, many states continue to look at ways non-physician providers can play a larger role in providing primary care in rural areas. Research suggests that, by expanding scopes of practice for non-physician primary care providers such as physician assistants and nurse practitioners, access to primary care services can be improved and the quality of those services will be comparable to that provided by physicians. Expanded scope of practice for non-physician practitioners also could potentially result in decreased costs, although more research is needed in this area to determine whether cost-savings can be achieved in rural areas. States also will want to develop better ways to measure the effects of expanded scopes

of practice on cost, quality and access to care. By attempting to find a balance between using non-physician primary care providers to the fullest extent of their education and ensuring that patients can seek treatment in a safe and cost-effective environment, states can potentially work toward meeting the growing health care needs of their rural populations. Bloniarz, , January Physician and other health professional services Washington, D. What Does the Evidence Tell Us? Are Rural Locations Vulnerable? Department of Agriculture Economic Research Service, Center for Rural Affairs, Leading Change, Advancing Health Washington,. National Academies Press, Naylor and Ellen T. Leading Change, Advancing Health. National Association of Boards of Pharmacy, American Academy of Physician Assistants. American Medical Association, Swankin, Reforming Scopes of Practice: A White Paper Washington, D. Citizen Advocacy Center, July State of Connecticut, State of Connecticut, Nov.

Chapter 3 : Project MUSE - Indicators of Home Care Use in Urban and Rural Settings

Promoting health and quality of life among rural older people has received little attention, especially in Spain where the number of interventions designed specifically for the rural elderly is.

National Security Aging in Place in Rural America For older adults living in rural communities, the challenge of aging in place is often magnified. What specific programs and policies have proven successful and could be replicated? View the full forum. By Terry Hill For older adults living in rural communities in the United States, the challenge of living independently as long as possible is magnified. Long distances, lack of transportation, as well as limited senior housing options, create barriers that too often find rural seniors in housing options that do not maximize their independence, and sometimes separate them from their families. Ironically, people who live in rural America and have strong independent values often find themselves in highly dependent situations in the final stages of their lives. Fortunately for rural seniors, two major trends are transforming the health care industry in this country, and will have a major impact on the challenges described above. The first major trend is the transformation of the U. If the providers can provide comprehensive care to the recipients with higher overall quality and satisfaction, at less total cost than the previous year, they gain bonuses based on this documented value. Given the ACO model, which has been copied by many state Medicaid programs, helping keep people in their homes as long as possible has become an important business objective. The home-based seniors and their families tend to be happier, the cost is substantially less, and the quality and safety can be provided with the use of a second major trend: The Lutheran Home Association, located in Belle Plaine, Minnesota, south of the Twin Cities, has more than seven years of experience using health monitoring technology to keep seniors and chronically ill patients in the least restrictive housing settings. This proactive intervention model is designed to monitor and prevent negative events such as falls or wandering, and will allow these individuals to stay in their homes as long as possible. This web-based center is scheduled to be completed in Other types of mobile health monitoring technology is predicted to be used widely in the near future. Health care providers are already capable of monitoring the vital signs of patients remotely; technology that can be worn by or attached to patients will provide daily readings of blood pressure, blood sugar, and a variety of other patient information to health care providers in rural clinics and hospitals. This ongoing monitoring of medical conditions combined with sensor technology will enable rural seniors and chronically ill patients to live safely in place as long as possible. In summary, rural seniors have historically faced formidable challenges to staying in their homes when sick or chronically ill. Two major trends will effectively overcome many of these challenges: This is all good news for rural seniors, for their families and for their health care providers. Each month contributors from different parts of the health and housing sectors will be invited to respond to a discussion topic. Please leave it in the comments.

Chapter 4 : Rural Nursing Facing Unique Workforce Challenges - RWJF

Aging in rural settings: life circumstances and distinctive features. [Raymond T Coward; John A Krout;] -- "This text provides the critical dimensions of growing old in rural environments. Prominent researchers explore issues related to life conditions, diversity, services, and public policies for rural.

However, it is not without its challenges This article will explore some of the advantages and disadvantages of aging in place as it pertains to those who choose to live in a rural setting. Advantages of aging in place in a rural setting The lifestyle in a rural setting is usually slower-paced than in an urban setting. Those elderly people who have lived in a rural setting for years or even decades may have a difficult time transitioning into a more urban setting and may be extremely unhappy if forced to do so. The pace of life in a rural setting may be more agreeable to those who have slowed down and prefer more peace and quiet. Further, community ties in rural areas tend to be higher An elderly person in a rural area will be more likely to receive emotional and social support from those around him or her. Particularly in very small towns, an elderly person may be viewed as something of a community treasure and may find that people enjoy dropping in to visit with and check on him or her. In contrast, in urban areas, an elderly person may easily become lost in the crowd and may find that he or she is living a life of relative anonymity. In addition to rent, basic services and goods also tend to be cheaper in rural areas, and an elderly person will find that his or her fixed income stretches further in these areas. Challenges in aging in place in a rural setting For all its advantages, there are some real challenges to those who wish to remain in a rural area as they age. Some of these challenges are little more than inconveniences; however, some of them can be very serious and even deadly. Living in a rural setting means that there will most likely not be any real attempt at providing public transportation. An elderly person may find that if he or she needs to go to the grocery store, he or she is faced with either attempting the drive or waiting for a friend or relative who may be able to provide transportation. As a person ages, the ability to drive tends to erode, and eventually many if not most elderly people stop driving altogether When your elderly loved one reaches this point, his or her options for transportation will be severely limited. In contrast, in urban areas, elderly people who do not wish to drive can easily take a bus, subway, or other viable form of public transportation. In addition to the transportation issue, rural settings tend to provide fewer services for the elderl. While there may be senior citizen centers in urban areas where elderly people may go for companionship, entertainment, and socializing, these opportunities are significantly limited in rural areas. Finally, the availability of medical services is somewhat limited in many rural areas. While a doctor or family practitioner is likely available pretty much anywhere, more specialized healthcare professionals may not be available. This means that an elderly person needing such services will have to take a long trip to an urban area. Depending on his or her health, such a trip could be impossible or even fatal. Conclusion Aging in place in a rural area has its advantages as well as its challenges. If your elderly loved one is considering this option, it would be a good idea to sit down with him or her and talk through these issues.

Chapter 5 : Aging in Place in a Rural Settingâ€”Advantages and Difficulties - Seniors Matter

Aging in Rural Settings has 0 ratings and 1 review. a concise state-of-the-art summary of the critical dimensions of growing old in rural environments.

As Brenda Causey, R. Causey is one of a number of nurse leaders working on projects supported by the Robert Wood Johnson Foundation RWJF aimed both at increasing the number of nurses practicing in rural communities and at expanding the share of new nurses with baccalaureate or advanced degrees. Rural Health Challenges Approximately one in five Americans lives in a rural areaâ€”nearly 60 million people, as of the Census. For many, medical care is miles away, and a fully equipped hospital still farther. The nurses who staff medical offices, clinics and small hospitals in these areas tend to be generalists, and need training across a broad range of areas so that they can provide primary care to patients. In cases that demand equipment and specialists beyond the reach of local hospitals, nurses are called on to help stabilize patients for journeys to larger hospitals elsewhere. Nurses at rural medical facilities generally live in the community itself, as Causey suggests, and many face profound economic challenges in their own families. Such hardships can make it especially difficult for nurses to continue their education beyond the point at which they can be licensed and start earning a paycheck. Moreover, many potential nursing students who are the first in their families to attend college grow up without any particular expectation of attaining a college degree of any kind. In all, 56 community colleges in the state offer associate degrees in nursing, while 18 universities award baccalaureate degrees. Every one of those graduates has an associate degree, she points out. The project brings community colleges in New York and North Carolina together with four-year institutions in their respective states to forge a unified approach to admissions and curriculum so that nursing students can enter community colleges on a four-year baccalaureate track. One objective is to make it easier for students to get and stay on a baccalaureate trackâ€”even students who are unable to travel far from their rural homes for reasons of money or family obligations. Experience has taught them that the connections to family and community that made the community college a first choice will also work to keep them providing care in the community for years to come. The effort is mobilizing nurse leaders with varying expertise, including work in hospitals, public health, long-term care, school nursing, community college nursing education, mental health, hospice, home health and military health. The project created local councils in two separate rural areas covering four counties, aiming for participation of 12 to 18 nurse leaders from each region. The councils met, established strategic priorities, consulted with Lake and colleagues, and then developed locally targeted initiatives. For example, the councils devised a marketing campaign designed both to recruit new nurses and to build the pride of profession of current nurses, in order to keep them in practice. Another council activity focused more specifically on recruitment, reaching out to high school students to encourage them to pursue careers in nursing. The effort included conversations with school counselors in each of four counties, as well as with secondary students among 16 schools. A follow-up effort will feature a mentoring program that puts practicing R. The project mobilized nurse leaders in what Lake describes as a collaborative partnership expected to live beyond the RWJF grant.

Chapter 6 : Aging in Rural Settings: Life Circumstances and Distinctive Features by Raymond T. Coward

Advantages of aging in place in a rural setting The lifestyle in a rural setting is usually slower-paced than in an urban setting. Those elderly people who have lived in a rural setting for years or even decades may have a difficult time transitioning into a more urban setting and may be extremely unhappy if forced to do so.

Chapter 7 : Rural Aging Introduction - Rural Health Information Hub

View more Rural Aging The nation's population is aging, and with that change comes increased healthcare needs. According to the Centers for Disease Control and Prevention report, The State of Aging and Health in America , the

population 65 years and older is expected to double over the next 25 years, due to longer life spans and the large number of baby boomers reaching retirement age.

Chapter 8 : Aging in Place in Rural America | Bipartisan Policy Center

While rural areas offer many benefits, supporting aging in place may require more careful planning and coordination than in urban settings. Most older adults would like to remain in their homes and communities, but the physical changes brought on by aging can impact their capacity to age in place successfully.