

UC Davis

UC Davis Electronic Theses and Dissertations

Title

Bureaucratic Entanglements: Barriers to Access for Older Adults Living in Rural Communities

Permalink

<https://escholarship.org/uc/item/5q12f6qw>

Author

Ramon Ramos, Cristian Soraida

Publication Date

2024

Peer reviewed|Thesis/dissertation

Bureaucratic Entanglements:
Barriers to Access for Older Adults Living in Rural Communities

By

CRISTIAN SORAIDA RAMON RAMOS
THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

Community Development

in the

OFFICE OF GRADUATE STUDIES

of the

UNIVERSITY OF CALIFORNIA

DAVIS

Approved:

Natalia Deeb-Sossa, Chair

Jesse Drew

Mark H. Cooper

Committee in Charge

2024

© 2024 Cristian Soraida Ramon Ramos

Abstract

Community Based Organizations (CBOs) play a crucial role in supporting clients to navigate healthcare and social services, often funded through grants and donations. Nevertheless, the burden of extensive documentation for both service providers and clients can erect barriers that inhibit CBOs from addressing community needs or deter clients from availing services that could enhance their standard of living. This research focuses on how neoliberal policies engender bureaucratic entanglements, thereby escalating the obstacles to access for older individuals in rural settings. The burden of excessive paperwork, combined with other obstacles such as poor quality of care, discourages service seekers from applying for programs beyond their most immediate needs due to fear of mistreatment. By centering the voices of these older individuals, the study aims to understand the impact of these policies on the healthcare safety net. In addition, service providers of Community Based Organizations share how the management of grant deliverables, funding and interorganizational collaboration impact service delivery. Finally, the research explores the concept of Community Cultural Wealth (CCW) as a potential tool for rural unincorporated communities to overcome the challenges that arise from healthcare access barriers.

Keywords: older adults, bureaucratic entanglements, neoliberal policies, healthcare, social services, Community Based Organizations

Dedication

A todos aquellos que han sido maltratados, ignorados y que han perdido la esperanza en los sistemas que deberían cuidar de nosotros. Sirvan estas palabras como testimonio.

Acknowledgements

Thank you to the community elders and providers who took the time to share their stories and experiences with me. Thank you to my father Juan Cruz, my mother Flora Ramos, and my sister Brianna Cruz-Ramos. *Thank you to my friends who are my chosen family.* Thank you to my dear mentors: Mary-Jo Ybarra Vega, Patrick Patterson, Lea Carol Patterson, Dr. Julie Postma, Kathleen DeMaria, Dr. Lee Burnside, Professor Emeritus John Toews, Dr. Sangeeta Hingorani and Dr. Charles Birnbach. I could not have traversed higher academia without you. Thank you to my committee, Natalia Deeb-Sossa, Mark Cooper and Jesse Drew, for showing me the power of words to catalyze change; I am grateful for your patience, guidance and encouragement to keep going even when I felt I could go no further. Dear grandpa, we did it. Rest in peace.

Contents

Abstract	iii
Dedication & Acknowledgements	iv
Introduction	1
Chapter 1: Bureaucracy, Nonprofits and Neoliberalism in Healthcare	4
1.1 How does bureaucracy show up within the healthcare system?	4
1.2 To what extent are these instances of excessive labor demands placed on CBOs a feature of neoliberal policy in healthcare?	7
1.3 Whose interests are being served as neoliberal policies take hold of the healthcare and safety net programs?	10
Chapter 2: Aging in the United States Healthcare System	14
Chapter 3: Methods	28
Setting	28
Qualitative Approach	29
Equipment and Data Collection	30
Participants	31
Community Support	34
Chapter 4: Results and Discussion	36
4.1 The importance of being in community	36
4.2 Older Adult Interviews	41
4.3 Service Provider Interviews	48
Discussion	54
Conclusion	56
References	60
Appendix	68

Introduction

Community Based Organizations (CBOs) mitigate barriers to access by supporting clients to navigate healthcare and social services networks; these activities are funded in part through grants offered by various governmental agencies, philanthropic organizations, and community donations. Although metrics measuring progress serve as accountability tools, considering the perspectives of service seekers and service providers also helps to understand whether the services being provided have the intended effect. For this reason, I have chosen to center the voices of the rural older adults attempting to access services. I have worked in direct, front-facing positions within both community-based organizations (CBOs) and healthcare institutions. My roles have included tasks such as patient intakes and health navigation. Through these experiences, I've observed the disconnect that sometimes exists between CBOs and the communities they serve. Oftentimes, this disconnect stems from grants that have strict grant deliverables which do not meet the specific needs of the community. CBOs can find themselves against the wall trying to meet grant deliverables whilst juggling client needs. For example, if there is not enough funding or staff capacity to assist a client, they are referred to another organization in hopes that they may be better served elsewhere. Understanding whether these services are effectively reaching individuals can aid in the revision of funding allocations and grant deliverables to maximize the joint effort of stakeholders. The primary objective of this research is to explore the ways in which implementation of neoliberal policies have altered the safety net provided by healthcare and social services. I theorize that neoliberal policies are being used as tools of bureaucratic entanglement within organizational structures, the consequences of which lead to increased barriers to access for older adults living in rural communities. For the purposes of this research, bureaucratic entanglement is defined as interruptions in processes and

excessively laborious procedures put in place to ensure organizational outcomes are met. This is a narrower look at the interplay between organizations and the impact of their structuring on the public than Vogler's (2019) theory of bureaucratic entanglement which focuses on “the complex interdependence between public administrative organizations and their environment” (p. 3). The literature review focuses on neoliberalism in healthcare as a lens from which to analyze responses from older adults and service providers interviewed in a rural community within Yolo County, CA for this project. In addition, Community Cultural Wealth (CCW) is highlighted as a transformative tool used by the community to maximize available resources to uplift one another despite the damaging effects resulting from the neoliberal policies which continue to shape the healthcare landscape.

A few examples of “barriers to access” include language barriers, inability to pay for care, digital literacy, and lack of transportation. Policy makers and institutions are aware of these barriers and are actively looking for ways to increase access around these problems as evidenced by California’s Master Plan for Aging (n.d.); yet I argue that one of the most damaging barriers to access is navigating the system itself. The act of navigating requires a basic understanding that allows one to predict and find a sensible route to access and navigate through healthcare and social service systems that for many are daunting. A person engaged in navigation is presumed to have tools which should aid in this activity; therefore, applying the term navigation to attempts at traversing the healthcare and social services landscape may be a misnomer. When bureaucratic burdens, such as excess paperwork, are passed on to individuals, the confusion and frustration resulting from these burdens can oftentimes result in older adults forgoing services all together. Navigation cannot occur when walls are actively being erected to prevent access.

The paperwork required to obtain multiple services is burdensome to the point of needing “health navigators” in the non-profit sphere whose sole purpose is to assist clients and patients. What does this type of position say about the ways in which assistance is provided to vulnerable populations? Why are the time, energy and resources which should be used to address health disparities being consumed by the bureaucratic entanglements of paperwork for providers and service seekers? These are some of the guiding questions of this research. Despite being a health navigator and case manager, I was at times left stumped when attempting to address the barriers to access faced by older adults. My proficiency in navigating the healthcare system fell short given the continuously changing laws and regulations within the healthcare and social services landscape. The goal of this project is to unveil the ways in which neoliberal policies lead to bureaucratic entanglements which purposely slow down the process of giving aid. The bureaucratic entanglements which will be highlighted by interviewees include the burden of grant deliverables placed on CBOs, the long approval wait times for services due to lack of funding and the excess paperwork passed on to clients and patients. Chapter I explores the relationship between neoliberalism in healthcare, bureaucracy and the CBOs communities rely on. Chapter II will address the realities of aging in the US healthcare system as it is currently structured. Chapter III goes into detail on the research location and methodology implemented for this research. Finally, Chapter IV will give an overview of the interview responses which highlight the personal experiences of providers and older adults within the healthcare and social services systems. Here, CCW will be highlighted as a tool used by community members and providers to leverage available resources for mutual upliftment, even amidst having to navigate bureaucratic entanglements for service provision and acquisition.

Chapter I: Bureaucracy, Nonprofits and Neoliberalism in Healthcare

1.1. How does bureaucracy affect Community Based Organizations?

“I’d rather spend my time helping somebody than doing a report that I don’t know what happens after I submit it.” (ALSNC, personal communication, March 16, 2023)

Bureaucracy is the monitoring of activities within an organizational hierarchy that is governed by processes ensuring duties and expectations are met (Weber, 1958). According to Ritzer (2004), “bureaucracies emphasize control over people through the replacement of human judgment with the dictates of rules, regulations and structures” (p. 27). This does not necessarily mean that all persons under bureaucratic oversight relinquish human judgment at the time of decision-making. As will be expressed by providers interviewed, there are instances where grant deliverables are incompatible with community needs which led to decisions made by CBO leaders that prioritized community needs over bureaucratic processes and vice versa. Leaders of community-based organizations should not be forced to choose between serving their community’s interests and adhering to bureaucratic procedures that ensure their organization’s survival. Ideally, these bureaucratic processes should enhance healthcare delivery, not obstruct it.

Monteiro and Adler (2022) suggest that there is confusion when trying to define bureaucracy which, depending on the context, is typically understood as institutions, processes, or tools of domination. They introduce three perspectives: bureaucracy as an organizing principle, bureaucracy as a paradigm and bureaucracy as a type of organization principle among other types. For the sake of clarity, this paper will focus on bureaucracy as an organizing principle which takes on the forms of instrumental rationality, value rationality and domination. Instrumental rationality seeks efficiency of processes while value rationality is “based on commitment to some ultimate value and involves conscious deliberation on the concrete meaning

to be attributed that value in the given circumstances” (p. 432). Bureaucracy as domination, on the other hand, is a principle whose purpose is to establish and reassert hierarchical forms of rule. Bureaucracy as principle is implemented and practiced to different degrees across organizations and institutions which may lead to bureaucratic entanglements.

Given the lack of bureaucratic standardization down the hierarchy, varying processes across sectors and governments can lead to unrealistic expectations which are assumed will translate at different scales to achieve outcomes. For example, the government agency granting funding holds a non-profit responsible for knowing that agency’s processes at certain extent whilst said organization has their own processes to incorporate the demands of the various funders which may look different from other non-profits and related sectors such as healthcare. This paper does not set out to argue against bureaucracy but rather attempts to highlight the consequences of bureaucratic entanglements in creating confusion at multiple levels of a hierarchy that hinder access to care. These mix-ups and delayed services result in harmful outcomes which create barriers around delivery of care. There seems to be a lack of consensus around which bureaucratic principle should be the common denominator across systems. The lack of standardized bureaucratic processes limits the effectiveness of services and is replaced by burdensome paperwork that is highly specialized and relevant only to the institution requesting proof for use of funding; the demands vary by institution. CBOs are left at the mercy of specialized government oversight and in the case of healthcare institutions, the insurance industry, which takes time away from addressing the social determinants of health defined by Gibbins and Wickramasinghe (2021) as “the economic and social conditions that influence individual and group differences in one’s health status” (p. 2). State retrenchment that removes safety nets creates gaps in care which results in a patchwork of services in the United States

known as the “healthcare system.” This patchwork is supplemented by the work of CBOs to address health disparities making them vital within a neoliberal framework of governance.

The inconsistency in structuring of CBOs is in part due to funding precarity that requires navigating the bureaucratic red tape of each funder. Despite having acquired legitimacy through the process of professionalization during the 1990s, non-profits made a shift from public serving institutions to accommodate the forced business-like models being requested by donors (Alexander & Fernandez, 2021). The logic behind this shift, according to donors, is a decreased dependency on external funding to achieve “self-sufficiency”, effectively treating CBOs as individuals responsible for their own well-being which is in line with the neoliberalization of healthcare and public services. The role of CBOs within a community often include education, service provision and advocacy. Given the political nature of advocacy, CBOs claiming advocacy as one of their core values are having to adopt risk averse behaviors and limit the innovations that would best-serve within a specific socio-political context to reach financial goals that maintain operations (Alexander & Fernandez, 2021). Inevitably, these bureaucratic entanglements are passed on to service seekers in the form of paperwork that includes every metric requested by each funder. These metrics are, in turn, used to justify current funding and to attract more donors. Forcing CBOs into a business-like model of operation (Soskis, 2020) has created an artificial scarcity which encourages competition within the sector and gives donors a level of control over outcomes that ensure their specific needs, whether or not in line with community needs, are being met. There is no clear consensus around which of the three principles—instrumental rationality, value rationality and domination—prevails within government institutions, CBOs and philanthropic institutions. The government functions through a closely interlinked bureaucratic system, the administrative intricacies of which are often

imposed on non-profit organizations as burdensome paperwork requirements. This implementation of administrative supervision, aimed at efficiency and accountability, exemplifies instrumental rationality. CBOs seem to be propelled by value rationality, with many of them having the mission to aid underserved communities by addressing the infrastructural gaps that hinder increased quality of life. Philanthropic institutions, on the other hand, have used bureaucratic domination to influence the outcome of political projects under the veil of value rationality. As stated by Alexander and Fernandez (2020), the government exhibits a bias towards the affluent, thereby allowing them to dominate the policy-making process. The economic elite have extended their influence over policies through private foundations, whose funding goals can override the public process. These are the same foundations which CBOs must appeal to for funding. Philanthropy and government have increased organizational demands by pushing for market-based solutions to social problems requiring that “nonprofits formalize administrative structures and processes, develop performance measures, professionalize boards, generate commercial income to become self-sustaining, and focus on individual service delivery” (Alexander and Fernandez, 2020, p. 373). In this context, the escalating complexity of bureaucratic procedures entrenched in the healthcare system has fostered an environment conducive to the manipulation of safety net services by neoliberal policies, particularly those aimed at serving historically marginalized communities.

1.2. To what extent are these instances of excessive labor demands placed on CBOs a feature of neoliberal policies in healthcare?

“There are some years that the Older Americans Act doesn’t get [considered]. . .they have to every so many years revote on it again and there have been years where that hasn’t happened, and we wonder if we’re going to get funding at all. . .we’ve always gotten some funding but it certainly hasn’t increased with the inflation or things like that” (PAAA, personal communication, March 8, 2023)

Neoliberalism is a political ideology which positions the state as the agent whose function is to reduce the barriers of capital flow within an economy on a national and global scale. Neoliberalism promotes the idea that the market will meet the needs of individuals, thereby placing all responsibility of a person's well-being on their actions within the market (Navarro, 2007). The implementation of neoliberal policies comes at the expense of the public given that increasing austerity measures are accompanied by a reduction in safety net programs (Baines, 2010). As Powell (2020) states, “A general move toward shrinking government...whether referred to as retrenchment, decentralization, new public management, or neoliberalism—resulted in a sharp reorganization of the public sector” (p. 11). The landscape of healthcare and social services has been transformed in such a way that the privatization of public services is becoming increasingly prevalent to keep institutions addressing health disparities operational.

According to Powell (2020), impact metrics requested by government agencies and the professionalization of nonprofit positions resulted in a restructuring of the environment within which nonprofits operated around the turn of the 21st century. This shift in focus from mission to metrics became the established way of running an organization. It is not that all nonprofits operate with a metrics-based approach as their primary objective, but these organizations can no longer operate without them. Although Powell (2020) states non-government donors make up a small percentage of nonprofit funds, this is not the case across the board; there are organizations that rely on significant donations made by philanthropic organizations which evaluate worthiness based on the number of people served or services rendered. Depending on the source of funding, the looming threat of losing funding is now persistent for CBOs if grant deliverables and reporting requirements are not met. Examples of grant deliverables and reporting requirements

include showing the impact of the number of people served, number of services rendered, itemized activities provided by staff, quarterly, bi-annual, and annual progress reports, financial cash transaction and expenditure reports, itemized population tracking data, program indicators, and program project management data (National Institutes of Health, 2021; Centers for Disease Control and Prevention, 2022). Requirements vary with each program or funder which is contingent upon the funder's purpose or goals. The measurement standards employed by governments and philanthropic organizations imposes a capitalist rationale on CBOs, making them susceptible to neoliberal ideologies. This rationale extends to different ways of offering financial support to organizations; Dignity Health, for example, offers direct loans, intermediary investments, line of credit, linked deposits, equity capital and guarantees with investment terms of 1-7 years at rates "generally at or below market rate" for the purpose of supporting "community health by giving local non-profit partners the financial tools they need to serve the underserved and improve their community's health and quality of life" (n.d). This system of funding acquisition and monitoring restructures organizations according to the principles of neoliberal capitalism, which are the guiding tenets of business operations. The implementation of the constraints and competition enforced by governments and philanthropies is an intentional design that could be challenged to restructure CBOs in ways that increase flexibility of service provision so that individual community needs are met. The enforcement of constraints and competition by philanthropic organizations is a deliberate strategy that could be contested to reorganize CBOs in a manner that enhances the adaptability of service delivery, thereby catering to the unique needs of individual communities.

Nonprofit organizations are entities that do not seek to generate profits for stakeholders. Instead, they are typically oriented towards social causes, providing services in a non-

commercial manner for the public good (Powell, 2020). They serve as conduits for concepts centered around public welfare, which can have a more pronounced effect at the local level. However, being vessels for ideas promoting societal well-being also implies that nonprofits must cater “not only to their constituents and clients, but also to their staff, members, volunteers, and donors” (p. 4). The demand to be responsive in multiple directions, what Alexander and Fernandez (2021) identify as “professionalization”, leaves nonprofits vulnerable to the infiltration of neoliberal ideologies and forces organizational focus to shift “away from the external relationships with publics and inward toward organizational demands” (p. 372). To understand how neoliberalism has permeated into public benefit entities such as nonprofit organizations providing health-related safety net programming, what follows is a brief overview of the origins of what is known today as the nonprofit sector in the United States.

1.3 Whose interests are being served as neoliberal policies take hold of the healthcare and safety net programs?

“Dignity, Kaiser and Sutter [hospitals] all have community grants and we are exclusively fighting each other for those grants and sometimes we get them and sometimes we don’t. For instance, I’ve already said that case management is a priority for us and we wrote a grant to do case management for people who are coming out of their hospitals and they didn’t fund it.” (SYHAA, personal communication, February 7, 2023)

Although nonprofits are meant to be socially oriented rather than profit-driven, the creation of what is known today as the nonprofit sector was “led by elite business and civic leaders who, although concerned with efforts to correct abuses by some foundations, nevertheless wanted to maintain a space for the power and influence of elite private philanthropy” which receives large tax exemptions (Powell, 2020, p. 8). In a way, CBOs are also perfect vehicles for neoliberal ideology given the incentive of philanthropies to legitimize these spaces. In my former workplace, the main task which kept the organization afloat was keeping the uninsured out of the emergency room and ensuring that if patients utilized emergency

services, they were assisted with obtaining health insurance either through the marketplace or through federally funding insurance programs such as Medicare and Medi-Cal. The demand to increase the number of insured on a quarterly basis was high. There was a substantial sum of money to be recovered for the hospitals that contracted the CBO so the hospitals' profit margins would not be negatively affected by visits that patients could never afford to pay. In this specific example, hospitals forced to privatize still managed to shift the expenses of patient care between themselves and the federal government. Here, the CBO played the role of an intermediary, necessitating a thorough understanding of how to maneuver through the bureaucracy of both federally funded health coverage, insurers, and the individual operational procedures of each hospital. This is just one instance of how neoliberal politics have transformed the delivery of services, as evidenced by the effects of privatizing public serving institutions such as hospitals.

Beginning in the 1980s, neoliberal ideology began to take hold of government during the Reagan and Thatcher era (Navarro, 1998). A change in political beliefs resulted in the government becoming more decentralized, opting to provide contracts across various sectors and grant funding, rather than establishing programs or departments for service delivery. The increase in government contracts, which signaled a shift from the creation of new governmental agencies or utilization of existing infrastructure for direct service provision, passed the responsibility of service provision to the healthcare and social services sectors, among others (Powell, 2020). An alliance began to form between nonprofit organizations and governments at the local, state, and federal levels. The transition of social accountability from the state to corporations necessitated the adoption of administrative norms, which resulted in the creation of documentation trails that demonstrated the influence and allocation of government funds. In the private sectors, the shift to neoliberal policies gave private funders such as philanthropists more

control over the organization of public discourse (Harvey, 2007; Powell, 2020, Powell and Bromley, 2020). As Harvey (2007) more pointedly argues, the increase in neoliberalization is “a political project to re-establish the conditions for capital accumulation and to restore the power of economic elites” (p. 19). This political project has forced CBOs to innovate in their search for funding. As will be highlighted by the interviewees in this study, this split in funding sources often puts CBOs in unstable positions. This is because the funding is usually short-term and under strict supervision by the grantors, while tackling disparities, particularly in rural regions, necessitates long-term commitments.

Some examples of barriers which require long-term commitments include greater financial burdens on providers and patients from lack of healthcare coverage options, online services, transportation, absence of services and persistent poverty (Douthit, Kiv, Dwolatzky and Biswas, 2015). The shift towards privatization is in part a result of insufficient funding by federal programs and the delegation of costs where possible. As Maeda & Nelson (2018) explain, “the incentives for any one insurer or employer to push for lower prices is limited because the benefits of doing so may not access directly to them. . . insurers have less incentive to negotiate prices because they can pass providers’ prices on to employers” (p. 8). The talk of incentives, market power, and negotiations is a prime example of neoliberal ideology at work given that ensuring health coverage in the US is a profitable business. The increase in austerity measures which promote individual responsibility “are dogmatically pursued despite the evidence we have about the importance of structural determinants of health, especially the role of political and commercial determinants of health at the national and global levels” (Viens, 2019). An increase in privatization and market pressures compels organizations to seek market solutions to social problems and service seekers to take responsibility for their health outcomes.

Privatization is a cornerstone of neoliberalism and is a strategy that has been implemented within healthcare and social services which has resulted in the utilization of “public bureaucracy” to service delivery by private providers (Hasenfeld and Garrow, 2012). While states reduce barriers to ensure a stable and growing economy, effectively increasing the government's dependence on the market, “each individual is held responsible and accountable for his or her own actions and well-being” (Harvey, 2007, p. 65). The idea that the market can and will provide for all facets of life leaving organizations and individuals responsible for finding solutions to obstacles encountered does not account for the entanglement of bureaucratic principles (Monteiro & Adler, 2022) which can lead to barriers in accessing services. The red-tape Harvey speaks of as being eliminated to generate market competition may be removed from corporations, but the burden is passed onto communities such as older adults living in rural areas and thus these groups are asked to seek market solutions for their aging bodies.

Neoliberal logic shapes the way agencies, non-profit organizations, and healthcare providers deliver care to older adults. The intentional and methodical shift towards privatization in healthcare and social services gives rise to bureaucratic entanglements. These entanglements, such as excessive paperwork to prove eligibility, increase barriers to access for older adults. The research interviews reveal several key points. Firstly, despite the availability of social services and healthcare, bureaucratic entanglements exist, which take the form of numerous steps to establish eligibility. The shift towards digital management of health information has further alienated service seekers that have little to no digital literacy. These systems are particularly challenging for older adults to navigate; as a result, many older adults choose to forego seeking out services due to excessive paperwork and digitization of health information. The procedures which are seemingly streamlined on the administrative end are passed down to service seekers,

but this does not diminish the burden which the service providers themselves face. It is a burden that is spread thinly throughout the system, enough that there is no one player that can be blamed for the bureaucratic entanglements which slow down service delivery. It becomes difficult to point fingers when so many of the smaller parts of the whole need fixing and maintenance. The processes that appear to be simplified at the administrative level are transferred to those seeking services, but this doesn't lessen the load that service providers bear. This burden is distributed thinly across the system to the extent that it's hard to attribute the bureaucratic entanglements slowing down service delivery to any single entity. It becomes challenging to assign blame when numerous smaller components of the system require repair and upkeep.

As we close Chapter I, which explored the relationship between neoliberalism in healthcare, bureaucracy and the CBOs providing services, Chapter II will address the realities of aging in the US healthcare system as it is currently structured.

Chapter II: Aging in the United States Healthcare System

“They [local hospital] let us use the van and I used to go take clients to the doctor. A lot of times you sit there...because doctor appointments is never quick and easy. And then we'd come home and they'd tell me, 'Could you please stop at Walmart so I can get my prescriptions or can you stop at Walgreens?'...I couldn't stop but I did because I feel like, 'why would I take them to the doctor and not to get your medicine? Why would you come and if you went to the doctor because you feel sick and you got that right and then not bring them with no medication?' So, it just didn't make sense. So, I stop and I said [to the client], 'go run.' And usually sometimes another half an hour [would go by] to get the medication but I believe that was a really big thing to get their medications when they do have a doctor's appointment.” (LEP, personal communication, March 4, 2023)

The above testimony is an example of a provider having to bend the rules to offer complete services. It is not uncommon for services to only meet half the client's need. None of the older adults interviewed for this research knew that they had access to transportation to and from appointments. In addition, government funded programs often contract with companies; for example, transportation companies have contracts with Medi-Cal to provide a free transportation

benefit. Yet this benefit doesn't account for activities such as prescription pick up, grocery shopping, and appointments to renew or apply for safety net programs. When it comes to accessing the transportation benefit, clients have access to interpreters at the Medi-Cal office, but there is no guarantee the language barrier will be bridged by the transportation company. In addition to language barriers, clients are expected to learn to schedule their appointments at least 5 days in advance for most transportation companies contracting with Medi-Cal given the high demand but may remember to cancel or reschedule a transportation appointment if their doctor's office reschedules a visit. The steps to completing one visit to a healthcare provider require an in-depth understanding of operations of various agencies and organizations from the time an appointment is scheduled to the day of the appointment. Given the increase in cognitive decline as people age (Ward, Touchet, Marfeo & Ward, 2020), the list of tasks required to make an appointment may prove unattainable for older adults that do not have access to caregivers or support (Fabius, Wolff, Willink, Skehan, Mulcahy and Kasper, 2021). Government agencies at the local, state and federal level must take these gaps into consideration when addressing access to services and quality of life for the aging population.

According to the latest iteration of the Healthy People initiative which outlines public health priorities in a decade's long plan of action, the priority areas centered around older adults include but are not limited to increase in physical activity, reducing hospital admissions for chronic illnesses such as ulcers and diabetes, awareness around dementia and cognitive decline diagnoses and injury prevention (Healthy People 2030, n.d.). On the website, priority areas across the lifespan are accompanied by a marker which gives the status of each goal from baseline data to target met markers. The purpose of the Healthy People initiative is to provide reliable data which can be used by stakeholders to address health disparities. Of the 20 objectives

outlined for the older adult population in particular, three objectives are in developmental stages meaning reliable baseline data is currently unavailable, 15 objectives are at baseline which indicates there is no progress data available, and two target areas have moved farther from the target since Healthy People 2020, the last iteration of these national objectives, was evaluated (Healthy People 2030, n.d.). Healthy People acquires data points from studies, surveys, samples and departmental systems with “federal government management or oversight” and publicly available sources to create baselines (Office of Disease Prevention and Health Promotion, n.d.). Despite the intended purpose of being a useful tool some regions of the country are less accessible for data collection and the objectives outlined for the 2030 initiative may not reflect accurately on all populations. Rural communities, for example, rely on resources in neighboring urban centers; yet the ability of these organizations and institutions to support rural communities can be difficult and tracking inconsistent. Initiatives such as Healthy People 2030 create expectations around what data is being requested from CBOs that contract with the government agencies to move the needle on these goals.

Data tracking is a reasonable approach to understanding the health disparities being experienced by different groups of people nationwide. Yet, the current infrastructure in the healthcare and social services landscape is not equipped to support the mounting needs of an aging population and although understanding needs is paramount for funding allocation, the burden of data collection requests by different funders placed on organizations addressing these disparities could be slowing down the progress around initiatives such as the Healthy People 2030 campaign. To clarify, data tracking is vital; it is the process, quantity and frequency of these data collections that may need redrafting. Bureaucratic processes around data collection are not typically seen as a barrier to access. Policies and procedures, metrics, and organizational

structuration are meant to be behind the curtain of operations which the public does not need access to but is inevitably affected by; yet, if examined more closely bureaucratic entanglements can act as a physical barrier to access for people who don't have the resources to meet the requirements arbitrarily created by a network of entities requesting data that is being collected ineffectively.

To date, an estimated 16.8% of the United States is 65 years of age and older (US Census Bureau, n.d.). Across the US, “more than three-quarters (77 percent) of counties already have older populations at or above the national average” (Mather, Jacobsen and Pollard, 2015). The Administration for Community Living (ACL) (2021), a branch of the Health and Human Services (HHS) Department, predicts the number of adults aged 65 and older is expected to almost double by 2060 which will comprise approximately 25% of the total population. The health of older Americans has become a priority given the rapid increase in this demographic. According to the World Health Organization (2022), some of the most common conditions in this age group include, “hearing loss, cataracts and refractive errors, back and neck pain and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression and dementia. . . [which are] the consequence of multiple underlying factors and include frailty, urinary incontinence, falls, deliriums and pressure ulcers” (n.d.) The aforementioned, among other conditions, are oftentimes compounding with serious effects on quality of life. The complexity of managing comorbidity coupled with the economic burden of care coordination and management has proven a challenge within the healthcare and social services landscape. Older adults find themselves in environments that make it increasingly difficult to age in place, with dignity and to achieve the quality of life desired. A study looking at barriers to healthcare seeking and provision among African American adults in rural Mississippi found that community members express

fear, medical distrust and experienced racism while providers “viewed the guidelines as a tug of war between pharmaceutical companies promoting the newest medication or treatment, and the federal government insurance companies focused on curbing healthcare spending” (Connell, Wang, Crook, Yadrick, 2019, p. 642). This tug of war providers speak of affects the way in which services are delivered which increases the burden on older adults.

According to the National Academy of Medicine (2016), some of the issues impacting the health and quality of life of older adults include poor coordination of care delivery for chronic conditions, shortage of trained professionals from geriatricians to caregivers, inadequate end of life care, and social isolation. Although evidence-based strategies for care delivery and coordination exist, they are oftentimes “hindered by organizational limitations, such as reimbursement restrictions and lack of effective coordination and sharing of data and responsibility among clinicians and organizations such as hospitals and clinics” (Rowe, Fulmer and Fried 2016, p. 1643). This lack of coordination seen across the healthcare system extends to social services and is of particular interest to my research. In theory, a person who has aged within the U.S. healthcare system should be familiar enough with general processes that allow for navigation; yet policy changes with trickle down effects to healthcare administration are continuously changing the landscape. Now imagine an older adult with on and off intermittent health coverage, who avoids provider offices unless absolutely necessary or who has worked precarious jobs for years and is afraid to seek care. Older adults are expected to understand the processes associated with regular check-ups, referrals to specialists, the nuances of federally funded health insurance, and application processes for community-based programs meant to improve quality of life. The fragmentation of care delivery resulting from bureaucratic

entanglements, one of which is disjointed communication between institutions, CBOs and government agencies, can be the first barrier for older adults trying to care for themselves.

For example, the economy surrounding health insurance operates on employers, insurers and providers are all weighing their options around payout negotiations under the premise of each entity attempting to obtain the best price (Maeda and Nelson, 2018). Overall, commercial insurers payout more to providers and hospitals than Medicare Fee for Service (FFS). If it is the market's job to provide, as one of the tenets of neoliberalism suggests, it is not providing for patients who happen to be the vehicle from which profit can be created. The stark difference in pay between commercial insurers and Medicare FFS is not conducive to providers wanting to offer care in rural areas when healthcare coverage is managed like a business venture requiring barebones efficiency in operations at every level to maintain or increase profit margins. The fine line which all parties involved must tow has created bureaucratic processes geared toward strict and time-consuming proof of service for payment that caters to the demands of insurance companies and Medicare-Medicaid programs, and in the case of CBOs any funders demanding proof of care delivery. In addition, the costs of increasing prices surrounding employment-based insurance trickle down to the employees. Insurance benefits offered by employers are an incentive for certain industries but given that rural communities house industries such as agriculture, forestry, mining, oil and gas (Davis, Rupasingha, Cromartie and Sanders, 2022) which are less likely to offer employer insurance, this may not ever be a choice (Yearby, Clark and Figueroa, 2022).

In response to an increase in the aging population the state of California, which comprises an estimated 15.2% of people 65 years of age and older, is implementing the Master Plan for Aging (MPA). The MPA began as an executive order and was later known as SB 228

which passed in 2019 (Office of Governor Gavin Newsom, 2019). The MPA consists of five goals which are meant to build up the existing infrastructure around services to promote quality of life for older adults and their caregivers. In implementing the MPA goals, the California Department of Aging seeks to create a formalized workforce out of family members already taking care of older family members. Given the amount of unpaid labor that goes into caring for the aged, family members responsible for caregiving duties would be trained and earn an income as caregivers. This income may relieve the burden of being unable to enter the workforce in order to care for a family member. It is also possible that the MPA initiatives creates a repository of laborers that can enter the healthcare workforce after their homecare services are no longer needed since they will receive the certifications required for caregiver jobs in institutional settings. The goals of the MPA are ambitious because the state recognizes that fragmented services and the high cost of long-term care is out of reach for many Californians. The state is strategizing with local leaders and community partners to implement this plan. Community partners refer to agencies and nonprofit organizations which have established relationships at a local level. The success of the MPA will depend on how well community partners can reach older adults. Rural areas are known as difficult to reach given their geographical locations with service provision lacking as a result.

In addition to barriers of access due to distance, rural areas suffer from a lack of qualified service providers (Douthit, Kiv, Dwolatzky, and Biswas, 2015). Health infrastructure remains underdeveloped and a shift in electronic provision of services across the healthcare and social services landscape has been difficult for many older adults whose digital literacy is low. Pandit, Eswaran, Bogulski, Rabbani, Allison, Dawson and Hayes (2023) found that in some rural areas, particularly southern states, the provision of remote patient monitoring (RPM) was highly

dependent on whether hospitals were part of clinically integrated networks with non-profit status or critical access hospitals (CAH) with for-profit status. They posit that belonging to a CIN increases the likelihood of offering any RPM services given that these hospitals are integrated within a larger system of healthcare providers which makes monitoring patients more seamless. A notable finding for the purposes of this study was the inverse correlation between the Hispanic population of southern states and the CAH status of hospitals; the higher the number of Hispanics the lower the likelihood of RPM services being offered (Pandit et al., 2023). This finding is significant because it highlights the additional barriers to access some communities must contend with when social determinants of health such as language barriers, socioeconomic status, educational levels, digital literacy, and insurance status are taken into account. After analyzing data from the Medical Expenditure Panel Survey (MEPS) administered by the Agency for Healthcare and Research Quality, researchers found that between the years 2014 through 2018, “limited English proficiency is associated with less health care use, whether measured by spending, episodes of care, or prescriptions, even after multiple demographic and health characteristics are accounted for” (Himmelstein, Himmelstein, Woolhandler, Bor, Gaffney, Zallman, Dickman & McCormick, 2021, p. 1131). Despite these findings not being representative of other non-English speaking groups in the US, the population of the unincorporated community where older adults were interviewed is composed of majority Latino-Hispanic residents. Notably, it was older adults who were more likely to have limited English proficiency and would require interpreter services. What is most concerning about language barriers is the miscommunication between patients and healthcare providers that can lead to confusion around diagnosis and treatment. Limited access to interpretation services in rural communities is often coupled with financial burdens for providers and patients.

In general, rural healthcare providers and patients suffer from the financial burden of practicing and acquiring care in rural communities respectively (Rowe et al., 2016; Douthit et al., 2015). As a result, providers tend to practice in more developed urban areas with pre-existing health infrastructure to support their practice or a population large enough to sustain a private practice. The lack of infrastructure coupled with the financial impact experienced by health care providers creates a vicious cycle that harms rural populations.

The bureaucratic mazes which have grown increasingly complex through the decades have made seeking basic assistance to maintain quality of life in the United States a time-consuming activity that may not yield desired outcomes for those who are most in need. Forgoing healthcare after being unable to navigate the healthcare-social services landscape is not an uncommon occurrence. As mobility declines older people are faced with the managing of co-morbidities on top of more practical tasks such as Activities of Daily Living (ADL). ADLs can be split into physical and instrumental activities; the former refers to activities of self-preservation such as eating while the latter refers to the ability to use critical thinking in conjunction with mobility to navigate and maintain the environment such as shopping or housekeeping (Edemekong, Bomgaars, Sukumaran & Schoo, 2022). For older adults, living in a rural community can make ADLs difficult to accomplish. This may be due to the geographical placement of rural communities which experience lack of infrastructure that supports ADLs such as senior centers and accessible transportation. In addition to infrastructure limitations, ADLs are also limited by cognitive decline, side effects from medications and hospitalizations (Edemekong et al., 2022).

Impacts on health and well-being are informed at the intersection of rurality, aging and socioeconomic status (Cohen, 2021) and can also be affected by determinants such as race,

religion, ethnicity, gender, culture and supportive social networks. Rural older adults lack access to basic needs around healthcare access, housing, caregiving, food, and digital literacy all of which are affected by transportation. Quality of life among older adults is also affected by living arrangements. Living arrangements affect the dynamics of how older persons navigate health and social services systems. Types of living arrangements, particularly in the US, have been impacted by the cultural shift that occurred around family values and dynamics identified by Ruggles (1996) as a change in attitude toward responsibility between family members and a change in values around marriage, divorce and familial structures. Ruggles (1996) states that “modernization theorists argued that literacy and education led to the breakdown of extended families. . .as increased access to these are where cultural shifts such as a push toward individualism begin” (p. 260). This cultural shift is just one schema which immigrants in developed countries have to navigate when attempting to age within multilayered cultural schemata. In the US there exists pockets of cultural practices that resist or coexist within the larger narrative of US culture which promotes independence throughout a lifespan.

Huffman, Regules, and Vargas (2019) assert that understanding living arrangements is vital for improvements in service provision for older adults as these arrangements have an impact on quality of life and health trajectories. The importance of research in countries where there is cultural homogeneity around living arrangements for the aged informs a core cultural schema which interacts with other cultural schemas a person may encounter within their lifetime. For example, some communities have a higher propensity for depression when living alone. Yet research that has been conducted around the effects of living alone versus other living arrangements has no consensus (Russell and Taylor, 2009). This could be because factors surrounding reasons for living alone within a larger cultural context vary depending on societal

consensus around acceptable reasons for living alone versus other living arrangements. Russell and Taylor (2009) found that Hispanics living alone in the state of Florida reported higher levels of depression than their non-Hispanic counterparts. To clarify, “Hispanics” is a catch all term for a multiplicity of cultures which is used by the medical and social services sectors in the US to offer “culturally competent” services to a wide-ranging group of people. In a more specific cultural context, the impacts of culture on living arrangements can possibly be attributed to what Huffman et al. (2019) calls “strong familialism,” among Mexicans. The common practice of large households, which often include extended family and parents being taken in by the eldest child when their care needs increase attribute to this sense of strong familialism. It is possible that this may be the case in a rural community such as the one this research project took place in given that a significant portion of the population identifies as Hispanic or Latina/o/x. Cultural context plays a role in the ways older adults access healthcare and social services in their local communities, but it should also not be used as an overgeneralization for understanding behavioral patterns in groups of people; rather, it can act as a compass to guide the conversation around possible solutions for barriers to access.

Transportation affects rural older adults greatly due to geographical location of residence in relation to where services are provided (Beverly et al., 2005). These barriers are greater for populations living in rural areas due to lack of infrastructure (Hardman & Newcomb, 2016; Williams & Mattos, 2021). Offering transportation services can be challenging given that the expense for fixed routes may exceed the use of routes in smaller communities. To respond to the need while trying to minimize cost, some transportation departments offer “demand-response services” which refer to picking up clients, transporting to requested destination and picking up upon request to transport back home. Despite the challenges surrounding infrastructure,

researchers found hesitancy to utilize public transportation may be due to fear of usage for previously car dependent individuals as transitioning to public transportation involves more than just getting on a bus given the decreased flexibility of public transportation versus travel in a personal vehicle (Wood, Winters, Brindle, Cefalu & Haddock, 2016). Continuity of care, access to food, mental health services, and social connections are all impaired by limited mobility. In healthcare, there are major concerns surrounding continuity of care for older patients with limited bodily mobility and transportation related mobility.

The likelihood of accessing medical care decreases for patients without health insurance who are less likely to attend scheduled follow-up visits than patients with insurance (Hardman & Newcomb, 2016). In addition, Hardman & Newcomb state that establishing trustworthy relationships with a primary care provider may be more difficult in rural communities due to convoluted and fragmented provision of care reported by older adults. Healthcare involves more than medical appointments. Basic needs such as food security and housing affect quality of life. Lack of access to food and healthcare can result in poor nutrition and management of chronic conditions that require regular follow-ups with medical providers (Durazo, Jones, Wallace, Van Arsdale, Aydin & Stewart, 2011). Older adults experience anxiety around purchasing food due to not having sufficient funds to purchase food of preference (Andress, 2017). According to Andress, older adults report having to make tradeoffs in their values around purchasing certain foodstuffs to ensure enough food was purchased. Andress asserts that to address the root causes of food insecurity which include factors such as built environment, social context, accessibility, transportation, and affordability. The most recent pandemic also highlighted the need for digital literacy and the benefits of being able to obtain food by being able to complete activities such as online shopping.

Covid-19 exposed the effects of forced isolation and reliance on technology which were needed to prevent viral spread. Older adults, many of whom have issues using new technologies, were asked to make a transition online. The number of older adults who lack internet access and digital literacy should be of great concern to service providers. Despite efforts to improve access to the internet, a Health Information National Survey administered in 2017 shows that access to the internet for adults 65 and older has been on an overall decline between 2017 and 2020 (US Department of Health & Human Services, 2021). Access to steady broadband connections and digital literacy play important roles in the quality of life of older adults especially given the isolation and increased barriers brought on by the Covid-19 Pandemic (Henning-Smith, 2020). Even though rural communities have some access to the internet, the infrastructure for high-speed internet in these communities is underdeveloped (Williams & Mattos, 2021). The compounding effects of these barriers in accessing services limit the ability of rural older adults to maintain and improve quality of life.

The changing landscape of politics, environmental impacts, and market fluctuations necessitate the reevaluation of strategies used to increase access to ensure the effectiveness of such strategies. Table 1 outlines some of the programs funded by the state, the eligibility requirements, and application process for obtaining these services. Obtaining community input on the needs or barriers faced should include the voices of older rural adults (Bacsu, Abonyi, Jonhson, Novik, Martz & Oosman, 2014). As funders such as the state, federal government and philanthropic organizations learn of the impact services have on rural communities, it is in their best interests to work in tandem with CBOs to ensure grant deliverables are realistic requests in line with community needs. Although statistical evidence points to the challenges of access for older adults living in rural communities and efforts to assist these regions across the country are

ongoing (Bacsu et al., 2014, Beverly et al., 2005; Durazo et al., 2011; Henning-Smith, 2020), testimonials from older adults trying to navigate healthcare and social services systems within the context of the current socio-political and economic framework give a more nuanced sense of program effectiveness.

Another feature of neoliberalism is that it places their responsibility of health on the individual which does not account for the structural inequalities which may have put individuals in poor health situations to begin with. The field of Community Development tends to focus on the various types of capital that are available to individuals and communities to understand how these can be utilized to improve upon the conditions that a group of people find themselves in. Yet as Richardson and London (2007) point out, it is not enough to leverage different types of capital when there are structural forces at play that are inhibiting an individual or a community's efforts to improve upon their conditions. This lack of acknowledgment by governing bodies is a dismissal of healthcare as a right which is in contradiction with government programs such as Social Security and Medicare. Constituents are encouraged and required to invest and contribute to those programs for them to be viable. If the state is washing its hands of responsibility, what happens to programs like Social Security, Medicare, Medicaid, food assistance, housing, transportation, and other social services which politicians' campaign under? Are they simply political tools to acquire votes with no substance behind them? In public health and in the healthcare field in general the social determinants of health are often cited as directly impacting the quality of life of individuals and Viens (2019) asks us to consider how political determinants also affect individuals and their health care needs.

Peterson and Walker (2021) point out that when neoliberal policies make the argument around individual responsibility, what is really being communicated is that persons with lower

socioeconomic status, individuals of color, individuals who continue to experience the effects of colonialism, individuals who belong to marginalized communities like the LGBTQIA+ community, immigrants, groups targeted based on political affiliation, religious affiliation, and the missing middle class are the groups most affected and most likely to sink further into lower class status. Bureaucratic entanglements slow down the process of giving aid and are converted into burdens that are passed on to the underserved in the form of paperwork, delayed processing times and unnecessary steps to utilize available resources. Responses given by rural older adults and the service providers that were interviewed are better understood within the framework of neoliberalism in healthcare. What follows is an overview of the research site, the qualitative approach used, an account of equipment and data collection, and an overview of participant selection.

Chapter II addressed the realities of aging in the US healthcare system as it is currently structured, in Chapter III I will go into detail on the research location and methodology implemented for this research.

Chapter III: Methods

Setting

The research site is an unincorporated rural community within the boundaries of Yolo County, CA. In this community, approximately one quarter of the population is over the age of 60, 12.4% of people living alone are over the age of 65, 29% of total households have members over the age of 65, and 92% of people can be identified as Hispanic or Latino (United States Census Bureau, n.d.). This site was chosen because it is a rural, farmworker town. There is a state route that runs through the community with the nearest city being 11 miles away. It is common for community members to travel across county lines as the next largest city, 27 miles

away, offers more services and commercial options. There is a pre-established relationship between community stakeholders and UC Davis researchers to ensure the community's needs are met. As a site that has already seen investment by the University of California, it is our collective responsibility to ensure this investment does not wane. We hope this project adds to the literature in identifying the barriers to healthy aging within rural communities in order to improve the quality of life for rural older adults. Rural communities are unique in their geographic location, demographic makeup, economy, and industry drivers (Richardson and London, 2007). Working with elders in this community may not be an approach that can be scaled; yet this approach of working alongside rural communities may facilitate a framework for community members in different parts of the country to engage with their elder populations in meaningful ways within the context-dependent frameworks each community finds itself in. It was hypothesized that older adults have difficulty accessing vital care alone due to the bureaucratic entanglement that results from applying neoliberal policies to the healthcare and social services landscape.

Qualitative Approach

This project used the transformative Community Based Participatory Research (CBPR) approach in which activist scholars attempt to identify injustices and bring about change working alongside a community that challenges those in power to act (Deeb-Sossa, 2019). According to Israel, Eng, Schulz & Parker (2013), "CBPR facilitates a collaborative, equitable partnership in all phases of research. . .[and] fosters colearning and capacity building among all partners" (p. 9). CPBR is an effective approach when working with resilient communities that have been continually marginalized and used as places of extraction for research. Given that communication strategies are important during the interview process, establishing trust between

interviewer and participant is necessary. The principles of CBPR that utilized in this research include: 1) respecting the whole community as a unit with a unique set of understandings that provide guidance on how to interact within and alongside its members, 2) identifying the community's strengths and building upon these, 3) ensuring that research is transparent and that interested parties have access and input throughout the process, 4) focusing on the specific needs of the community within the larger context of their county and state and 5) ensuring that interactions with service providers make them aware of the issues facing the community and providing feedback on how they can better support older adults aging in rural areas (Israel et al., 2013). The PI presented the research proposal to a group of community stakeholders and asked if they believed the subject matter of the research was relevant and necessary in their community. Feedback was given and PI received permission from community stakeholders to move forward with the project.

Equipment & Data Collection

Before interviews were conducted, a research proposal was submitted to the university's Institutional Review Board (IRB). The UC Davis IRB Administration declared the research project exempt, after which data collection proceeded. At the start of each interview for both rural older adults and service providers, the PI gave a summary of the research, obtained verbal informed consent, and asked if the interviewee had any questions before proceeding. Each group had an interview guide (see Appendix). The interview guide for rural older adults focused on questions around food security, transportation, technology, access to various healthcare services, quality of life and social services questions. Interviews were conducted in the interviewees preferred language, either Spanish or English and all materials were translated by PI. The interview guide for service providers focused on questions around the types of services offered

by each CBO, geographic differences in service delivery, challenges in servicing rural older adults and funding. All service provider interviews were conducted in English. Interviews were semi-structured to focus on healthcare and social services issues whilst giving interviewees the opportunity to share experiences related to these topics. The semi-structured approach to interviews was chosen to gain a nuanced understanding of the issues from the positionality of both groups—community members and service providers (Silverman & Patterson, 2022). Older rural adults were given a \$50 gift card upon interview completion as a thank you for participating in the study. Due to funding limitations, service providers were not compensated and agreed to be interviewed on a voluntary basis. Interviews were recorded using a Zoom-H4N Pro Handy Recorder. Interviews ranged from 20 to 60 minutes depending on how much the participants wanted to share. After each interview was conducted the mp4 file was transferred to a password protected portable hard drive and erased from the recorder’s memory card. Media files were played back and summarized in separate documents for each interview. Any testimonies relating to health care and social services experiences were transcribed verbatim. All the written summaries and transcriptions were saved to the password protected hard drive. Responses were grouped into themes for both rural older adults and service providers.

Participants-Rural Older Adults

One-on-one, semi-structured interviews were conducted with the exception being interviewees who preferred having a trusted source present and the three men living in a labor camp which requested to be interviewed as a group. Recruitment was done through fliers, at community events such as the food bank distribution and word of mouth. Despite the use of fliers, the success of recruitment was dependent on snowball sampling, a qualitative method, which involves referrals from interviewees (Silverman & Paterson, 2022). Given the size of the

town and the community's preference for obtaining information from their trusted sources, most of the people interviewed only agreed to do so because a trusted source had told them about the research and suggested they participate. Interviews captured the individual experiences of older adults living in rural communities and the individual perspectives of service providers that highlight their experiences servicing rural communities. Although the original intent was to interview community members 65 years of age or older, there was interest from individuals below this age limit who were struggling with multiple issues and wanted to tell their story. Except for a 55-year-old community member, the remaining participants were 60 years of age or older. Pseudonyms are used to protect each participant's identity.

A total of 10 older adults were interviewed for this project (Table 1). The oldest person interviewed was 93 years old while the youngest person interviewed was 55. Although the PI had originally set an age limit of 65 years and older, there were community members who came forward and asked that their story be heard. Given that this research is grounded in CBPR, the PI listened and interviewed the older adults that wanted to be interviewed. There was a total of four women and six men interviewed. Four of the twelve participants reported living alone. Three of the interviewees were older men living in a labor camp on the outskirts of the community. People of the labor camp have their own living accommodations during slow periods of the year and share rooms when harvest is in full swing. Their group interview was conducted in the common dining and kitchen area of the labor camp. All three men lived in separate rooms at the time of the interview since it was their off-season. Three additional male participants who were interviewed lived with their spouses. One of the interviewees lived in a home with four other family members having someone present in the home most of the time. Her neighbor, on the other hand, also interviewed, lived with two family members but was alone for most of the day.

The three remaining interviewees were recruited at the food distribution site where the principal investigator volunteered. Two of the food distribution recruits agreed to interviews in their home while the third requested the interview be done at the community resource center due to her precarious living situation. The last person to be interviewed was a sixty-year-old woman who had just been approved for an apartment at the only apartment complex in the town and the interview was done in her home. Her recruitment was through a friend who checks up on her regularly to ensure her needs are met.

Participants-Service Providers

A total of six service providers were interviewed although one of them was also a community member and living with the spouse that was interviewed as a rural older adult. Her insights on how community members navigate healthcare and social services were invaluable as she is the main contact for persons needing assistance in this community. Five of the six interviews were conducted over video call using Zoom. Four of the six service providers were familiar with the PI's community work and agreed to an interview via email. One service provider was contacted after the director of a CBO shared the contact information with the PI. The contact information for the last service provider was obtained through the CBO's website. Emails were sent to all service providers explaining the research, objectives and requesting an interview. All six providers agreed, and interview appointments were individually scheduled around the provider's availability. Participation of service providers was voluntary, and they were not monetarily compensated. Provider names are maintained anonymous and are addressed with acronyms that include the initial of their first name and the organization's acronym.

One of the service providers was part of an organization that assists low-income people with legal issues ranging from housing to healthcare. The food bank service provider was the

director of programs and she spoke about the increasing demand for food bank services all throughout the county. The California Department of Aging contracts agencies that serve at a local level; these agencies serve various counties and are divided up by “Planning and Service” areas. The Executive Director interviewed oversees the agency with the most counties, seven in total, in California. One of the community organizations with the most impact in the county is a CBO that supports people experiencing domestic violence & trafficking, but their reach extends far beyond this realm as they also function as resource centers for the county with various locations throughout the region. The Program Director of this CBO agreed to an interview. The Executive Director for the CBO whose mission is to provide education, advocacy, and resources to the aging population of the county also agreed to an interview. It must be disclosed that the principal investigator (PI) worked under the supervision of this Executive Director for a period of six months.

Community Support

The PI offered support to the older adults interviewed. Given that this research is grounded in the principles of CBPR, the PI made various efforts to become familiar with and be supportive of the community. Such efforts included: volunteering during food distribution days, picking up food from the food distribution and delivering to the elders that could not make it, helping to build a kiosk in the community garden, taking elders to medical appointments or to pick up medications, assisting with phone calls to various organizations or medical offices if elders requested assistance, helping with applications, connecting elders with programs such as Meals on Wheels and organizing community meetings. Given that community building is not a process that can be rushed, the PI visited and supported the community for almost a year before conducting interviews with elders.

Conversely, the PI received support from community members in recruiting elders and spreading the word about the project. One of the community members which manages the community garden helped recruit three of the eleven interviewees. The resource coordinator of the resource center connected the PI with five of the eleven interviewees. Three of the eleven interviewees were recruited during food distribution days. The support of community gatekeepers was invaluable in recruiting participants given that the members of this community rely on word of mouth and close ties for information.

In addition to the overarching results, stories of the oldest and youngest of the interviewed will be shared in detail to highlight how aging can look different from person to person and the influence of support networks on a rural older adult's quality of life. Following these two cases, a more general overview of common themes around living arrangements, food security, transportation, technology, accessing healthcare and social services will be discussed from the perspective of rural older adults. Finally, the service provider responses will be discussed based on the themes of service provision, barriers, and funding.

Now that I have described the research location and methodology implemented for this research, Chapter IV will give an overview of the interview responses which highlight the personal experiences of older adults and providers within the healthcare and social services systems. Here, CCW will be highlighted as a tool used by community members and providers to leverage available resources for mutual upliftment, even amidst having to navigate bureaucratic entanglements for service provision and acquisition.

Chapter IV: Results & Discussion

4.1 The importance of being in community

During the recruitment process, LEY and a community member in charge of the community garden reached out to suggest I should interview Tabatha, the only participant under 60 who was interviewed for this research study. Despite not meeting the age requirements, I chose to interview the participant because she was experiencing geriatric symptoms of someone much older than 60 and community leaders were encouraging her story be heard. Physical deterioration is not uncommon in unhoused adults; unhoused older adults have been found to experience geriatric conditions similar to those of housed older adults 20 years their seniors (Brown, Hemati, Riley, Lee, Ponath, Tieu, Guzman, & Kushel, 2017; Brown, Kiely, Bharel & Mitchell, 2012). Furthermore, as a practitioner of CBPR it was important that I honor the wishes of the community given that CBPR allows for the community to guide the research process. What follows are two detailed profiles of the youngest and oldest participants interviewed which give insight into how their social supports influenced their ability to navigate the bureaucratic entanglements found in healthcare and social services.

Youngest Participant

The youngest of the participants, whose exact age will be omitted due to safety concerns, is a woman in her 50s who experienced homelessness for a period of six years and continues to be at risk for homelessness despite her current living arrangement. She shared her experience of having been homeless and the things that she had to do on a daily basis to live on the streets. Tabatha expressed being proud of the ways in which she was able to support the homeless community around her by giving out food when she had the funds and providing shelter to sex workers in her alley which she guarded as her private space. Tabatha has been a caregiver from a

young age, having cared for her father for years and later on her spouse. The loss of her spouse and a spent inheritance compounded with self-reported mental health issues pushed her to homelessness.

Tabatha grew up near the rural community where interviews took place and did not stray far throughout her life, having only crossed a county line to a nearby town that is 35 minutes away from her current living arrangement. She reports having come back to the area to care for a friend; she is now a live-in caregiver but is not yet receiving in-home supportive services (IHSS) hours as she is afraid that having an income will affect getting social security benefits. Friends and providers have expressed concern in Tabatha's efforts to work as a caregiver given the multiple health issues, she is juggling to make her eligible for IHSS support herself. Upon further conversation, Tabatha shared that she is experiencing domestic violence at the hands of the friend she is caring for but is afraid to seek help because she is even more afraid of being homeless again. She reports that despite being grateful for all she's been through; at her age she can no longer navigate homelessness the way she once had. Tabatha expresses gratitude for her life experiences yet acknowledges that her age has made it more challenging to cope with homelessness. The hardships Tabatha has endured are evident in her physical appearance and health. In addition to having her teeth knocked out of her mouth while she was experiencing homelessness, Tabatha shared, "my hips are going out. Hopefully I won't have to have hip surgery [again]. . . I have COPD. . .my feet swell" (personal communication, April 6, 2023).

When asked how she feels navigating the healthcare and social services system she reports knowing what to do with confidence and states it is a matter of "just doing it", referring to going to the county offices, filling out the paperwork and providing the required documentation. Yet it is not such a simple matter of "just doing it." Tabatha suffers from mental

health issues which require medication management and being off the medication greatly impacts her ability to complete tasks. The difficulty in getting psychiatric services due to her Medi-Cal lapsing and having multiple scheduled appointments either rescheduled or canceled by the provider's office. It is difficult to pinpoint the exact cause which affects Tabatha's ability to follow-through with the starting the process of obtaining services which would improve her quality of life, but lack of access to mental health is certainly one of them.

The inability to obtain services is compounded by the lengthy processes themselves. For example, when asked about accessing dental care she reported already having looked into the processes, finding two options: wait five years before getting dental work through Medi-Cal or bypassing the wait by going to the courthouse to obtain paperwork which states she was abused. After having obtained this paperwork, she would have to take it to a dentist and get a referral to a specialist willing to take on her case. Given past interactions with the courthouse and the multiple steps needed to obtain dental work, Tabatha has chosen to wait five years to receive dental work that would be covered by the state health insurance.

The PI offered support with mental health services, but Tabatha declined restating she knew what to do and had a friend who helped her. Yet when asked who she would call in case of an emergency, Tabatha responded, "no one. Just me. . .I try to figure it out my own self or if I want to go to Walmart or something, I hope someone is going there, you know, but normally just me" (personal communication, April 6, 2023). She did, however, accept help with her phone troubles as she is enrolled in California Lifeline which offers devices and phone plans by contracting with phone companies, but her service was not active, and she was unable to make calls. Her troubles were echoed by various clients in the community also enrolled in California Lifeline with the same service provider and similar issues. Given Tabatha's precarious living

situation and her apprehension to leave for fear of becoming homeless once again, having a working phone in case of an emergency and to access services is a vital tool to address gaps in her care.

Oldest Participant

Elvira is a community member that has been residing in the rural town for more than 30 years. Upon entering the home, I was greeted by walls carpeted in family photos and porcelain figurines dispersed throughout the space in between plants and furniture. On the armchair rest lay a handful of sewing projects that included cross-stitching and intricate crocheted doilies. The interviewee began by sharing her journey from Mexico to her current home. She has 11 children and was a farmworker for 45 years. Her husband, now deceased, lived with her up until his passing, after which time she chose to live alone in the apartment they had shared. She shared the experience of caring for her spouse as a difficult time having seen his mobility decline because they had been an active couple that enjoyed the outdoors. Elvira states she has a lot of support from the daughters that live nearby and receives phone calls from most of her children on a regular basis despite them being dispersed throughout the country. She enjoys living alone but also expressed gratitude for having family close by. I was shown a photo of her great-granddaughter who was smiling ear to ear and wearing a crocheted hat Elvira had made. It is important to note that one of her daughters lives a few doors down in her own apartment and another daughter is a 35-minute drive away but sees Elvira once per week in addition to frequent check-in calls. Most of her answers to questions around access to food, needing assistance, quality of life and healthcare revolved around the support and communication with her children. When asked about qualifying for CalFresh the interviewee waived her hand and said:

“Oye, no te sé decir pero me han dicho unas amigas, ‘Elvira tu puedes [tener] el [ebt]’ pero me da flojera porque después mis hijas me tienen que llenar tanto papel y no quiero

abusar tanto de mis hijas. Ahorita vivo bien. Cuando podemos nos vamos a las verduras [food distribution], nos vamos en el carrito de ella [su hija] y hay vamos a veces.”

“You know, I am not too sure but my friends have told me, ‘Elvira, you can [qualify] for [ebt]’ but it makes me lazy because then my daughters have to fill out so much paperwork and I do not want to take advantage of my daughters. I live comfortably at this time. When we can we go to the vegetables [food bank distribution site], we’ll get in her little car [her daughter] and sometimes we’ll go.”

After having proudly displayed photos of all 11 children in their youth, Elvira shared that one of them, now in his 60s, had been diagnosed with Alzheimer’s and was living in a nursing home. Her child’s decline has been difficult, and she expressed a deep sadness around no longer being able to see him. Elvira shares that her once curious child no longer recognizes her when she calls on the phone and knows he has gained a significant amount of weight which has put him in a wheelchair and affected his quality of life. In a sense, Elvira has had to grieve the loss of her child twice, the first was with the Alzheimer’s diagnosis, and the second time was when she was cut off by her son’s spouse from seeing him in person. When asked how she processes her lived experience as a 93-year-old in good health with that of her 60-year-old child living with Alzheimer’s Elvira shared:

“Pos triste, triste, triste que un hijo...siento que no aguanto yo el día que se me muera mi hijo. Eso es lo único que tengo que...siento que yo me voy detrasito del.”

“Well sad, sad, sad, having a child...I feel I will not bear the day he dies, my son. That is the only thing that...I feel I will go right after him.”

Elvira is in remarkably good health, which she attributes to the support of her daughters and having a strong familial network. She is ambulatory without a walker, is still active in her craft, cooks for herself, is in constant communication with loved ones and reports never having experienced feelings of loneliness or isolation. Her doctor speaks Spanish which she is grateful for as she feels comfortable sharing her healthcare needs with him. Despite never learning how to drive, she has made use of public transportation when she needed to and is driven by her

family members. In an emergency, the daughter that lives a few doors down is able to respond within minutes ensuring Elvira receives the care she needs. She does not have internet or a cellphone but reports not needing these resources given that she is comfortable using her landline and her children support her with tasks requiring technologies beyond her home phone. Elvira's story highlights the impact support networks have on quality of life.

4.2 Older Adult Interviews

Quality of life, Accessing Healthcare and Social Services

One of the three men living in the labor camp, 71-year-old Alfredo, has Medi-Cal and Medicare; he was able to navigate the healthcare system thanks to a family member. Gregorio, a U.S. resident, has not tried to apply for coverage despite being likely to qualify for Medi-Cal and Medicare given his demographic markers; if he needs to see a doctor, Gregorio will get to the volunteer run health center in two but his last visit was three years ago. Federico, the 61-year-old, has BlueShield and was attempting to call the insurance regarding dental coverage but was having trouble getting through to a customer service representative. Tabatha's Medi-Cal coverage had lapsed as she had not provided the required paperwork to renew. The rest of the older adults interviewed have coverage either through Medi-Cal and/or Medicare or through Covered California. 75-year-old Jacinto is unable to access Medicare benefits due to his immigration status, but he does have full scope Medi-Cal given the expansion on May 1, 2022, which gave adults over 50 years of age regardless of immigration status; he now has access to a primary care provider and is being monitored by a Spanish speaking doctor.

More than half of the interviewed reported seeing a doctor as an unpleasant experience they would rather avoid. Some of their complaints stemmed from the long wait times to see a provider and when finally getting an appointment only having a few minutes of one-on-one

contact, rescheduling, or canceling of appointments, insurance mix-ups, language barriers and referrals that did not go through. Yet, chronic conditions such as managing hypertension or diabetes necessitated regular check-ups with providers. One of the three men living at the labor camp, 68-year-old Gregorio, was hesitant to share his experiences and stated he neither needs a doctor nor wants to seek care. There was hesitancy in most of the interviewed to access services such as dental and vision care. Three adults mentioned a preference for getting dental work in Mexico given that it is cheaper and more accessible for them due to providers speaking their language.

Half of the older adults interviewed lived with either a spouse, partner, or family yet this did not mean older adults living alone were worse off than those living with family. Two of the older adults living alone had supportive friends and family nearby and the men living in the labor camp were supportive of one another. The interviewed which seemed to fare best in joint living arrangements were men living with their spouse. They relied on their spouses to navigate the healthcare system by enrolling in health insurance, setting up appointments, calling providers and insurers when issues arose, picking up medications and ensuring follow through with visits. Those interviewed with children and grandchildren also mentioned having supportive kin to assist with activities of daily living and service access. Seven of the ten interviewed had been living in the community for decades and fostered strong ties to their community.

Food Security, Transportation, & Technology

Most older adults interviewed preferred to purchase food in the neighboring town as the box stores offered competitive prices. Some were willing to cross county lines to purchase food at cheaper prices. There are two gasoline stations with convenience stores, a market and two Mexican restaurants in the unincorporated town in which the interviewed older adults live. 60-

year-old Denise expressed frustration surrounding the high prices of food in town, “I waste them [Cal-Fresh benefits] here because everything is so expensive [at the] little convenience stores, but sometimes I gotta use ‘em” (personal communication, April 20, 2023). Another reason for traveling out of town for food was that there were more culturally appropriate options in neighboring towns. All of the interviewed or a spouse made use of the foodbank distribution, but only two of the eleven participants utilized the Cal-Fresh benefits. Most of the participants were Mexican American and among this group there was a stigma associated with applying for the food assistance program. The shared sentiment was they were able to get by as long as they had and could continue doing so because there were others in greater need than they were at the time of the interviews. Despite there being programs such as Meals on Wheels and other food distribution programs, not all interviewees were open to the idea of signing up for them. Luz, an 85-year-old living with her grandson and great-grandkids stated she prefers to cook her own food “even if its beans, but one’s own cooking. And that food, you've seen it right? You’ve tried it right?” [*aunque sean frijoles verdad, pero de uno. Y esa comida pos si las visto, no? Si la has comido, no?*] (personal communication, April 10, 2023). The conversation was followed by a discussion of culturally appropriate foods and the discomfort of eating the foods that were offered. There is a difference between having access to food and having access to food which has nutritional and cultural significance that people want to eat.

Another important aspect of living in a rural, unincorporated town is having access to technology which connects residents to services, family, and friends. All the interviewed older adults had cellphones which they could use to varying degrees. Most could call and text, but could not use the phone for video calls, web searches, or navigating healthcare apps. Yet despite having limited understanding of the technology, it was relied upon for medical appointments,

work and to stay in communication with friends and family. The three men living in the labor camp are able connect with family members but have difficulty using the phone beyond calls.

Gregorio states:

“Ósea que no lo sabemos usar oiga. Días atrás vi que me llegaban los mensajes pues si lo oía que sonaba, pero no se sacar los mensajes. Y a veces que le mandan mensaje a uno en Ingles pues menos. Ósea uno no más lo usa así para hacer una llamada o le llamen a uno.”

“Well, we don’t know how to use it. Days back I saw some message come in and I heard them but I did not know how to retrieve the messages. Sometimes we receive messages in English and then we understand even less. We, one uses it just to make a call or to receive a call.” (personal communication, March 5, 2023)

Half of the interviewed had access to a personal vehicle which they drove. The other half relied on others for transportation. Three of the 10 participants stated being dependent on the Yolo Bus pilot program which offered rides to seniors for \$1 and would pick them up at a requested location. After the program ended in 2023, the fare rose to \$4 per trip or \$30 for a monthly pass which the older adults interviewed found inaccessible; they had to use other alternatives for transportation to and from appointments, prescription, and food pick-up. One of the participants, 66-year-old Memo, shared that he offers rides to neighbors and friends in need of transportation.

He states:

“Mucha gente de aquí al rededor no habla inglés y pues yo mas o menos me hago entender con mi poco Ingles que se. Los llevo, les doy raite y interpreto también. . . los amigos que me conocen saben y pues como ahorita no estoy trabajando tengo más tiempo de llevarlos.”

“Los of people around here do not speak English and well, I make myself understood, more or less, with the little English I know. I’ll take them, give them a ride and interpret for them. . .the friends that know me know that I am not working at this time and have more time to take them.” (personal communication, March 3, 2023)

Bureaucratic Entanglements

Some of the interviewees had stories to share regarding why they no longer seek services. One such case was that of Federico, a 61-year-old living in a migrant camp, who sought care at an

emergency room after a sudden onset of cramps in his extremities and stomach which were endured for twelve hours before seeking care. He recounts the encounter as follows:

“Fui al hospital, a la emergencia, y lo único que me dieron fue un vasito de agua cuando yo me estaba muriendo de los calambres. Yo digo, algo tuvieron que haber echo para evitar y ahí estaba me paraba por los calambres y me hacía así [gestures]. . . pero si fue un bil de 900 pesos el que me mandaron por el vaso de agua. Me hicieron examen de sangre, pero me dijeron, ‘no, tu estas bien. Te puedes ir.’ . . . ¿Como que nomas por un vaso de agua \$900, señora? Eso es completamente ridículo y lo que después me entere que son voluntaries los que van a la emergencia. Son doctores aprendices los que van a la emergencia. ¿Van a aprender y ahí se quieren cobrar para su estudio? No señor.”

“I went to the hospital, to the emergency [room], and the only thing they gave me was a little glass of water when I was dying from the cramps. In my opinion, they should have done something to avoid [the cramps] and there I was standing from the cramps and I would go like this [gestures]. . . but I did get a \$900 bill for that glass of water. They did some tests and said, “no, you’re fine. You can go.’ . . .How is it that they can charge \$900 just for a glass of water, ma’am? That is completely ridiculous and later I find out they are volunteers that go to the emergency [room]. They are doctors in training that go to the emergency [room]. They go to learn and from this they want to finance their studies? No sir.” (personal communication, March 5, 2023)

Federico did not know that hospitals offer limited financial assistance to patients who are uninsured. He could have requested a breakdown of the bill and applied for assistance, but for someone that has difficulty answering the phone it is unlikely that he could have applied on his own. It is negative experiences such as the one recounted which push service seekers away from safety net programs and the healthcare system. Yet despite the long wait times that may come with applying for social services, some service seekers are willing to wait especially for assistance with housing. Denise, 60, has lived in the community for almost twenty years and has waited two years to be approved for housing assistance. She reports having checked on the housing application every week for two years and expressed gratitude for her current living situation. A change in environment was needed given that Denise has navigated lymph node and breast cancer in addition to a heart attack shortly after the first chemotherapy treatment. After an incident approximately six years after chemotherapy treatment, she had a defibrillator inserted

which has gone off at random sending her to the emergency room every time. She states “a shotgun goes off in my head and then it’s all over and you’re so weak. . .this last time I was in the hospital they turned it [the defibrillator] down so now it will only go off when my heart stops because I have AFIB where my heart flutters and it will go off. That’s why I drink [alcohol], I’m always paranoid that it’s going to go off. But I need to calm down about it because they say it’s not supposed to go off unless I just go completely out again. . .I see my therapist about it” (personal communication, April 20, 2023).

Having secure housing makes a marked difference in how Denise and her support system handle these frequent hospitalizations. Denise support system with includes her ex-husband has made navigating the healthcare system accessible; she expressed the shared reciprocity between her close friends. If she really needed to, Denis could navigate the health care system on her own, but given all of the medical issues, hospitalizations and multiple medical appointments it would be incredibly difficult on her own. She is cognizant that having a strong support network makes the healthcare system more navigable.

Navigating the healthcare system takes more than family support, especially for complicated situations such as the experience with the medical system which Jacinto, a 75-year-old living with his spouse, has endured since suffering an accident that almost ended his life. Approximately five years ago, Jacinto was working as a *paletero* (ice cream man) pushing his cart around town when a truck ran a stop sign and crashed into him. He was not properly treated in the emergency room as an x-ray post-accident did not show the internal fracturing he lived with for months before getting an MRI showing severe internal fracturing in several sections of the spinal column and clavicle. Jacinto and his wife were thrown into unknown territory having to navigate multiple providers, medical bills, untreated pain, fears of becoming addicted to

medication and a complete change in lifestyle after the accident. Jacinto explained that for a time they had help from an MSW that submitted an Emergency Medi-Cal (EMC) application on his behalf every month that would help pay for his visits, but after a new MSW took the post Jacinto stopped seeking case post-accident because “the other [MSW] would ask for a bunch of things y we would no longer get it [EMC]. It expired every month. We had to renew every month” [*la otra nos pedía un montón de cosas y ya no lo pudimos agarrar. Se le bencian cada mes. Lo teníamos que renovar cada mes*] (personal communication, February 25, 2023). Despite EMC having a standard application process, the change in MSW made all the difference in Jacinto's access to treatment. It is such barriers that get created when paperwork is interpreted differently which can cause irreparable damage.

The older adults interviewed for this research have had experiences which make them second guess whether it is safe or possible to seek support when a health crisis emerges. From limited digital literacy to having symptoms ignored, the amalgam of these experiences creates barriers to access. They have accepted support from friends, family, the church, CBOs and community members willing to help in order to receive the care they need. Yet they have not sought support beyond their most immediate needs. Despite most of these older adults being eligible for multiple programs listed in Table 2, most stated they either did not know the programs existed or they were discouraged by the application process. For example, Elvira did not want to apply for Cal-Fresh because she perceived the paperwork as a burden to her children. Jacinto was only able to access vision and dental care, Meals on Wheels, assistance with transportation, scheduling appointments, getting up to date with vaccines, assistance with picking up medications post appointments and access to a Spanish speaking PCP on a regular basis after we made phone calls to various provider offices, Medi-Cal and CBOs to fill out the applications,

provide proof of eligibility documents, and phone interviews required to jumpstart his care. Memo, Ernesto and Alfredo would avoid care were it not for family. Gregorio completely shuns medical care, while Luz, due to an unwanted change of PCP, is averse to visiting doctors. Federico, on the other hand, only seeks help when it's absolutely essential. In our interview, Federico revealed that he regularly suffers from intense anxiety symptoms. However, his negative encounter in the emergency room has tainted his view of the healthcare system, leading him to avoid treatment.

4.3 Service Provider Interviews

Services provided

The five providers interviewed represented CBOs that addressed food security, legal services navigation, older adult case management, crisis intervention, wrap around services for the general public and targeted services for older adults wishing to age in place. Several organizations, especially those offering wrap around services, stated having a “no wrong door” approach to create a “one-stop resource hub and access point for long-term services and supports (LTSS) and benefits in states and territories” (National Council on Aging, 2023). In theory, clients reaching out are connected to the services sought even if the organization contacted is unable to offer the service themselves. This requires interorganizational collaboration, which all providers interviewed mentioned as a vital practice to ensure community needs are met. Yet not all collaboration is created equally. As JEY recounts:

“I think collaboration is a very good thing. If we could collaborate together, we could maximize services, but part of the collaboration is to be available and to be fair. Because sometimes in the collaboration one of the organizations gets all the money and don't really do the work. Like we subgrant from others and our numbers are higher than them but they get a bigger amount of money than we do” (personal communication, March 20, 2023).

Contracting, subcontracting, and outsourcing service provision are features of a neoliberal healthcare system. Just because organizations are collaborating on paper doesn't necessarily mean that this cooperation is reflected in practical, on-the-ground work.

There are CBOs that reduce barriers to access by helping older adults with the paperwork needed to apply for programs and services. One service provider stated that the best indicator of need is income. The tax filing assistance program the organization offers is a way to get clients through the door and speak with them one on one to identify additional needs aside from assistance with filing taxes. This process is very informal, clients are not pressured to provide any information they are not comfortable with providing; yet, at the same time, Personal Identifiable Information (PII) can still be captured given the requirements of filing taxes which gives the organization most of the information for grant tracking purposes. JEY states that speaking the client's language and being bicultural makes it easier to connect with clients and engender trust (personal communication, March 30, 2023). Even though the organization does not have grants specifically aimed at older adults, a significant number of their clients fall into this age group. These individuals are not denied services due to insufficient funding.

Funding

The providers interviewed stated their main sources of funding included federal funding, state funding, private donations, and various grants; one provider mentioned receiving interest on legal trust accounts but also stated that this type of funding was inconsistent. Not one organization which the interviewees belonged to relied on less than three streams of funding. One particular organization needed to hire a grant manager given they handle "up to 20 different funding streams at a time coming in all with different reporting criteria and timelines. . .to make sure that [reporting] happens" (GYFB, personal communication, March 13, 2023). Some

organizations rely on more than just funding. The foodbank, for example relies on foodstuff donations and GYFB pointed out that the availability of resources varies greatly depending on the county's resources; a comparison was made between Marin County, one of the richest counties in California and Yolo County which is "one of the most impoverished counties in the whole state" have different levels of access to food and the type of food that is provided (GYFB, personal communication, March 13, 2023). GYFB's description of the foodbank's reliance on the market is an example of the neoliberal shift within the social services sector. She describes the organization's efforts to ensure community needs are met:

"What we're trying to look at is finding more funding to purchase some food and we've never, we've always been like 80% donated and like 20% purchased and now we might have to start shifting that a little bit and finding some more funding either from state, the county, cities or private donations to be able to start purchasing some more food because we are seeing such dramatic decline [in donated foodstuff]" (personal communication, March 12, 2023).

An increased instability in the market such as inflation may lead to more conservative food handling by grocery stores which translates in reduction of what food banks can offer to the community. Food banks are being asked to rely on excess foodstuffs. Food from grocers gets diverted from the landfill and supplemented by food provided by local farmers to households in need. Still, trusting the market to provide is a logical fallacy exposed by this concrete example of what a food shortage can look like across the chain of production and distribution—the market cannot and does not reliably provide as purported by supporters of neoliberal policies. GYFB also points out that private donations from the community are limited given that there are other organizations doing community work which means private donors must choose where their support is allocated.

The overarching consensus among the providers was that obtaining funding is a challenge, especially long-term funding. Two of the five providers mentioned having received

large sums of funding via the American Rescue Plan (ARP) Act which allocated funds for response and recovery during the COVID-19 pandemic as a positive development. The caveat being:

“all of these grants have a layer of ‘covid this’ and ‘report COVID that’ but that’s not even what we’re reporting on anymore and the money is so delayed, we’ve kind of ignored that piece honestly. We’re just reporting what we know needs to be reported because we’re not reporting COVID numbers anymore, but the grant says that [we must]” (GYFB, personal communication, Marh 13, 2023).

SYHAA echoes this sentiment:

“it was a lot of money that all came at once but now there’s a giant cliff. At the end of 2024 those grants go away for everybody. . . So big infusions of money is fun, but it sure would have been nice to have maybe a little less and for a longer about of time because sustainability is a really, really key thing when trying to address needs in the community” (personal communication, February 27, 2023).

Although this type of funding and program expansions such as the increase in benefits for Cal-Fresh recipients during the Covid-19 Pandemic have transformative effects, it is but a momentary reprieve from the systemic injustices which vulnerable communities have faced for decades. And when the funding disappears, it’s like the ground is swept away from beneath those who have become dependent on these aids—not just service seekers, but the organizations themselves.

Reasonableness of Grant Deliverables

When asked if grant deliverables were reasonable, some service providers stated they were especially if the service provider responsible for acquiring grants ensure they do not apply for funding that does not align with community needs. Some grants are more flexible than others, the key is understanding what they grant is asking for. As PAAA states, “federal government sets things in stone and part of what we do is monitoring the contracts of the people we are giving

money to so we provide them with technical assistance and if they're having trouble, we try to help them because we want to make sure that people are getting the best services possible so there doesn't tend to be a whole lot of wiggle room in what we do" (personal communication, March 8, 2023). Notably, it was the service providers belonging to organizations that have the U.S. government as their primary funder who reported grant deliverables to be reasonable. The services providers belonging to smaller organizations which rely on more varied and unstable funding sources did not agree. According to SYHAA:

"there are two problems with grants: you have to do what the granter says whether that's not exactly what you want or not, you need to have a structure to respond back and let them know that you're doing what they said they were going to do and almost always grants are time specific. So, you're able to start a program, do something, and then it ends. And that's difficult for both an organization from a sustainability [standpoint] and being able to pay your staff but also for people receiving the program. It's like the program was there and now the program is gone. If it was meeting a need then that's a problem" (personal communication, February 27, 2023).

SYHAA's highlights the short-lived reprieve grants offer and the aftermath when funding ends. She shared that once a need in the community is identified, the organization's perpetual struggle is finding funding to continue addressing the need after funding from the first grant ends. In addition to the short-term nature of grant funding, there is also the issue grants aligning with community needs: LEY shares what grant fund usage looks like in practice:

"I've done the same job with different grants. Currently I'm a client navigator and we do income tax assistance, we do EDD assistance, we assist with resources and if we don't have them ourselves and we don't know, we navigate the system and we try to get the client whatever they need. . . "I don't really see myself looking like, 'oh this is the only grant and this is [these are] the only clients [I can assist]'. . . whatever grant we get. . . I just help anybody" (personal communication, March 24, 2023)

For LEY, it does not matter if the grant is for one specific demographic. As echoed by other service providers, her organization has a revolving door policy which varies with the seasons, but grant deliverables are not seen as an impediment to service provision.

Challenges in service provision

LEY recounted the success of a pilot program through Yolo Bus which allowed older adults to pay one dollar for their trips, but which ended after one year. This limited mobility for those who came to rely on the program and more people started asking LEY about transportation alternatives. The bus vouchers their organization would give out would be rejected by the drivers and although there were \$30 monthly bus passes available, the issue was having that sum of money available which is not always feasible for low-income older adults living in rural communities. This pilot program, despite its popularity, is just one example of short-term solutions for systemic problems that require long-term commitments. Other service providers also mentioned transportation being one of the biggest barriers to access in assisting older adults, not just in rural communities but urban areas as well since of the services require clients to travel.

LEY shared that many services get underreported because she may be multi-tasking with various clients or get asked for assistance off the clock. LEY is an integral part of their community and does not stop supporting neighbors simply because the workday is done. This is crucial to comprehend for rural communities: the close relationships that individuals maintain take precedence over professional limits, as the very people that LEY helps are the ones they engage with regularly. This mentality extends to how they understand grants and department funding. Client navigators such as LEY are indispensable gatekeepers for their communities; the years of trust they have gathered from being a consistent staple in their community is an asset that brings people through the door; grant funders and CBOs understand this.

Discussion

Having heard both Tabatha's and Elvira's experiences, I understood how crucial a sense of community is to enhance a person's quality of life. Tabatha's story involves experiencing grief alone, housing precarity, drug addiction, and comorbidities as a homeless person whilst Elvira, despite having experienced grief and hardships, has been fully supported by her family and has been aging in place according to her wishes. Fully recounting each woman's story gives the reader insight around aging whilst juggling personal struggles which may be compounding with bureaucratic entanglements resulting in barriers to services. Despite the different living arrangements and overall health of each woman, both decided to forgo services which they would have qualified for given the eligibility requirements because of the lengthy processes and or paperwork. For Elvira, having increased food security is not something she deemed necessary in this specific case, it does not severely impact her quality of life. For Tabatha, having access to medication management, dental care and secure housing could be the difference between having quality of life and merely surviving.

Regardless of the age limit chosen for this research to account for the social services older adults qualify for, Tabatha's story deserves to be told. Brown et.al. (2022) found that unhoused older adults in California are 3.5 times more likely to die compared to the general population. Being homeless as an older adult could result in not living beyond 60 for someone like Tabatha. Reaching the age of 60 would make her eligible for additional supportive services only available to older adults. Yet getting to this age group has been rather difficult due to the compounding effects of mental and physical issues as well as the bureaucratic entanglements which deter people like Tabatha from seeking services. Social services, often referred to as a "safety net," were originally designed to provide additional support during challenging times, not

to exclude those who are unable to meet certain criteria. The shift towards neoliberal policies in healthcare and social services has transferred the full burden of care onto individuals, ignoring the systemic disparities that disproportionately impact vulnerable groups.

The burden of paperwork and lengthy processes have dissuaded the interviewed from accessing services for which they likely qualify given their demographic markers. Yet, despite the bureaucratic entanglements which may deter individuals from applying for services, it is crucial to highlight the strengths which community members offer to ensure older adults are cared for and can access services. The community where the older adults were interviewed utilize Community Cultural Wealth (CCW) to bridge the gaps between healthcare access and aging. CCW is a framework that champions community interconnectedness to overcome systemic barriers. Manzo, Rangel, Flores, and De La Torre (2018) documented how promotoras (health promoters) utilized CCW during the recruitment process for a study involving 400 children in their community; their research shows how a tool like CCW can be incorporated within established bureaucratic processes to bridge the cultural gap between institutions and communities. Yosso (2005) outlines six types of capital as community cultural wealth: aspirational capital, linguistic capital, familial capital, social capital, navigational capital and resistant capital. It is important to acknowledge the tools being utilized by communities to create change. All of the older adults and some of the service providers interviewed utilized at least one form of capital to address a need. For example, Memo was able to not only transport friends to appointments, but also maneuver through a social institution by utilizing his limited English proficiency to bridge the language barrier between provider and patient. JEY shared that providing support to the community can sometimes result in legacies whereby those who received the support can pass on the knowledge to others. A wellness group started by JEY has

seen the children of the original participants come back to volunteer during tax filing season. The seeds planted by JEY have come to fruition to create lasting networks of support. Communities do not just require capital to be injected into them to thrive. They, too, possess various forms of capital which are drawn on to succeed even in the face of harsh realities.

Conclusion

As demonstrated above, neoliberal policies have restructured the healthcare and social services landscape (Alexander and Fernandez, 2021; Baines, 2010; Powell, 2020; Viens, 2019). This research focused on the impacts of neoliberalization of safety net programs which results in increased barriers to access for older adults living in rural communities and provided an overview of the current state of aging within the US healthcare system. The service providers interviewed shared the impacts of funding or lack thereof on their ability to provide services. Older adults living in a rural area exposed the gaps in the bureaucratic processes which prevent or deter them from seeking care. Community Based Participatory Research created a space for community members to share journeys and receive support in seeking care which is testament to the transformative power of CBPR (Manzo et al., 2018; Deeb-Sossa, 2019). Finally, this research opens a dialogue around Community Cultural Wealth's essential role and acknowledges that communities have capital which is utilized to ensure members are cared for despite the obstacles which may arise when accessing care (Yosso, 2005). Future research on this topic could focus on how CCW can be integrated within a reformed system that utilizes all forms of capital to ensure healthy communities.

The professionalization of CBOs with an increased focus on metric-based reporting shifts the attention away from addressing community needs to addressing funder needs that are in line with their goals (Alexander and Fernandez, 2021). Project based funding has become a popular

way of providing CBOs with support; but projects tend to have time constraints that do not address the systemic barriers faced by historically marginalized communities. When alignment between a project and community needs does occur and the community comes to depend on this programming, such as was the case with the Yolo Bus Pilot program, there is no guarantee that a program which has become so integral in a community will continue. Programs such those administered by the Department of Transportation should be started with the intention of follow-up that ensures a commitment to seeking funding which would sustain programming should the community respond positively by utilizing the services.

Community services not only require secure funding, but they should also be implemented as long-term commitments to a community until the program is no longer needed or is resolved outside of the programming. For example, it could be that a bill is passed to create permanent infrastructure addressing a systemic gap that had resulted in unjust treatment of marginalized communities in which case a program might come to an end and the focus would shift to addressing other community needs. This type of long-term investment would ensure that service seekers who come to rely on the programs are not placed in precarious situations for sudden termination of services like was the case with the increased funding to the Supplemental Nutrition Assistance Program (SNAP) during the COVID-19 pandemic which was withdrawn in March, 2023. Increasing SNAP benefits increased food security to millions which was then taken away; this was a short-term solution for a long-standing problem in the US. Various examples of this type of aid exist to highlight the precarity which is created by the governing bodies that offer temporary relief without taking into consideration the severe impact that the changing economy has on families and individuals.

Sustained funding for CBOs from governmental agencies could be supplemented by funding from philanthropic organizations that, in addition to offering funds based on short-term projects, also provide funding to whole communities. An example of what funding a whole community could look like would be providing an annual budget over a period of five years that is dispersed across CBOs based on the organization's size, number of average services rendered, or type of services rendered. As can be noted, this research is not against data collection and tracking or bureaucracy, in general, but rather promotes the streamlining of intra and interorganizational bureaucratic processes. This funding model could translate to private donations in that having a community fund would give donors the option to contribute to their community as a whole, knowing their contribution would be dispersed across multiple organizations. This restructuring in bureaucracy is not only an administrative shift but has the potential to create a shift in how we perceive aid and who it impacts. In addition, reducing competition between organizations who are all seeking funding decreases the precarity CBOs find themselves in when trying to remain operational. Collaboration between organizations functions differently when entities have the time and space to work together.

Policy reform which addresses the amount of information required for service seekers to meet eligibility would start to make the healthcare and social services landscape navigable for older adults. Services seekers would not have to present their income, proof of address, citizenship, employment status, familial status and supplemental documents every single time they are applying for a program. Paperwork could be reduced to a one-time application which captures the data that non-profit organizations collect for administrative purposes. This documentation would exist in a governmentally administered and monitored patient protected system where CBOs have access to the information and can communicate with one another to

ensure clients are being referred efficiently for services. If any additional information or updates to information were needed, any of the CBOs with access to the system could assist clients in uploading the information to maintain it up to date across all the organizations and institutions involved in their care.

An integrated information system not only provides service seekers a choice with regards to who can access their information, it would also increase organizational efficiency in capturing information and redirect time spent on administrative tasks outward to service provision. For example, if a service seeker is applying for Medi-Cal, the application could include the following question: “Do you authorize your personal information to be shared with the following programs and organizations: Cal-Fresh, Yolo County Food Bank, Meals on Wheels, Yolo County Housing Authority, Low-income Energy Assistance Program, CA Lifeline, the Affordable Connectivity Program and Medicare?” Service seekers would not only be informed of existing programs they may qualify for, but they would also have the choice to omit programs or organizations they do not want to access their information. In this way, access would be restricted until the service seeker reaches out to a program themselves and gives consent for their personal information to be accessed. This could reduce administrative costs and is a logical step in reducing the barriers to access for older adults living in rural communities.

References

Administration for Community Living. (2021, November). "Minority Aging." *U.S. Department of Health and Human Services*.

Administration for Community Living. (2021). "2020 Profile of Older Americans." *U.S. Department of Health and Human Services*. Retrieved from https://acl.gov/sites/default/files/aging%20and%20Disability%20In%20America/2020Profileolderamericans.final_.pdf

Alexander, J., & Fernandez, K. (2021). The Impact of Neoliberalism on Civil Society and Nonprofit Advocacy. *Nonprofit Policy Forum*, 12(2), 367–394. <https://doi.org/10.1515/npf-2020-0016>

Andress, L. (2017). Using a social ecological model to explore upstream and downstream solutions to rural food access for the elderly. *Cogent Medicine*, 4(1), 1393849. <https://doi.org/10.1080/2331205X.2017.1393849>

Bacsu, J., Jeffery, B., Abonyi, S., Johnson, S., Novik, N., Martz, D., & Oosman, S. (2014). Healthy Aging in Place: Perceptions of Rural Older Adults. *Educational Gerontology*, 40(5), 327–337. <https://doi.org/10.1080/03601277.2013.802191>

Baines, D. (2010). Neoliberal Restructuring, Activism/Participation, and Social Union in the Nonprofit Social Services. *Nonprofit and Voluntary Sector Quarterly*, 39(1), 10-28. <https://doi.org/10.1177/0899764008326681>

Beverly, C. J., McAtee, R., Costello, J., Chiu, T., & Reid, K. (2005). Needs assessment of rural communities: A focus on older adults. *Journal of Community Health*, 30(3), 197-212. <https://doi.org/10.1007/s10900-004-1958-y>

- Brown, R. T., Kiely, D. K., Bharel, M., & et al. (2012). Geriatric Syndromes in Older Homeless Adults. *Journal of General Internal Medicine*, 27, 16-22. <https://doi.org/10.1007/s11606-011-1848-9>
- Brown, R. T., Hemati, K., Riley, E. D., Lee, C. T., Ponath, C., Tieu, L., Guzman, D., & Kushel, M. B. (2017). Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. *Gerontologist*, 57(4), 757-766. <https://doi.org/10.1093/geront/gnw011>
- California Department of Aging (n.d.). "Master Plan for Aging." <https://mpa.aging.ca.gov/>
- Cohen, A. (2021). The Challenges of Intersectionality in the Lives of Older Adults Living in Rural Areas with Limited Financial Resources. *Gerontology and Geriatric Medicine*, 7, 1-9. <https://doi.org/10.1177/23337214211009363>
- Census Bureau. (2021). S0102 Population 60 Years and Over in the United States (ACSST1Y2021.S0102). Retrieved from Census Bureau Data
- Centers for Disease Control and Prevention. (2022, April 19). Reporting. Retrieved February 29, 2024, from <https://www.cdc.gov/grants/already-have-grant/Reporting.html>
- Connell, C. L., Wang, S. C., Crook, L., & Yadrick, K. (2019). Barriers to Healthcare Seeking and Provision Among African American Adults in the Rural Mississippi Delta Region: Community and Provider Perspectives. *Journal of Community Health*. Advance online publication. <https://doi.org/10.1007/s10900-019-00620-1>
- Davis, J. C., Rupasingha, A., Cromartie, J., Sanders, A. (November 2022). *Rural America at a Glance: 2022 Edition*. US Department of Agriculture Economic Information Bulletin Number 246.

- Dignity Health (n.d.). “Increasing Capital for Underserved Communities.” Retrieved February 29, 2024, from <https://www.dignityhealth.org/about-us/community-health/increasing-capital-for-underserved-communities>
- Deeb-Sossa, N. (2019). “Introduction.” *Community-Based Participatory Research: Testimonios from Chicana/o Studies*. University of Arizona Press.
- Douthit, N., Kiv, S., Dwolatzky, T., & Biswas, S. (2015). Exposing some important barriers to health care access in the rural USA. *Public Health*, 129(6), 611–620.
<https://doi.org/10.1016/j.puhe.2015.04.001>
- Durazo, E., Jones, M., Wallace, S., Van Arsdale, J., Aydin, M., & Stewart, C. (2011). “The Health Status and Unique Health Challenges of Rural Older Adults in California.” *UCLA: Center for Health Policy Research*. Retrieved from <https://escholarship.org/uc/item/0ds8j0w9>
- Edemekong, P. F., Bomgaars, D. L., Sukumaran, S., Schoo, C. (2022, November 19). *Activities of Daily Living* [Government Website]. National Library of Medicine. Accessed March 28, 2023 <https://www.ncbi.nlm.nih.gov/books/NBK470404/?report=classic>
- Fabius, C. D., Wolff, J. L., Willink, A., Skehan, M. E., Mulcahy, J., & Kasper, J. (2021). Community-based long-term services and supports: Are the needs of older adults and their caregivers being met. New York, NY: *The Commonwealth Fund*.
- Gibbins, R., & Wickramasinghe, N. (2021). Social determinants of health in the U.S.: A framework to support superior care co-ordination and leverage digital health solutions. *Health Policy and Technology*, 10(2), 100523. <https://doi.org/10.1016/j.hlpt.2021.100523>

- Hardman, & Newcomb, P. (2016). Barriers to primary care hospital follow-up among older adults in rural or semi-rural communities. *Applied Nursing Research*, 29, 222–228.
<https://doi.org/10.1016/j.apnr.2015.05.003>
- Harvey, D. (2007). *A brief history of neoliberalism*. Oxford University Press, Incorporated.
- Hasenfeld, Y., & Garrow, E. E. (2012). Nonprofit Human-Service Organizations, Social Rights, and Advocacy in a Neoliberal Welfare State. *Social Service Review*, 86(2), 295–322.
<https://doi.org/10.1086/666391>
- Henning-Smith, C. (2020). The Unique Impact of COVID-19 on Older Adults in Rural Areas. *Journal of Aging & Social Policy*, 32(4–5), 396–402.
<https://doi.org/10.1080/08959420.2020.1770036>
- Himmelstein, J., Himmelstein, D. U., Woolhandler, S., Bor, D. H., Gaffney, A., Zallman, L., Dickman, S., & McCormick, D. (2021). Health Care Spending and Use Among Hispanic Adults With and Without Limited English Proficiency, 1999–2018. *Health Affairs*, 40(7).
- Huffman, C., Regules-García, R., and Vargas Chanes, D. (2019). “Living Arrangement Dynamics of Older Adults in Mexico: Latent Class Analysis in an Accelerated Longitudinal Design.” *Demographic Research* 41:1401–36. doi: 10.4054/DemRes.2019.41.50.
- Israel, B. A., Eng, E., Schulz, A. J., & Parker, E. A. (2013). Introduction to methods for CBPR for health. In *Methods in community-based participatory research for health* (pp. 1-38). Jossey-Bass.

- Maeda, J. L. K., & Nelson, L. (2018). How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare with Medicare Fee-for-Service Prices? *The Journal of Health Care Organization, Provision, and Financing*, 55, 004695801877965. <https://doi.org/10.1177/0046958018779654>
- Manzo, R. D., Rangel, M. I., Flores, Y. G., & De La Torre, A. (2018). A Community Cultural Wealth Model to Train Promotoras as Data Collectors. *Health Promotion Practice*, 19(3), 341–348. <https://doi.org/10.1177/1524839917703980>
- Mather, M., Jacobsen, L.A., & Pollard, K.M. (2015). “Aging in the United States.” Population Reference Bureau. *Population Bulletin*, 70(2), 1-16 [PDF]. Retrieved from <https://www.prb.org/wp-content/uploads/2016/01/aging-us-population-bulletin-1.pdf>
- Monteiro, P., & Adler, P. S. (2022). Bureaucracy for the 21st Century: Clarifying and Expanding Our View of Bureaucratic Organization. *Academy of Management Annals*, 16(2), 427–475. <https://doi.org/10.5465/annals.2019.0059>
- National Institutes of Health. (2021, October 12). Post-Award Monitoring and Reporting. Retrieved February 29, 2024, from <https://grants.nih.gov/grants/post-award-monitoring-and-reporting.htm>
- Navarro, V. (1998). Neoliberalism, “Globalization,” Unemployment, Inequalities, and the Welfare State. *International Journal of Health Services*, 28(4), 607–682. <https://doi.org/10.2190/Y3X7-RG7E-6626-FVPT>
- Navarro, V. (2007). Neoliberalism as a class ideology; Or, the political causes of the growth of inequalities. *International Journal of Health Services*, 37(1), 47–62. <https://doi.org/10.2190/3431-RN80-7M24-8U78>

- Office of Disease Prevention and Health Promotion. (n.d.). Healthy People 2030. Retrieved from <https://health.gov/healthypeople>
- Office of Governor Gavin Newsom. (2019, October 11). "Governor Newsom Signs Legislation to Bolster Support for California's Senior Citizens." *California Governor*.
<https://www.gov.ca.gov/2019/10/11/governor-newsom-signs-legislation-to-bolster-support-for-californias-senior-citizens/>
- Pandit, A. A., Eswaran, H., Bogulski, C. A., Rabbani, M., Allison, M., Dawson, L., & Hayes, C. J. (2023). Factors Associated with Remote Patient Monitoring Services Provision by Hospitals and Health Care Systems in the United States. *Telemedicine Journal and E-Health*, 29(7), 1014-1026. <https://doi.org/10.1089/tmj.2022.0266>
- Peterson, C. L., & Walker, C. (2022). Universal health care and political economy, neoliberalism and effects of COVID -19: A view of systems and complexity. *Journal of Evaluation in Clinical Practice*, 28(2), 338–340. <https://doi.org/10.1111/jep.13631>
- Powell, W. W. (2020). What is the Nonprofit Sector? In W. W. Powell & P. Bromley (Eds.), *The nonprofit sector: A research handbook* (pp. 3-18). Stanford University Press.
- Richardson, J. A., & London, J. K. (2007). Strategies and Lessons for Reducing Persistent Rural Poverty: A Social Justice Approach to Funding Rural Community Transformation. *Community Development*, 38(1), 92–107. <https://doi.org/10.1080/15575330709490187>
- Ritzer, G. (2004). McDonaldization and Its Precursors. In *The McDonaldization of Society* (pp. 24-42). Pine Forge Press.
- Rowe, J. W., Fulmer, T., & Fried, L. (2016). Preparing for Better Health and Health Care for an Aging Population. *JAMA*, 316(16), 1643. <https://doi.org/10.1001/jama.2016.12335>

- Ruggles, S. (1996). "Living Arrangements of the Elderly in America: 1880–1980." Pp. 254–71 in *Aging and Generational Relations over the Life Course*, edited by T. K. Hareven. De Gruyter.
- Russell, D., & Taylor, J. (2009). Living Alone and Depressive Symptoms: The Influence of Gender, Physical Disability, and Social Support Among Hispanic and Non-Hispanic Older Adults. *The Journals of Gerontology: Series B*, 64(1), 95-104.
<https://doi.org/10.1093/geronb/gbn002>
- Silverman, R. M., & Patterson, K. L. (2022). *Qualitative research methods for community development* (2nd ed.). Routledge New York and London.
- Soskis, B. (2020). A history of associational life and the nonprofit sector in the United States. In W. W. Powell & P. Bromley (Eds.), *The Nonprofit Sector* (pp. 23–80). Stanford University Press
- U.S. Department of Health and Human Services. (2021). Increase the proportion of adults with broadband internet (HCHIT-05). Retrieved from [Healthy People 2030 Data](#)
- United States Census Bureau. (n.d.). Knights Landing CDP, California Profile.
<https://data.census.gov/cedsci/all?q=Knights%20Landing,%20CA>
- Viens, A. M. (2019). Neo-Liberalism, Austerity and the Political Determinants of Health. *Health Care Analysis*, 27(3), 147–152. <https://doi.org/10.1007/s10728-019-00377-7>
- Vogler, J. P. (2019). The Entanglement of Public Bureaucratic Institutions: Their Interactions with Society, Culture, Politics, and the Economy. In D. J. Boudreaux, C. J. Coyne, & B. Herzberg (Eds.), *Interdisciplinary Studies of the Political Order: New Applications of Public Choice Theory* (pp. 99-129). Rowman & Littlefield International.

- Ward, C., Touchet, E., Marfeo, E., & Ward, N. (2020). Mobility and Cognitive Decline in Older Adults with Cognitive Impairment. In *The Cambridge Handbook of Cognitive Aging: A Life Course Perspective* (pp. 701-716). Cambridge University Press.
<https://doi.org/10.1017/9781108552684.043>
- Weber, M. (1958). "Bureaucracy," in: From *Max Weber: Essays on Sociology*, eds. H.H. Gerth and C. Wright Mills. New York: Oxford University Press. 956-963.
- Williams, I. & Mattos, M. K. (2021). We're Still Here: Addressing the Diverse Healthcare Needs of Older Adults in Rural Areas. *The Public Policy and Aging Report*, 31(4), 126–128. <https://doi.org/10.1093/ppar/prab017>
- Wood, J. P., Winters, P. L., Brindle, E. M., Cefalu, M. S., & Haddock, K. S. (2016). Older adult transportation in rural communities: Results of an agency survey. *Journal of Public Transportation*, 19(2), 154-167. <http://doi.org/10.5038/2375-0901.19.2.9>
- World Health Organization. (2022, October 1). Ageing and health. Retrieved from [WHO Fact Sheet](#)
- Yearby, R., Clark, B., & Figueroa, J. F. (2022). Structural racism in historical and modern US health care policy. *Health Affairs* (Millwood), 41(2), 187-194
- Yolo County California. (n.d.). CalFresh. *Health and Human Services*. Retrieved April 17, 2023, from
<https://www.yolocounty.org/government/general-government-departments/health-human-services/welfare/calfresh-formerly-food-stamps>
- Yosso, T. J. (2005). Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race Ethnicity and Education*, 8(1), 69–91.
<https://doi.org/10.1080/1361332052000341006>

Appendix

Table 1
Rural Older Adult Participant Interviewees

Age	Gender	Race/Ethnicity	Living Arrangement
61	Male	Latino/Hispanic	Labor camp
68	Male	Latino/Hispanic	Labor camp
71	Male	Latino/Hispanic	Labor camp
60	Female	White	Alone
61	Male	Latino/Hispanic	Spouse
93	Female	Latino/Hispanic	Alone
75	Male	Latino/Hispanic	Spouse
85	Female	Latino/Hispanic	Son & grandchildren
66	Male	Latino/Hispanic	Spouse, nephew & mother-in-law
55*	Female	White	Friend

Note: Demographic markers of participants. Two additional interviews had to be discarded due to recording errors. *The testimony of a fifty-five-year-old community member was included given that community members as well as the participant expressed great interest in having her story told.

Table 2

Government-funded Programs for Vulnerable Populations in California

Program	Eligibility Requirements	Application process
Medi-Cal : Healthcare coverage	Being part of a vulnerable population: 65 or older, living with a disability, children, pregnant women, persons with breast or cervical cancer, refugees (depending on their situation). CA residency, below the Medi-Cal income limit (138% Poverty Level : \$20,121 for a household of 1). Requested documents : identity, income, immigration status, residency, other income, resources, additional proof for health coverage	Application is processed by an “Eligibility Specialist,” applicant contacted by specialist for missing information, letter sent to applicant with eligibility decision. Typical wait times: 45 for non-disability and 60 plus days for people claiming a disability in their application.
Medicare : Part A (hospital insurance), Part B (Medical insurance), Part C (Medicare Advantage), Part D (Drug coverage) and supplemental coverage. Medicare holders and also have Medicaid if they meet the eligibility requirements for both.	Federally funding health insurance managed by the Social Security Administration for people 65 years of age or older. Must have worked a total of 40 quarters that paid into Medicare taxes. Must be a legal resident or citizen of the U.S. Some people under 65 and living with disabilities qualify for Medicare.	Initial enrollment: 6-month enrollment window—four months before turning 65 to two months after turning 65. Special Enrollment: within eight months of stopping work or group health plan ending. General Enrollment: Between January 1 and March 31 each year with “typically a life-long penalty” which is not further explained.
Cal-Fresh : Food assistance	Eligibility based on household size and income, certain expenses, and legal status.	Applications can be completed online at GetCalFresh.org , by phone with a county representative, in person, via mail and by fax.
Affordable Connectivity Program (ACP) : broadband and device access	Household income at or below 200% of the Federal Poverty Guidelines (\$29,160 for a household of 1), prior approval to a government assistance program, prior approval to the CA Lifeline benefit, participation in tribal assistance programs. Documents required: ID, proof of program participation, proof of household income	Online form requesting home address and contact information is provided so that applicants can receive a call from an ACP representative. According to the website, “The Affordable Connectivity Program will stop accepting new applications and enrollments on February 7, 2024.”
CA Lifeline : discount phones and services	Although there is a state and federal discount available, “only one discount per household” is allowed. Qualification based on current enrollment to a government assistance program or by income. Note: income limit for this program differs from that of Medi-Cal and the ACP benefit.	Applications can be processed through existing home or cell phone company service, enrollment code is sent in a pick envelope, form must be filled out, signed and mailed to the California LifeLine Administrator alongside required documentation. There is also an online application available. The renewal process begins 105 days prior to the one-year mark of being enrolled in the program with an option to renew online.
Low Cost Auto Insurance Program	Valid driver’s license, current vehicle registration, income eligibility guideline (Maximum income of \$37, 650 for a household of 1), own a vehicle with a value of 25,000 or less, minimum age of 16 years old (legal emancipation if under 18), clean driving record, immigration status not factored into eligibility.	Online application available at mylowcostauto.com The cost is dependent on county, applicants age and the length of time they’ve held a license.
Low Income Home Energy Assistance Program (LIHEAP) : discounts, waivers or cash assistance related to energy assistance (heating, cooling, crisis and weatherization).	Income eligibility: \$34,593.96 for household of 1	Service seekers can call their local electricity provider and ask to see if they qualify for the program.

Public Housing	<ul style="list-style-type: none"> • 18 years of age or older • Citizen or eligible noncitizen • Earn less than 80% of the Area Median Income (AMI) • Waitlists with preferences (for homeless, disabled, elderly, etc) give priority to applicants that meet preference requirements which vary from complex to complex. 	<ul style="list-style-type: none"> • According to the county’s Public Housing Authority, “the wait can be lengthy, typically years” (Yolo County Housing, 2022) • Federal regulation requires annual reevaluation of tenant income and family size. • There is a pre-application to get on the affordable housing waitlist.
--------------------------------	---	--

Note: Provides a list of government-funded programs available to low-income earners in the state of California. Contractors, businesses, by which services are provided, have been mentioned where applicable. It should be noted that these programs are just some examples of available social services, but there exist others such as [SSI](#) and [unemployment benefits](#) among others which were not including in this list.