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# Healthcare trends and attitudes of migratory winter visitors in the Rio Grande Valley

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# HEALTHCARE TRENDS AND ATTITUDES OF MIGRATORY WINTER VISITORS IN THE RIO GRANDE VALLEY

A Thesis

by

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## ABSTRACT

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This original research explores the general trends and attitudes of migratory winter visitors to the Rio Grande Valley regarding the local healthcare environment/options, general health status, and attitudes toward alternative medicine. The sample consisted of 115 winter visitors to the Valley, and exploratory data was gathered through a self-administered questionnaire. The average respondent was female, over 70 years old, had a high school level education, and reported earning a minimum average of $20,000/year for the past five years. Most respondents had Medicare coverage; over half had private insurance coverage. Commonly reported health conditions were visual problems, joint/bone problems, and high blood pressure. Additionally, participant observation allowed for an inside perspective on social networks and embeddedness within local, winter visitor R.V. parks.

## DEDICATION

*This thesis is dedicated to my*
*my husband, Troy, and my daughter, Olivia,*
*who love me for who I am and not just what I am doing.*
*You both remain my daily inspirations.*

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# INTRODUCTION

Over the past few decades, the United States has seen a dramatic shift in its age-related demographics. Included in this shift is the population explosion of senior adults. Resulting from this major demographic shift, the 65+ population (interchangeably referred to as senior citizens in this thesis) has rapidly increased in our country. Hence a focus on issues affecting their overall quality of life and health has become increasingly important. Most important are issues pertinent to healthcare trends and attitudes along with the overall health status of senior citizens in the United States. The health status of this population remains an important indicator of our nation's ability to meet the needs of this rapidly growing segment of the U.S. population.

Major population increases among the 65+ population coupled with a parallel rise in the cost of healthcare contribute to an urgent need to document how today's seniors are managing their health as well as paying for their healthcare. By focusing on the health status and healthcare conditions of a small segment of the senior citizen population, those who migrate during the winter to warmer environments, this thesis explores an important component of the much wider scenario addressing the overall health status and healthcare policy issues relevant to our older population. The review of the literature that follows

attempts to provide a brief profile of some of the most salient issues related to healthcare expenditures. In addition, the review of literature touches upon alternative therapies and the inclination for this 65+ population to utilize alternative medicine. Finally, some general theoretical literature focusing on aging, as well as a couple of articles dealing directly with migratory seniors, rounds out the review of literature.

A review of healthcare expenditures, the social policy research literature and the popular media indicate that there is a steady increase in the cost of healthcare plaguing our society. In fact, according to a 2001 report at the Texas State Comptroller's website, $198 million consumer dollars were spent on healthcare in 1998 compared to the $167 million consumer dollars spent 5 years earlier; thus, there was an astonishing nearly 19% increase in national out-of-pocket expenditures (Texas State Comptroller's Office, 2001). Additionally, under the Medicare Program, federal government spending increased by nearly 48% over a 5-year period from 1993 to 1998 (Texas State Comptroller's Office, 2001). In 1999, an AARP report projected that Medicare beneficiaries age 65 + would spend an additional 19% of their incomes on healthcare and health related services (Gross & Brangham, December 1999). As policy-makers become more aware of the changing demographics and increased healthcare expenditures, they are likely to react through policy-making that addresses relative concerns. Meanwhile the media -- with increasing frequency -- bandies about key issues that are important to the aging population of our nation. Included in these pertinent issues are the very hot topics of health and healthcare.

Migratory seniors who engage in a type of seasonal movement from one location to another are usually attempting to escape their cold, northern homes (often in the Northern or Western United States, and even sometimes from Canada). Every fall/winter season, thousands of winter visitors, or Winter Texans, descend upon the Rio Grande Valley to spend the coldest months in a warmer climate. This multitude of senior citizens in one location creates a unique environment from which to draw research participants. In the Rio Grande Valley, between 120,000-140,000 Winter Texans or winter visitors visit the Rio Grande Valley every year. These visitors, typically senior retirees, pump an estimated $300 million into the local economy during an average season, and a majority of this money is spent on healthcare and health related expenditures.

The Rio Grande Valley of Texas constitutes the target area for this study, and the target sample consists of retired winter visitors. Due to the convenience of a large population of senior citizens in relative proximity to one another, the participants in this study are comprised of a sample of local winter visitors. Participant recruitment took place mainly at local winter visitor RV resorts. The RV Resorts were located in Donna, Harlingen, Pharr, and Weslaco. Recruitment of one sub-sample also occurred through the snowball technique from contacts at a local church – which was determined to be a church that counts winter visitors as a majority of its congregate. The following presented data resulted from the administering of a questionnaire on health and related issues to 115 participants.

## CHAPTER 1

One purpose of this study is to investigate the general trends and attitudes of migratory winter visitors in the Rio Grande Valley regarding the local healthcare environment/options in comparison to the healthcare environment/options of their primary residences away from the Rio Grande Valley. Additionally, this study will assess the general health status of migratory winter visitors. Because the demographic characteristics for this set of individuals has not been comprehensively examined and described, another goal of this research is to provide a descriptive exploration of the winter visitors as a whole. This study will also examine the attitudes of seasonal migratory visitors toward the use of alternative medicine and further analyze to what extent the subjects have penetrated the distinct geographical and cultural landscape of the Rio Grande Valley by assessing their level of experience with local, traditional alternative therapies. Finally -- in an attempt to further strengthen my research by incorporating the use of triangulation -- an observation-driven side of this research highlights patterns of health-related activities in the RV parks and addresses the presence of social networks and embeddedness.

Through exposure to winter visitors on various levels of social occasions, I developed a curiosity about this group of part-time Rio Grande Valley residents. In addition, a course at the University of Texas-Pan American on Health and

Aging piqued my interest in the changing landscape of our society and, in particular, on the emergence of a large population of senior citizens. I soon realized that a social anomaly exists in the Rio Grande Valley that might allow one easier access to engage in exploratory research on senior winter visitors and their health trends; thus, this study began as an exploratory and descriptive research project spurred -- in large part -- by my own curiosity. Due to the ever-present topic of health at the forefront of many political debates, and the obvious correlations between health issues and life expectancy (as well as correlations between health issues and the elderly), I felt that health would be a tenable focus for this research. Alternative medicine seemed like another appropriate research topic as the alternative therapies industry has sky-rocketed over the past couple of decades, and there is not an abundant body of literature addressing alternative medicine use by the elderly.

*Review of Literature*

As this original research project is descriptive and exploratory in nature, and due to the geographic distinctiveness of the senior visitors to the Rio Grande Valley, I did not set out expecting to uncover a multitude of literature about winter visitors on which to base my research. However, after searching in a multiplicity of fashions and cross-referencing several variations on terminology (i.e., snowbirds, winter Texans, migratory seniors, etc.), I actually found a few articles about -- as well as research on -- migratory winter visitors. In addition to articles about migratory winter visitors, I have also selected some items dealing with alternative medicine, in general that have a focus on seniors. Additionally,

this study includes some theoretical articles from compilations on aging, policy, and theory. As my survey deals mainly with trends in health and healthcare patterns, my review of literature includes statistics pertaining to the general health and healthcare status of a sample of 65+ cohorts; the inclusion of this data is mainly for comparison purposes. Finally, I provide general statistical information about a selection of topics including winter visitors to the Rio Grande Valley and elsewhere, national health expenditures, age demographics, and theoretical perspectives on aging.

General Population Information and Historical Stereotypes

According to recent demographic research, there is a population explosion in the United States (as well as worldwide) of people age 65 or older. In 2000, there were an estimated 35 million people -- who accounted for nearly 13 percent of the U.S. total population -- in this age group. In fact, according to statistics cited in the *Older Americans 2000 Report*, "the number of older Americans has increased more than ten-fold since 1900, when there were 3 million people age 65 or older" (Federal Interagency Forum). Due to the fact that the baby boom generation will be entering that age category in less than a decade, it is projected that by the year 2030, the size of this older population will double -- growing to around 70 million. At this point, one in five people will be age 65 or older (Federal Interagency Forum, 2000). In light of these trends in the number of seniors in the United States, research focusing on the same population is appropriate and tenable. Thus, support for the current research topic lies in the increasing number of older people in our country.

To gain a better understanding of senior citizens and the stereotypes with which they've endured throughout the years, the following essay by R. H. Binstock is included in the review of literature. Also offered in this essay are insights on the forming of public policy within the context of the stereotypes existing during the era of the policy-making. Binstock – a prominent social scientist – highlights the inclination for stereotypes associated with older Americans from the 1930s to the present. According to Binstock (2002), from the 1930s until around the 1980s, most public policy surrounding older Americans was "framed by an underlying ageism, the attribution of the same characteristics, status, and just desserts to a heterogeneous group that has been artificially homogenized, packaged, labeled, and marketed as 'the aged.'" However, Binstock asserts that contrasting to that of racism and sexism, the typecasting stemming from ageism did not necessarily always yield negative results for the aged. From this atmosphere of ageism were born homogenizing policy programs, such as Medicare, that viewed the older population as "the same by providing them with benefits and protections primarily on the basis of old age" (Binstock, p. 348).

Up until the late 1970s, most people viewed older Americans fairly compassionately, seeing them as "poor, frail, socially dependent, objects of discrimination, and above all 'deserving' (see Kalish 1979)" (Binstock, p. 348). At this point, "compassionate ageism" was in full swing and illustrated by many policies and programs; in fact, a U.S. House of Representatives appointed committee identified 49 committees and subcommittees of Congress that

administered 134 programs benefiting the elderly. However, around 1978, older Americans were beginning to be viewed as a more affluent and influential set, and simultaneously, "attacked as a burdensome responsibility" (Binstock, p. 349). Binstock (2002) specifies some examples of media-related ageist propaganda of the time, and he asserts that there was a dramatic shift in the public climate from compassionate ageism to viewing the elderly as selfish, "greedy geezers" (p. 350). This, according to Binstock, may have been due to three major factors: a "serious cash flow problem in the Social Security system that emerged within the larger context of a depressed economy," the boom in the total amount and proportion of U.S. dollars expended on benefits to the elderly, and the general improvement in economic status of many older Americans (p.350-351). These historical shifts in the way older Americans are viewed would, naturally, also alter the framework through which aging theory developed.

Health Status: Physiological and Psychological

J. Mirowsky and C. E. Ross (1992) address the concept of age and its relation to depression, as well as offer summaries of some theoretical perspectives on aging. The authors note that despite its apparent lack of complication as a measure, age is actually an intricate human trait. According to the article (1992), "Maturity, decline, life-cycle, survival, and historical trend suggest different...sometimes opposite," yet not necessarily "mutually exclusive" predictions about aging, as well as the relationship between age and depression (Mirowsky & Ross, p.188). Included in the article are highlights from the aforementioned theoretical paradigms. "Age as decline" addresses the concept

of the "accumulation" of aging; that is, during the process of summing and integrating experience, people also "sum and integrate failures, faults, injuries, and errors" (Mirowsky & Ross, p.188). Over time, "cumulative physical problems compound," and decline occurs in the "emotional realm as well, as a consequence of physiological decline or as an independent process" (Mirowsky & Ross, p.188). The authors suggest that the "decline hypothesis" indicates that the average depression levels for "successively older adults" (p.188) increase at an accelerated rate.

According to Mirowsky and Ross (1992), "age implies a stage or phase (p.189)" in the cycle of one's life. Throughout the course of one's life, "status and prospects rise and fall" (Mirowsky & Ross, p.189). Around the age of 60, "the progression into old age sharply increases the percentage of retired and widowed," while "average earnings and total family income" decreases. The authors contend that "life-cycle hypothesis (Mirowsky & Ross, p.189)" says that depression levels decline beginning around early adult years into middle age and then subsequently begin to rise from that point forward. "Age as survival" says that as one grows older, there is an increase in the likelihood of traits associated with survival, and these traits may "create a false impression of aging's effect, making it appear more beneficial or benign (Mirowsky & Ross, p.190)" than is true. Related to depression, the "survival hypothesis" produces a dichotomous association. On one hand, average levels of depression seem to "decrease in progressively older age groups" when adjusting for marriage and socioeconomic

status; on the other hand, depression appears to increase in progressively older groups when adjusting for gender (Mirowsky & Ross, 1992, p.190).

"Age as historical trend" notes the impact of one's life position in the course of historical events. "Age marks the place of one's cohort in the major trends of recent history" (Mirowsky & Ross, 1992, p.191). Events occurring in the world during one's lifetime can have an enormous impact (either positive or detrimental). The authors continue with an historical discussion of educational opportunity and average levels of education, concluding that lower levels of education may have an effect on certain age cohorts' propensity for depression. This hypothesis says that "average levels of depression are higher in older groups," and adjusting for education explains some of this increase (Mirowsky & Ross, 1992, 191). "Age as maturity" entails "the summation of growth and development, in that as people age, they seem to become more "experienced, accomplished, and seasoned" (Mirowsky & Ross, 1992, p.188). This process and the subsequent "self-integration (p.188)" take time. "Aging increases practice with living, and the extent of self composition," and with an increase in "insight and skill, social and psychological traits and tendencies merge into an increasingly harmonious world" (Mirowsky & Ross, 1992, p.188). The "maturity hypothesis" says that as individuals grow older, their average level of depression drops.

According to Schieman *et al.* (2002), existing research seems to support the conclusion that depression tends to be highest in young adults and then steadily declines through midlife. The authors contend that some studies also

support evidence of an increase in depression in older individuals or "the oldest old." On the other hand, more recent research "reinforces the notion that older people have fewer symptoms of depression and/or disorder" (Schieman *et al.*, 2002, p.261). Building on a prior study uncovering a negative, linear relationship between age and depression, the researchers explore what "personal and social conditions contribute to the negative, linear age-depression relationship," and "what factors, if any, suppress the size of that relationship" (Schieman *et al.*, 2002, p. 261).

Using secondary data analysis, Schieman *et al.*(2002) used second wave interviews of 731 community dwelling physically disabled individuals and -- matched by age, sex, and location of residence -- a sample of 850 non-disabled individuals. The authors broke the two samples out into 7 age cohorts. Based on findings, the authors concluded that in both samples, the older respondents reported lower levels of economic hardship, slightly higher religiosity scores, and fewer negative interpersonal exchanges. "The average, older disabled respondents reported lower levels of mastery, more physical impairments, and poorer self-rated health" (Schieman *et al.*, 2002, p. 270-71). Average levels of mastery and self-related health were also lower among the older, non-disabled adults.

Schieman *et al.*(2002) cite "stress process theory" and the prediction that "economic hardship and conflictive interpersonal exchanges are sources of stress that can threaten emotional well-being." Additionally, Schieman *et al.* note that "age-related gains" may counter the effect of "decline or loss" (2002, p. 275-

77). The "gain" view is grounded in "socioemotional selectivity theory," and it depicts later life as a time in which older adults are more content with certain aspects of life, such as "economic circumstances and socioemotional arrangements." The authors state that less economic hardship and fewer negative exchanges – "two critical stressors" – assist in the explanation of why older adults report fewer depression symptoms (Schieman *et al.*, 2002, p.277-78).

In a recent journal article, P. Drentea (2002) utilizes secondary data analysis to test her hypotheses about the effects of retirement on mental health. She concludes that when it comes to greater levels of positive affect and less anxiety and distress, retirement is favorable over working; however, working may be better than retirement in some ways because retirees seem to experience a sense of less control, "in part due to fulfillment and in part due to less complexity and problem solving" (Drentea, 2002, p. 187). According to the author, more and more people are retiring at younger ages, and the workforce is also gradually diminishing. The author suggests that to bolster the workforce and also to add to the quality of life of older individuals, perhaps jobs, "or other opportunities," that offer higher levels of autonomy may help "retain retirees in the workforce and maintain high levels of well-being" (Drentea, 2002, p. 188).

In another depression-related article, M. K. Potts (1997) – utilizing the "socioemotional selectivity theory as framework" (p. 348) – focuses on the role of social support in association to depression. Recently, there has been an increase in "age-segregated retirement communities" (Potts, 1997, p. 348). Potts

sites the contributing factors of "predicted increases in the older adult population, the desire of most older people to live independently, and medical advances that delay institutionalization" (1997, pp. 348-349). The existing body of research indicates "social support is an important predictor of good physical and mental health, life satisfaction, and reduced risk of institutionalization among older adults" (Potts, 1997, p. 349). Additionally, social support may decrease some of the negative effects of common stressors associated with aging. In her study, Potts sought to compare the "quantity and quality of social support from friends within the retirement community with support from friends living elsewhere" (1997, p. 349).

The "activity theory" maintains that although older age characterizes certain role losses (i.e., employee), new roles and activities develop to replace the lost roles. Thus, from this perspective, aging is seen as a time of discarding old roles and developing new ones. Alternatively, the "disengagement theory" indicates that as people age, they begin to disengage from interaction with others and become more socially detached. However, according to Potts (1997), the Carstensen's "socioemotional selectivity theory provides an alternative and possibly integrative view of aging" (pp. 349-50). This theory suggests that the reduction of "interaction in later life [is] 'the result of lifelong selection processes by which people strategically and adaptively cultivate their social networks to maximize social and emotional gains and minimize social and emotional risks' (Carstensen, 1992, p.331)" (citation - Potts, 1997, p.350).

Using this theory, Potts developed her study, in which four of her five hypotheses were ultimately supported. "In terms of network quantity, social support levels were higher for friends within the retirement community" (Potts, 1997, p. 357). On the other hand, "in terms of perceived quality and confidant relationships, social support levels were higher for friends living elsewhere" (Potts, 1997, p. 357). In comparison to the lack of an effect of social support from friends within the community, Potts maintains that social support from friends living outside of the community "consistently predicted low levels of depression" (1997, p. 357). Additionally, "in two instances (network quantity and confidant relationships), social support from friends outside the retirement community (Potts, 1997, p. 357)" predicted low levels of depression, even when controlling for the support from friends within the community (Potts, 1997, p. 358). Potts concludes that both the maintenance of old friendships as well as the nurturing of new friendships play imminent roles in the depression levels of older adults. Thus, she suggests that social workers utilize her findings to support designing and evaluating interventions "aimed at improving the well-being of older adults...in retirement communities and other age-segregated settings" (Potts, 1997, pp.359-60).

In addition to psychological challenges, it generally follows that as one ages, he/she will become more susceptible to physiological health challenges. The Center for Disease Control's National Center for Health Statistic's website (Center for Disease Control, 2003) includes data that can be manipulated into custom made tables, and one area available for research is "Trends in Health

and Aging." While investigating the trends in health of the 65+ population of respondents for this survey, I discovered that the number one chronic health condition (excluding vision and auditory impairment) of this same group of cohorts is hypertension, with nearly 47% of the respondents reporting this condition. 37% of the respondents reported arthritic symptoms, the second highest reported chronic condition. Rounding out the top six reported chronic conditions were heart disease (31.8%), cancer (18%), sinusitis (15%), and diabetes (13.5%). This topic is supported by the National Institutes on Aging, a division of the National Institutes of Health (Center for Disease Control, 2003)

In a recent article, P. T. Harvey (2003), reports on "common eyes iseases of elderly people" and offers tips on "identifying and treating causes of vision loss" (Harvey, 2003, p.2). According to the Harvey (2003), 38 million people worldwide are blind, and 22 million of these are age 60 years or older. "Age-related macular degeneration (AMD), cataract, glaucoma, and diabetic retinopathy" are the most common causes of vision loss (Harvey, 2003, p.2). In addition, 110 million people live with "low vision" (Harvey, 2003, p.2). When combined with the increase in life expectancy and the aging of society, Harvey claims that these issues draw attention to the need for "effective eye care for elderly people to minimize vision loss from age-related conditions" (2003, p.2). In light of this contention, the author reviews and discusses signs and symptoms of AMD, cataract, glaucoma, and diabetic retinopathy. She, then, highlights treatment options for these conditions. Harvey stresses that "early diagnosis and

prompt referral of patients with eye disease" are essential in "maximizing treatment benefits" (2003, p.2).

Healthcare Shortages and Health Coverage Policy

In a recent article, K. C. Fleming *et al.* (2003), argue that, "the older adult patient has unique characteristics that demand differentiation from the usual care of nonelderly adults" (p.1032). Thus, to meet the healthcare needs of an aging society, an adequate network of qualified healthcare providers must be in place. According to Fleming *et al.* (2003), research shows that -- indeed -- the U.S. is not prepared to keep up with the growing healthcare requirements of our aging population. On the contrary, Fleming *et al.* maintain that a decline exists in the general historical trend in healthcare providers -- as well as healthcare funding -- for the elderly. Not only is there an impending continued shortage of healthcare professionals in general practice, the same is true of subspecialty areas for the elderly, such as geriatrics.

One indicator for the current shortage and subsequent decline in healthcare providers is the potential labor shortages. According to Fleming *et al.*, "it has been estimated that 126,000 nursing positions in hospitals are currently unfilled," and the "ratio of working-age adults to older care recipients will decline by 40% between 2010 and 2030" (2003, p. 1027-28). The number of working adults, aged 20 to 44 years, is predicted to decline by four percent from the present number of 104 million to 99.5 million in 2010. The growth in jobs for RNs may be further by current efforts to curb Medicare and Medicaid expenditures.

Predictions for 2020 place the RN workforce at around the same size as it is at present, or 30% short of projected needs (Fleming *et al.*, 2003, p.1029).

In addition, Fleming *et al.* note that population projections through 2030 illustrate the need for double to triple the present number of "full-time equivalent physicians" to treat the elderly (2003 p.1033). Unfortunately, federal support for *undergraduate medical and graduate medical training* has waned due to "fears of physician surpluses in recent decades". The authors also note that "increases in demand for physician services, and aging physician workforce, and trends toward reduced work effort" will expose a shortage of more than 200,000 doctors by 2020. Overall, "a shrinking workforce, an aging population, financial concerns, and increased consumer demand" will amount to a severe shortage in the number of future healthcare personnel (Fleming *et al.*, 2003, pp. 1033-36). In closing, the authors suggest that one solution to the future dilemmas lies in viewing "medical practice and nursing care for older adults" as "desired services deserving adequate investment," and recognizing "such expenditures" as a "potential economic engine rather than an unproductive drain on resources" (Fleming *et al.*, p. 1037).

The projected shortage of healthcare professionals is alarming, and it seems even more disturbing if one calculates the nation's present dependency on healthcare professionals by the annual healthcare expenditures. In addition to the healthcare expenditures discussed earlier, the U.S. General Accounting Office (GAO) lists some more current statistics on its website. Based on the GAO figures, "expenditures on health-related programs are now one of the

largest components of federal spending, totaling an estimated $433 billion in fiscal year 2001, or about 23 percent of all federal spending that year" (GAO Strategic Plan 2002-2007, 2002). Furthermore, an area of major concern is the dramatic increase in Medicare expenditures, which totaled an estimated $264 billion in 2002. At the current rate, Medicare expenditures are projected to nearly double by 2030, and one portion – the Medicare Hospital Insurance Trust Fund – is projected to begin showing a deficit in 2016 and to be entirely exhausted by 2029 (GAO Strategic Plan 2002-2007, 2002).

Recent news reports focus on the extreme public interest in policy pertaining to prescription drugs. Currently, Congress is in the process of passing legislative reform that may allow Medicare coverage for prescription drugs. However, as is typical with political issues, not everybody is pleased with the most recent legislative attempts to alter current coverage. In a recent CNN news article, S. Turnham (2003) chronicles the most recent round of debate over a new bill before Congress. Turnham contends that the majority of the "$400 billion" price tag on the bill would be for coverage of prescription drugs. However, some Democrats are unhappy about the bill because they feel that it does not adequately address the potential for private insurance to drop prescription drug coverage altogether if the supplemental Medicare bill were passed. Medicare beneficiaries would be required to pay around $3,600 annually out-of-pocket –mainly in a monthly premium and a deductible – before "catastrophic care" would take effect. "Poorer seniors," those earning less than $12,123 annually, would be exempt from both the monthly premium and the $275

deductible. Instead, a co-payment of $2 to $5 for each prescription drug purchase would be required. Turnham states that seniors earning up to $13,470 a year would "also get more generous benefits than wealthier seniors" (Turnham, 2003).

According to the government Aging Statistics website, in 1996, roughly 69% of "non-institutionalized Medicare beneficiaries," had coverage on their prescription drugs through either an HMO plan, Medicaid, a supplemental Medicare plan, or some other source. Those who did not have any coverage had less out-of-pocket and insurance covered expenditures than those individuals with coverage. Out-of-pocket prescription drug expenditures, however, were 83% greater for individuals who lacked coverage all together than for those with prescription drug coverage (Federal Interagency Forum, 2000).

Complementary and/or Alternative Medicine

One area of healthcare expenditures that is not typically covered or reimbursed by most types of medical insurance is alternative medicine; however, this has not stopped alternative medicine from increasing in popularity. In recent years, there has been much focus on the prevalence of the use of complementary and alternative medicine (CAM), and there is an abundance of literature about CAM. However, the vast majority of this literature does not single out the older population. This section deals with the prominence of CAM and touches on some specific articles related to the elderly and CAM usage. In 1991, Congress established the National Center for Complementary and Alternative Medicine (NCCAM), which is now a subsidiary of the National Institutes of

Health, to research "unconventional therapies" (Wilt *et al.*, 2001, p. 150). According to Micozzi from the Harvard Medical School, alternative medicine refers to "those practices explicitly used for the purpose of medical intervention, health promotion or disease prevention that are not routinely underwritten by third-party payers within the existing U.S. healthcare system" (1996, p.5). Micozzi also asserts that this definition is a "diagnosis of exclusion," thus implying that alternative medicine encompasses all that mainstream medicine is not presently promoting (1996, p.5). Defined as such, alternative medicine can include anything from chiropractic approaches to homegrown herbal healing, and excludes mainstream, or conventional, medical treatments.

W. B. Jonas and J.S. Levin (1999), the editors of a book about complementary and alternative medicine, suggest that the primary purpose of the book—"to provide medical and healthcare professionals with useful and balanced information about CAM in general"—is an "ambitious and difficult task" (p. xi). This is due to several factors: first, CAM systems are beneficial in ways that are not easily definable or describable in conventional terms; furthermore, CAM is "characterized by a long-term history of vigorous antagonism; differing standards of education, training, and practice; and lack of consensus as to what constitutes sufficient evidence of safety and efficacy" (Jonas & Levin, 1999, p. vii). Even with these apparent setbacks, further research suggests that CAM use is on the rise in the United States. This coupled with the fact that the National Institutes of Health includes a government-developed center -- the National Center for Complementary and Alternative Medicine (NCCAM) -- to deal with issues related

to complementary and alternative medicine provide major support for the significance of researching alternative medicine.

Although complementary and alternative medicine use is increasingly more common, its utilization by the elderly has not received much attention in research literature. In a 2001 article, E. P. Cherniak *et al.* reported on their study, which included the primary research objective of investigating the "prevalence and predictors of use of CAM by the elderly" (Cherniak *et al.*, 2001, p. 277). A total of 421 respondents drawn from ambulatory geriatric patients at an academic hospital in Manhattan and from an outpatient clinic at a VA hospital were targeted through convenience sampling. The respondents were interviewed using a survey questionnaire examining the "use of CAM by older adults and their perceptions of patient-physician discussions regarding these therapies" (Cherniak *et al.*, 2001, p. 278). The survey consisted of 138 items and explored "current," or use within the past year, CAM use. Independent variables included demographic characteristics like age, gender, ethnicity, religion, insurance status, level of education, marital status, self-reported health status, medical conditions, and use of conventional medicine. Out of the total sample, 58% had utilized some form of CAM; from the academic hospital over 72% had used CAM, while nearly 44% of the VA clinic respondents reported CAM usage. The strongest correlations for use were being female, having more education, the presence of thyroid disease, and the presence of arthritis. Use did not show correlations with income, race, age, or self-reported health status (Cherniak *et al.*, 2001, p. 278-279).

Cherniak *et al.* (2001) noted a higher prevalence of CAM use in this sample of geriatric respondents then previously reported in national surveys. In this group of respondents, CAM use was greater in women and in the more highly educated. The investigators also suggested that because women are the "primary consumers of healthcare in general," (Cherniak *et al.*, 2001, p.279), the same association may hold true for women and CAM use. Arthritis and thyroid disease seemed to be mild predictors for CAM use. The authors note that prior studies by Eisenberg *et al.* (1998) and Rao *et al.* (1999) also singled out arthritis as a predictor for CAM use (Cherniak *et al.*, 2001, p. 279). Thyroid disease in this study was not a predictor among the female-only subgroup, and the researchers were unclear about the reason thyroid disease might be a predictor. The authors also discussed the generalization limitation of the study: the respondents were a convenience sample of ambulatory adults in an urban and ethnically diverse area and not a random sample across the United States.

In another article exploring predictors and patterns of CAM use among elderly persons, Astin *et al.* (2000) surveyed 728 respondents who were voluntary enrollees in a new Blue Shield plan (Shield 65), which is a Medicare risk product that offers coverage for acupuncture and chiropractic treatment. Health Risk Assessment (HRA) data, which was collected in an initial risk assessment at the time of enrolling in the program, was available through Blue Shield for 675 of the 728 respondents. After 12-15 months of enrollment, secondary HRAs were mailed to the 588 members who were still enrolled in the

program; of these, 496 completed and returned the HRA (Astin *et al.*, 2000, pp.M4-M5).

Approximately 41% of the respondents reported some CAM use in the previous year with herbal medicine (24%), chiropractic (20%), massage therapy (15%), and acupuncture (14%) being the most frequently reported types of CAM used. Eighty percent of those who used CAM reported at least some improvement in their symptoms due to the CAM therapies. Alarmingly, nearly 60% were not discussing CAM use with their conventional medical doctors. Some frequently cited health problems related to CAM visits were back problems, chronic pain, general health improvement, and arthritis. The most frequently cited reasons for the seeking CAM therapies "in general" included dissatisfaction with conventional medicine, pain management, and fear of drug side effects. The major predictors for seeking CAM included the following: higher level of education; being younger; reporting either arthritis and/or depression/anxiety; not being hypertensive; engaging in exercise; practicing meditation; and making more frequent doctor visits (Astin *et al.*, 2000, pp.M5-M7).

Based on the health risk assessment data taken from the two time points, the researchers were able to gather changes in health status of the respondents. Of CAM users reporting on their general health status, 26% reported a worsening, 7% reported an improvement, and 67% reported no change. Similarly when compared to the nonusers of CAM reporting on general health status, 28% reported a worsening, 10% an improvement, and 62% no change.

Fifty percent of the respondents wanted coverage for chiropractic, 43% for massage, 33% for acupuncture, and 31% for herbs. Twenty-six percent of the respondents reported that they had enrolled in the program because of its chiropractic coverage, and 20% enrolled because of the acupuncture coverage (Astin *et al.*, 2000, pp.M5-M7).

Astin *et al.* (2000) suggest that a significant amount of seniors are both interested in and utilizing various forms of CAM. Additionally, Astin *et al.* note that lack of communication between healthcare providers and elderly patients is a major concern. This may point to a poor level of communication between patients and their physicians, and also suggest that patients are fearful of disclosing such information. Furthermore, without open communication about CAM use, doctors and patients will be less aware of potential negative interactions between their conventional and CAM treatments. Thus, the authors point to the importance of improving and encouraging discussion of CAM use between the elderly and their physicians Astin *et al.* 2000, M7-M8).

Migration and Seasonal Winter Visitors

To better approach the topic of migratory winter visitors to the Rio Grande Valley, I thought it important to review some of the literature surrounding these nomadic seniors. In a 2001, C. F. Longino, Jr., touches on the study of what he deems "cyclical migration". Longino suggests that "intellectual interest" first spurred the "study of migration" (2001, p.103). The body of knowledge surrounding retirees who move developed, at first, out of curiosity rather than out of necessity; however, more recently, this trend has begun to change. According

to Longino (2001), "an increasing number of states have begun deliberately, and sometimes vigorously" recruiting retirees from other regions "as a part of their economic development policies" (p.103). Although the Census Bureau does monitor the number of individuals who fill out their census forms away from their primary residence, this number has not been further grouped by age. Fortunately, many local communities – including some in Texas, Arizona, and Florida – have engaged in surveys of migratory seasonal visitors.

According to K. E. McHugh and R. C. Mings (1996), in the past, there was "an implicit assumption in the literature that aging in place and migration are mutually exclusive options for the elderly (p.530). McHugh and Mings introduce an alternative way of viewing seniors: "the notion that elders may reside in multiple locales, forging place attachments and experiences via seasonal migration and recurrent mobility (1996, p. 530). In a longitudinal study, the authors use "biographical portraits" of five couples that migrate between summer and winter homes to illustrate the "attachment to place among the elderly" (McHugh & Mings, 1996, p. 531). McHugh and Mings (1996) maintain that there are three major phases in the circle of migration: separation, experience, and return (p. 531).

Separation deals with the concepts of "home and journey" (McHugh & Mings, 1996, p.538). Home, according to McHugh and Mings (1996) involves a feeling of "rootedness, long habitation in a place" and "is also a state of mind centered on a sense of belonging and security" (p.538). One couple reported that although they are rooted in their ancestral home in North Dakota, they also

feel at home in their Arizona winter home. This is due to the ability to form friendships and "religious fellowship". In contrast to -- or "challenging" -- home is the "celebration of journey and the call to adventure" (McHugh & Mings, 1996, p. 538).

McHugh and Mings (1996) also report on three varying degrees of in place attachment: "still rooted, suspended, and footloose" (p. 538). Six out of the twelve couples interviewed are rooted. That is, they have a "life-long bond to their home community" (McHugh & Mings, 1996, p.539), are deeply satisfied with this bond, and typically have never considered relocating permanently. Three out of the remaining six are suspended. These couples have more emotional turbulence when it comes to migrating. According to McHugh and Mings (1996), suspended snowbirds show "signs of loosened moorings in long-term homes" and "are in transition or flux regarding commitment to summer and winter communities" (p.539). Finally, the last three couples are considered by the authors to be footloose. These couples have been more nomadic through the course of their lives, and "they are not rooted in any particular place"; thus, "mobility in retirement...is an extension of a migratory lifestyle initiated as young adults" (McHugh & Mings, 1996, p. 539).

The migration experience involves "place-making" and "personal and collective identity" (McHugh & Mings, 1996, p.539). Place-making occurs in varying forms, but when seasonal visitors travel to locations and create winter or retirement communities, they "engage in place-making" (McHugh & Mings, 1996, p. 539). Identifying one's self based on location or place "reflects both personal

and collective dimensions" (McHugh & Mings, 1996, p. 539). "People-place bonds are reflexive (McHugh & Mings, 1996, p. 539)," so once a person ascribes meaning to a place, he/she derives a sense of personal identity from the place. Additionally, winter visitors are embedded in a community by which a collective identity is defined. Typically, RV parks -- where the winter visitors reside -- are age segregated and "inhabited primarily by middle-income, active elderly, most of whom share a history of RV travel"; therefore, these same communities characterize "enclaves of an aged subculture" (McHugh & Mings, 1996, p. 539).

Finally, McHugh and Mings discuss the concept of return -- "the resolution of tension between home and journey" (1996, p.542). Depending on the individual winter visitor's circumstance of return, return may be "experienced as an annual event and may also represent a final journey home" (McHugh & Mings, 1996, p.542). Events such as a decline in health, financial burdens, family crises, or simply "changing interests may lead to a cessation of seasonal migration" (McHugh & Mings, 1996, p.542). Many of the couples in this study felt that at some point, they may be "required to amend their migratory lifestyle and settle in place" (McHugh & Mings, 1996, p.542). For those rooted visitors, this may mean a permanent return to the "home that has nurtured and sustained them" (McHugh & Mings, 1996, p.542). However, the suspended couples may choose to settle either in their place of origin or in the location of their winter homes. In closing, McHugh and Mings suggest that "embedded in our life-course trajectories" are ideas that "have relevance beyond elders who seasonally migrate" (1996, p. 546). Our early life experiences can "set individuals on

divergent paths that are amplified over the life course" (McHugh & Mings, 1996, p.546).

Rio Grande Valley Winter Visitor Research

In an attempt to narrow my review of literature and begin to focus on my actual topic of research, I have included the following data summary from an annual research project that targets my same population -- the senior winter visitors to the Rio Grande Valley. At the University of Texas-Pan American's Center for Tourism in Edinburg, Texas, Dr. Vern Vincent and his colleagues engage in an annual survey that includes winter visitor respondents. The survey was partially conducted at three local area malls where the winter visitors are targeted, and RV park managers in the Rio Grande Valley completed another portion of the survey. Highlights of the results for the most recent survey (2002-2003) can be obtained through a link at the Center for Tourism's website, www.cobra.panam.edu/tourism. The majority of the results are descriptive statistics including questions on location of origin, time spent per year in the Rio Grande Valley, and annual income. The key goal behind the study is to obtain economic information related to tourism in the Rio Grande Valley.

In the most recent report that included 1,878 respondents, there were an estimated 123,000 -- down 14% from 143,000 two years ago and down seven percent from last year -- winter visitors to the Rio Grande Valley during the fall 2002, spring 2003 season. The winter visitors for this same time period pumped an estimated $250 million into the local economy; however, this was a $79 million decrease from two years past. The majority of respondents came from the

Midwest and remained in the Rio Grande Valley for an average of 3.5 months. The respondents' median annual income was approximately $45,600.00. The average amount spent on the current year's trip to the Rio Grande Valley was $4,100.00. The respondents made approximately 5 trips to Mexico during their stay in the Rio Grande Valley. On average, this was the 8th trip to the Rio Grande Valley for the respondents, and the majority of them have plans to return for the 2003-2004 year. However, as many Rio Grande Valley winter visitors are repeat visitors, and the 1st time visitors totaled only 6%, -- down 4% from the 2000-2001 season -- the report suggests that the next few seasons may continue to show some decline in winter visitors to the area. Acccording to the website summary, respondents cited three major indicators that might affect their decision to return to the Rio Grande Valley: 1) health issues, 2) terrorism threats, and 3) poor performance of the economy (Vincent, 2003).

## CHAPTER 2

### *Methodology*

#### Sample

After running into many winter visitors in the Rio Grande Valley and subsequently noticing the absence of a majority of the aforementioned population during the summer months, I began to realize how the demographic landscape of this area changes during the onset of winter and then again when the warm winds of summer begin. Because I have acquaintances that are winter visitors, I casually spoke to a few of them about an idea I had to research healthcare in the Valley. This group of people seemed particularly pleased that somebody might actually want to research them, and as health is such a salient concern to seniors as well as the general public, researching health/healthcare seems a valid problem. Additionally, as I began to dig a bit deeper, it became apparent that winter visitors are not really a target population for studies. Although this study focuses on healthcare, the winter visitors are just teeming with compelling topics to be researched.

I developed my research focus of the population of winter visitors to the Rio Grande Valley of Texas. However, I had little clue as to how and where I might access this group. The Rio Grande Valley is home to a large number of RV/Mobile home parks, and according to the University of Texas-Pan American

Winter Visitor Study, the majority of winter visitors (81%) live in RV trailers or mobile homes. Consequently, I decided to choose RV parks as the sampling frame. The target population has become visible and known in the RGV as a focused cluster of individuals; thus, it seemed reasonable to assume that relatively high level of homogeneity exists among the winter visitors. Additionally, my research perspective is exploratory and descriptive, since I had to deal with a serious time constraint of collecting data in the middle of the Spring (close to the point of a mass exodus of winter visitors returning to cooler regions). Given these serious limitations, random sampling was not viable for this study. Instead, I decided on convenience sampling, and I also ended up using the snowball technique to gain access to some of my respondents. However, I did end up drawing the majority of my respondents from a park in the lower Rio Grande Valley, two in the Mid Valley, and a fourth in the Upper Valley.

Although convenience sampling (or availability sampling) and snowball sampling do not allow much room for inferences to the target population, I felt that the sampling procedures used to select the sample were appropriate. This study was not intended to be explanatory in nature; thus, the use of probability sampling was not necessary. Additionally, because some winter visitors may have already exited the Valley for the season, at this point in time, a truly representative sample -- even through the most rigorous random sampling procedures -- seemed highly unlikely. Furthermore, during my perusal of prior published literature on my research topic, I was unable to locate any research on the healthcare trends or general health status of winter visitors to the Rio Grande

Valley. Therefore, my sampling technique was tenable in that the research goal was to investigate prevailing attitudes and trends that had been previously unexplored.

Questionnaire

As mentioned above, the research design for this study includes a self-administered questionnaire of 115 participants recruited to the study from a convenience sampling technique. I decided to use a self-administered questionnaire precisely because of time constraints, in-depth interviews with 100+ subjects was just not feasible. In addition, as addressed later, I had the initial intention of conducting the survey in an interview fashion, and the winter visitors I approached at one RV park were not receptive to that idea. The data collection instrument is a twelve-page survey consisting of 26 question areas (some with multiple sub-questions). The survey includes basic demographic questions, questions about types of medical payment (i.e., private insurance, Medicare, etc.), questions about general health status, questions about specific types of illnesses (including the Center for Epidemiologic Studies Depression scale -- CES-D -- a 20 question depression index), questions about healthcare treatments (conventional and alternative) and attitudes about these treatments. A large portion of this questionnaire was completed through the generosity of Dr. Elena Bastida and the University of Texas-Pan American's Minority Biomedical Research Support Program (MBRS). Dr. Bastida allowed me access to her questionnaire so that I could model my questionnaire after the UTPA MBRS questionnaire used in a longitudinal study on Rio Grande Valley residents.

Most of the questions are close-ended, and others are open-ended questions. In several areas of the questionnaire, question sets are included to get a better understanding of the respondent's experience -- of lack of -- with alternative medicine. Finally, the Center for Epidemiologic Studies Depression Index (CES-D) was added to the survey to measure the concept of depression in the respondents. The levels of measurement used to obtain data in this survey are nominal, ordinal, interval, and ratio. The questions flow progressively from more general information, such as age, date of birth, and level of education to the more specific information of specific illnesses and treatments thereof. In order to complete this research, the mandatory research application was submitted to the University of Texas-Pan American's Institutional Review Board (IRB) for approval. Additionally, as per the IRB, I completed some online tutorials on research involving human subjects. Finally, as per IRB requirements, I created an Informed Consent Form clearly outlining in detail my research intentions to the participants.

At the end of the survey, there was an option for the subject to include his/her first name only and contact telephone number if he/she wished to further discuss the topic of alternative medicine (this being defined as "medicine/therapies other than conventional mainstream medicine"). If he/she opted to fill in this information, in order to maintain confidentiality, the subject was instructed to tear/cut this paper from the survey and turn it in separately to the survey facilitator. If the subject was not comfortable providing this information, he/she was also given the option of contacting the principal investigator via the

listed telephone number. Subjects were instructed to read and subsequently sign the Informed Consent Form prior to answering any questions on the survey. Two copies of the consent form were provided to the subjects; one was clearly marked "your copy." In addition, the final page of the survey included a thank you from the investigator to the subjects, and the subjects were again instructed on how to turn in the survey. In these instructions, it was noted that the copy of the Informed Consent Form marked "your copy," was the subject's copy for his/her own records. Subjects were told to complete the survey, tear off both Informed Consent Forms, turn in the signed top copy of the Informed Consent Form and the survey (as well as the optional contact information for further discussion, if so desired) to the survey facilitator, and keep the second Informed Consent Form for their personal records.

Field Experience and Participant Observation

As mentioned, I utilized participant observation to complement my research. The participant observation was not used to construct the questionnaire, but rather to inform the data and add to the description of my sample and the setting. Through this qualitative arm of research, much was learned. It is not an easy task to engage in research, in general; however, it is -- in some circumstances -- extremely difficult to penetrate the real world. The following detailed account includes my experiences, and subsequent observations, in the field.

The first people with whom I connected were a local winter visitor couple that I've been acquainted with for several years. Through this couple, I was able

to meet with their RV park director and activities coordinator, who granted me the actual access to one of the Mid Valley park's weekly meetings. The park director suggested that I come early to the meeting and begin going table by table with my questionnaire to find interested candidates. Because this was my first real attempt at data collection in the "real world," it was intimidating to actually go up and ask each table of winter visitors if they would be interested in participating in my interview. Additionally, even though the park director had briefly acknowledged my presence at the meeting, I was hampered by the lack of an audible introduction and explanation of my intentions. Several of the individuals at the tables were nearly unapproachable, and at first, I felt overwhelmed and discouraged. However, after expressing my concerns to the director, I was able to gain more direct access to the visitors through a formal self-introduction on the PA system.

I had hoped to leave the meeting with some completed questionnaires in hand and a few subsequent scheduled interviews; however, to my surprise, the majority of the people that I approached were not interested in participating in the survey if I had to administer it to them. The fact that these individuals were somewhat reluctant about participating in face-to-face interviews was consistent with ethnographic research; however, I still needed to collect the data. Thus, I had to come up with a spontaneous alternate way of conducting the survey. After a brief discussion with the park director and my acquaintance, it was decided that the survey would be self-administered and hand-delivered to the park office in-box (with signed consent forms separated from the survey to

ensure anonymity). Initially, I had intended to use incentives to encourage people to participate in my study; however, my acquaintance assured me that incentives were not necessary at her particular park. Several days after my initial visit to the park, I was able to obtain 25 completed questionnaires.

The second park I accessed, which is located in the Upper Valley, is a much larger park located in the than the first, and this park happened to have its own health coordinator. The park manager spoke with me via telephone conversation, and referred me to the health coordinator. After our initial phone discussion in which I briefly explained my research intentions, the health coordinator asked me to meet with him in-person to further discuss my research plan. As with the first park, I brought up the topic of participant incentives, and this time, the idea was welcomed. The health coordinator felt that with such a large park, the diversions and distractions were of such multitude that the winter visitors might need an extra nudge to spur their participation in the study. Rather than spend money on expensive, novelty type incentives, the health coordinator suggested I opt for more economical gift certificates to places that winter visitors frequent. Accordingly, I purchased the following three prizes to award to randomly drawn survey participants (based on their signed consent forms): 1st prize - Golden Corral Gift Certificate; 2nd and 3rd prizes - Barnes and Noble Gift Certificates.

After deciding upon the incentives, the park manager (through gentle nudging by the health coordinator) allowed me access to the park's weekly meeting, and building from my experience with the first park, I decided to have

them self-administer the questionnaires. Interestingly, this was a park that I chose to cold call from the phone book (along with about 6 others) and as with the other cold called parks, this park told me that they were booked for guest speakers at their meetings. One park even told me that they charge $250.00 to individuals who want to come in and promote themselves to the visitors. However, after I gained access to the current park, I realized that perhaps the aforementioned park had the misimpression that I intended to market something to them. At the meeting, the health coordinator introduced me to the park residents in attendance and allowed me to explain a bit about my research. Potential participants raised their hands to receive a questionnaire, and then I gave them some guidelines for completing the questionnaire and returning it to a box in the health coordinator's office. In accordance with the larger number of park members at the community meeting, which enabled me to distribute a greater number of questionnaires, the majority (56) of my respondents came from this park.

Notably, at both this park and the first park, winter visitors approached me afterward to inquire more about my research. A recurring theme in our discussions centered on how the park residents feel somewhat ignored when it comes to health-related research. Additionally, some residents were under the impression that my research was directly connected to the medical community here in the Valley and that their participation in the questionnaire might result in some policy- making/changing within the medical community. However, I quickly let these individuals know that the purpose of this particular questionnaire was

more exploratory or descriptive in nature; however, I did mention that perhaps future research could address more specific issues that are pertinent to the winter visitor population (as seniors and/or tourists).

My third sampling setting involved a local area church that receives quite a boost in attendance during the winter visitor season. This church has more of a "new age" spiritual slant to its program, and I included this church to see if there were any obvious disparities in the respondent's experience with alternative medicine based on religious affiliation. However, as further discussed, the number of completed questionnaires from this location inhibited my intentions. The gatekeeper in this situation, another personal contact, assisted me in gaining access to the church's board of directors who ultimately permitted me to come to the church one Sunday and make a formal announcement about my research. The President of the board suggested that I offer an "amigo" meal to encourage participation in my questionnaire. The following Sunday, I returned to the church with my questionnaires and lunch for any potential respondents. At the beginning of the service, the platform host announced my return, and members were invited to the Fellowship Hall for complementary lunch as they filled out their questionnaires. There were not nearly as many interested church members as I had anticipated, so I left the church with very few questionnaires completed and a lot of left-over food; however, I was not greatly discouraged as the number of completed questionnaires from the second park was higher than expected. Additionally, I had one more source of participants, and this source was extremely enthusiastic about assisting me in my research endeavor.

A fourth, unexpected contact emerged during my participation at a forum held by the local Area Agency on Aging. A fellow graduate student introduced me to a nurse who happened to be a winter visitor from Canada. After briefing her about my intended survey, my contact expressed her willingness to assist me in accessing more respondents. Prior to leaving the forum, we exchanged telephone numbers. After we visited a couple of times via telephone, the woman offered to take some blank questionnaires to her own RV park – located in the Lower Valley – rather than have me come into the park and facilitate the questionnaire distributing process. Unlike my first RV park contact, the nurse did not feel comfortable having me approach the park manager about accessing the park directly. This contact worked and lived in the lower Valley; thus, I made a short road trip to leave the questionnaires with her at her office. After a couple of weeks, she telephoned to say that the questionnaires were completed, so we agreed to meet again in Harlingen for dinner and the questionnaire exchange. Surprisingly, her snowballing resulted in 24 completed questionnaires!

Finally, 7 of my questionnaires came through a close contact that agreed to distribute questionnaires at a Mid Valley RV park dance. These questionnaires were distributed over a 3-week period and the completed questionnaires trickled in gradually. This less structured way of distributing the questionnaire at RV parks was not as effective as the format used at the first three RV parks. This may have been due to several factors. The potential respondents were in an environment where they intended to be entertained and have a good time rather than to receive information or to be recruited for a study.

Additionally, the individuals were charged upon entry to the dance, and there were no incentives offered to encourage their participation in the questionnaire. Finally, the potential participants might have responded more readily if I had actually been present to explain my research goals. In spite of these considerations, the dance data-gathering process did yield slightly better results than my data-gathering attempt at the church.

Through my visits to the RV parks, I gained an inside perspective (albeit minute in comparison to those who live in the parks) on some activities that promote health, whether intentional or latent. Special events and activities abound at the parks. As one manager said, they have numerous activities almost every day of the week, and the turnout at these events is quite high. A smaller park that I visited had roughly 20 couples lined up playing (or waiting to play) shuffleboard before the weekly meeting. My acquaintance at that park said that in comparison to the season peak for winter visitors, this number was nominal! According to the larger park I visited, it is the only park in the Valley that has its own healthcare coordinator. This park has been touted as "the healthiest" RV park in the Valley. The healthcare coordinator told me that the park had recently acquired one of a limited number (5or 6 at the time, I believe) stand-alone heart defibrillators, and that the park had on call 5 volunteer couples who had been trained and certified through the park in CPR and first aide.

Additionally, this park has at least one dance per week, and the tables are full at this dance. On a side note, I have a personal contact that plays in a band that performs for such dances, and I had the opportunity to attend a dance at this

same RV park one Saturday night last winter. The dance floor was packed the entire time with twirling partners who danced to anything from bohemian polkas to country and western waltzes to classic rock-n-roll! The dance lasted for 3 hours, and the numbers on the dance floor never dwindled. This is not the only park that hosts such activities, as my contact's band alone performs 3 nights a week at different parks throughout the Valley.

In addition to an inside perspective on activities within the parks, I also experienced firsthand the social networks of some parks. During the weekly meeting of my visit to the smaller park, a woman stood up during announcements and said that her friend, also a park resident who had already returned home, appreciated everybody's support and sympathy regarding the death of her daughter. This woman read from a thank you note that the woman had written specifically for the park residents. It was heartrending letter, after which, even I had watery eyes and a stuffy nose. Similarly, at the larger park, a recently widowed woman stood up and thanked everyone personally for their support, kindness, cards, flowers, and food (she quipped that she had gained weight from all of the dishes that her fellow residents had brought/sent) during her husband's illness and after his subsequent passing from cancer. This woman told a joke about conversation she'd had with her husband just days prior to his passing. She told him that when he passed, she knew that he was going to heaven to be with his first wife, and that when she passed, she would go to heaven to be with her first husband. However, she asked him, if it wasn't too much trouble, if the

two of them could meet secretly sometimes and carry on an affair. Again, in the course of my visits, it was a poignant moment.

Research Limitations

Limitations are always an important part of research presentation, and my research has several limitations. First, as previously mentioned, my sampling procedures do not allow much room for making inferences or generalizations back to any population; however, this limitation is not a real threat as this research is not explanatory, but rather exploratory and descriptive. In addition, the assumed higher level of homogeneity of this group may effectively cancel out the aforementioned limitation. Second, because my sample is not necessarily representative of the population of winter visitors to the Rio Grande Valley, subsequent replicate research might yield slightly different results. However, again, due to the assumption of a high degree of homogeneity among the winter Texan population, this limitation may not be crucial.

Dataset Creation & Analysis

My original sample goal was 100 respondents; however, after collecting all of the completed questionnaires, I actually ended up with a sample of 115. The statistics software package used for data entry is SPSS 10.0 for Windows. Because some of the 26 question areas were subdivided into several items (including filter type and contingent questions), I have over 150 variables in my data when each instrument item is considered separately. Additionally, as this was an exploratory project, I wanted to ask a wide variety of questions so that I could investigate any subsequent, interesting patterns in the data. I wanted to

use Dr. Vincent's UTPA Winter Visitor Study as a comparison device for some of the descriptive data; thus, I ran common descriptives and frequencies on the data to get some general information about the breakdown of gender, age, income level, education level, and religious affiliation. Afterward, I decided to run frequencies on nearly all of my questions to identify emerging patterns. Due to general health trend statistics for the general population of the 65+ cohorts, I also wanted to compare the most common illnesses reported by my sample to that of the CDC's national statistics; consequently, I looked closely at patterns in the data's health status. In an attempt to evaluate the health patterns more effectively when comparing to the CDC data, I isolated two age cohorts from my sample (the *61-70 years old* cohort and the *more than 70 years old* cohort). While inputting my questionnaires, I created a separate data set for the CES-D index because I needed to enter the raw scores and then formulate the actual index score for each respondent. I performed the creation of my data set(s), as well as all of the input, manually.

# CHAPTER 3

*Findings from the Questionnaire*

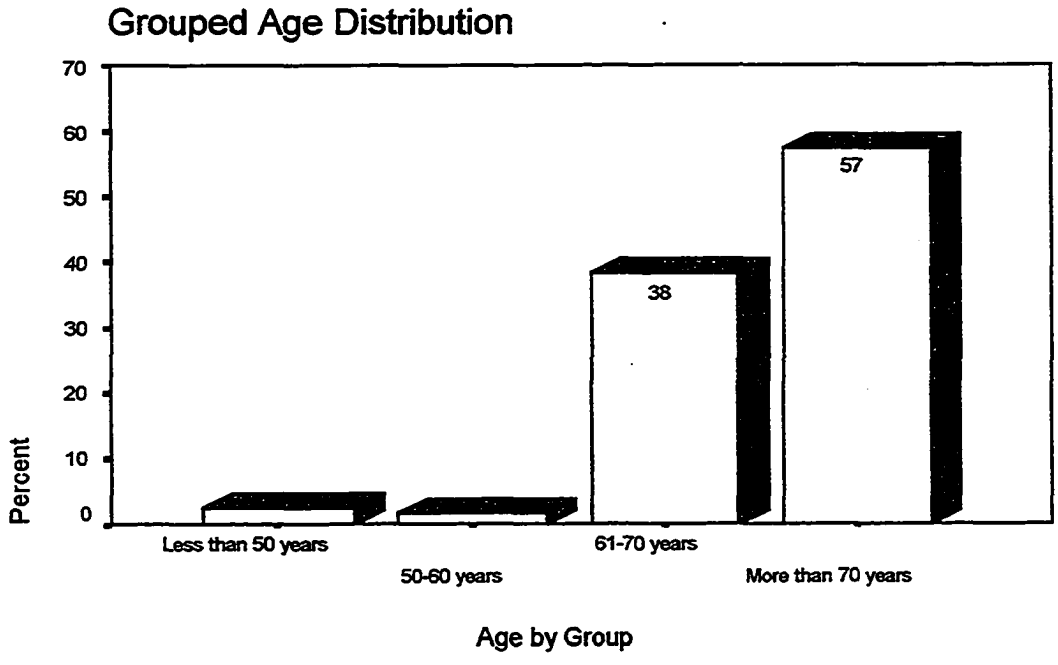
The following section discusses data and findings from the self-administered questionnaire. SPSS software was used to analyze the data. Included are various tables and charts to illustrate the frequencies and/or descriptives related to this dataset.

General Information

Table 1.1 (on the following page) is a bar graph illustrating grouped age distribution. As illustrated, the majority of the respondents – 57% – were over the age of 70 years old. The second highest percentage of respondents -- 38% -- was from the 61 to 70 year old cohort. Finally, the two younger cohorts of less than 50 years and 50 to 60 years included less than three percent and less than two percent, respectively.

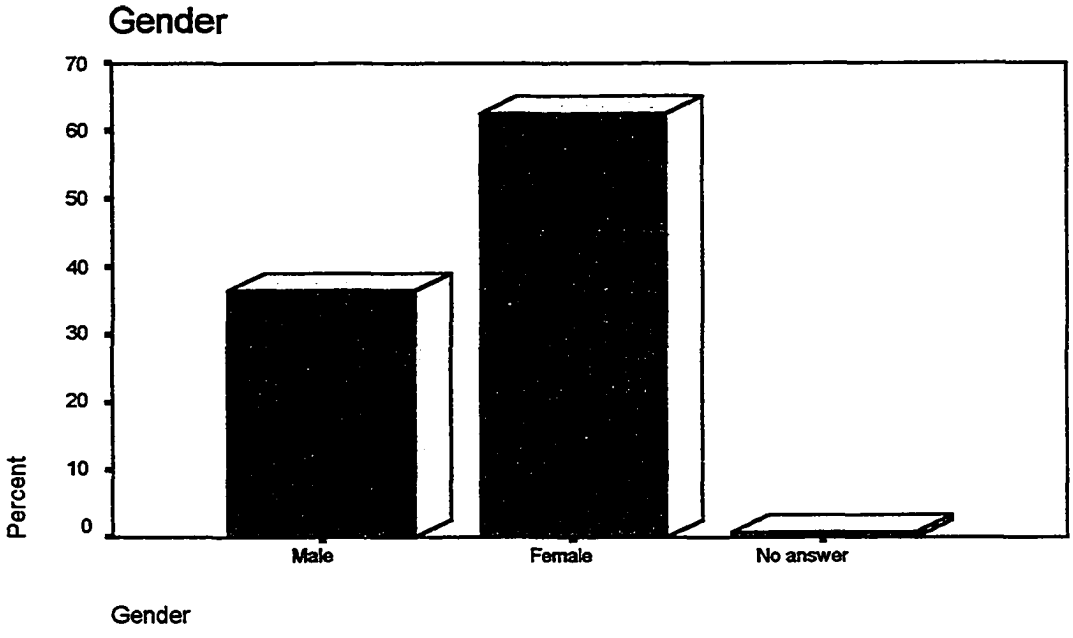
Table 1.1 - Grouped Age

Distribution




The following table, Table 1.2, illustrates the gender of the respondents. In keeping with the existing body of knowledge regarding the mortality rates for men and women, the majority of the respondents (72) were female, which represented nearly 63% of the total sample. Males represented only 36% of the total participants with a total of 42 males participating in the study. This higher number of females may be due to a number of factors including the mortality rate discrepancies between females and males, and/or that more females than males were open to participation in the questionnaire.

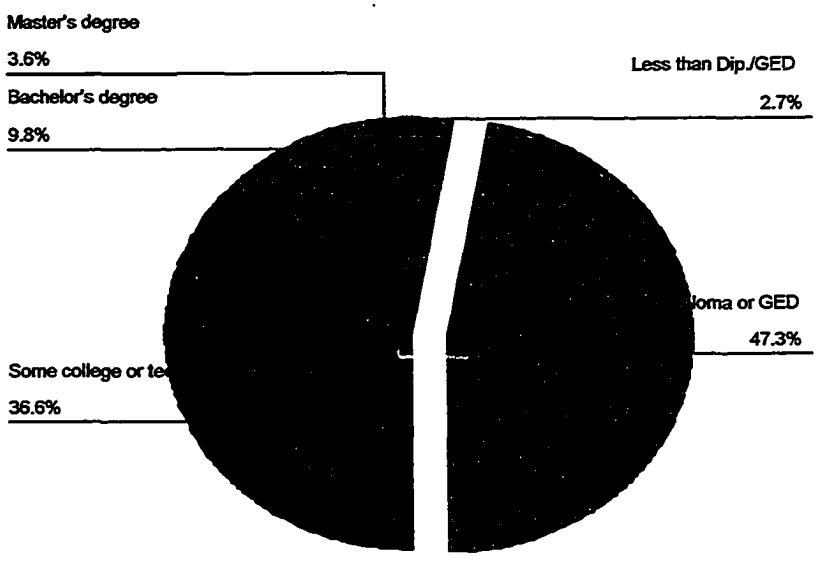
Table 1.2 - Breakdown by Gender




A total of 83 respondents (72.2%) spend from 3-5 months in the Rio Grande Valley, while 29 (25.2%) spend 6 months or more in the area. Only 2.6% of the respondents reported that they spend less than 3 months in the Valley. When assessing the length of time respondents have been coming to the Valley, it was found that 47.8% of the respondents have been coming for over 12 years. Thirty-two percent of respondents have been traveling to the Valley for 7 to 12 years, 16.5% of respondents have been coming for 2 to 6 years, and 3.4% of the respondents have been coming for less than 2 years.

The following pie chart (Table 1.3) represents the distribution of the sample based on level of education.

Table 1.3 - Level of Education




As noted, 47.3% of the respondents earned a high school diploma or GED, 36.6% attended some college or technical school training, 9.8% completed a Bachelor's degree, 3.6% completed a Master's degree, and 2.7% had less than a high school education.[1]

The following pie chart (Table 1.4) includes a breakdown by average annual income level for the past 3 years.

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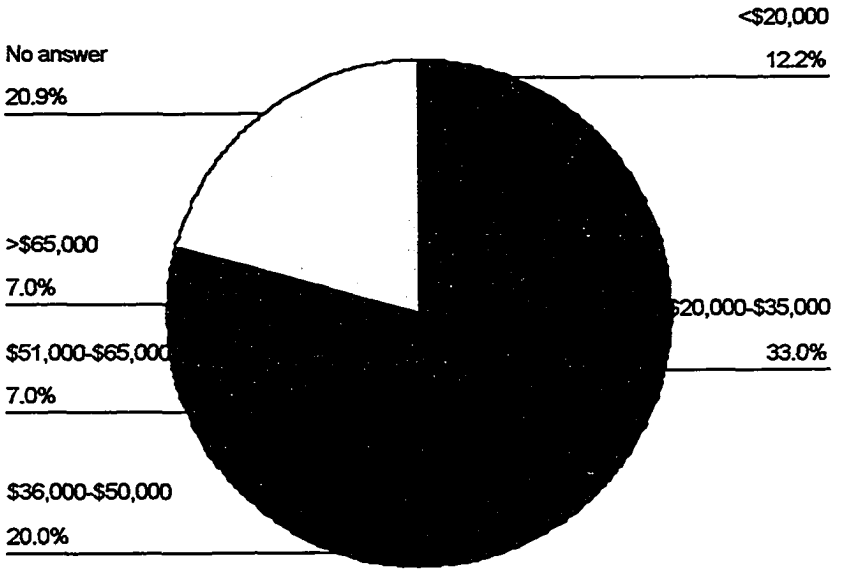
[1] Excluded from the pie chart, 3 individuals marked "no answer" to the question regarding level of education. On a note, one of the respondents included a letter addressed to the researcher with feedback about the questionnaire. This same individual approached the researcher at one of the RV park meetings and said that he was a retired professor who taught for over 30 years. Therefore, it is tenable to assume that on of the three respondents who marked "no answer" may be this same gentleman.

Table 1.4 - Income Level




As indicated by Table 1.4, the largest percentage of respondents identified themselves as earning anywhere from $20,000 to $35,000 for the last five years. Other than the "no answer" option, the second largest percentage of respondents identified with the $36,000 to $50,000 category. Roughly 12% fall in the less than $20,000 category, and both the $51,00 to $65,000 category and the more than $64,000 category have seven percent each.

Healthcare Payment Options

The following section highlights trends in the types of payment options that are available to this sample of winter visitors. Approximately 23% of the respondents utilize cash when paying for their medical care. Medicare coverage extends to about 81% of the sample; over 75% of respondents with Medicare have the plan that covers hospitals, and 74.8% have the plan that covers

doctors. In keeping with their higher income levels, less than 4% of the respondents have Medicaid coverage. This question was asked in two different areas of the questionnaire. Of interest, 3.5% gave no answer to the question appearing the first time, but the second time, the exact same percentage of respondents answered "yes" to having Medicaid.

Over 63% of the sample indicated that they are covered under some type of private insurance plan. Just over six percent of the respondents have Veterans coverage. When asked about unpaid medical bills, the majority of respondents (83.4%) indicated that they do not have any unpaid medical bills that are not covered by insurance or other payment programs. Less than 10% of the respondents answered "yes" to the question of unpaid medical bills not covered by insurance or other payment programs.

Conventional Healthcare – Experiences With and Attitudes Toward

To gauge this sample of winter visitors' experiences with and attitudes toward conventional healthcare, several categories of questions were included in the questionnaire. When asked whether or not the respondents have a regular doctor that they visit in the Rio Grande Valley, 62% replied "yes." When asked about the most recent visit to a doctor, 81.7% of the total sample responded that they had seen a doctor in the last 6 months. When combined with the number of respondents in the total sample who responded that they had a doctor visit in the last 12 months, over 92% of the sample were included. Seventy-nine percent of respondents indicated that they experienced no difficulty in locating a doctor in the Rio Grande Valley. Only 2.6% of respondents responded that they had

experienced difficulty locating a doctor in the Rio Grande Valley. In comparing the cost of healthcare in the Valley with that of their primary residence, 51.3% of respondents reported that the Valley and their primary residence are roughly equivalent in price. Nineteen percent responded that the Valley is more expensive, while only 3.5% of respondents feel that healthcare in the Valley is less expensive than that of their primary residence. Twenty percent of respondents did not know how Valley healthcare compares in price to that of their primary residence, and the remainder (6.2%) of respondents marked "no answer" or did not mark anything.

When asked to rate the quality of the medical attention they receive while at their primary location of residence, 77.4% of respondents indicated that the medical attention was satisfactory, 18.3% reported that it was average, 4.3% marked "no answer" or did not answer. None of the respondents reported that the medical attention received while at their primary location of residence was unsatisfactory. When asked to rate the quality of healthcare they receive while in the Valley, 53% of respondents indicated that it was satisfactory, 17.4% felt is was average, 12.2% said that they do not know, 12.2% marked "no answer" or did not answer, and 5.2% indicated that it was unsatisfactory. While in the Valley, winter visitors often make trips to Mexico, and sometimes, these over-the-border visits result in medical care/services expenditures. To get an idea of healthcare related places the respondents visit, some questions about medical attention received in Mexico were included in the questionnaire. Twenty-six percent of the respondents reported that they received medical attention in

Mexico. When questioned more specifically about the type of medical attention received, 24.3% of the total sample reported going to the dentist in Mexico, and 23.5% reported going to the pharmacist.

Non-conventional/Alternative/Cultural Healthcare

This section highlights findings related to non-conventional healthcare. There were three major sets of questions on non-conventional healthcare. The first category dealt with healthcare other than conventional medicine. Nearly 29% of respondents said that they had utilized healthcare other than conventional medicine at some point in time. The most popular type of non-conventional healthcare was chiropractic, with nearly 21% indicating that they had utilized a chiropractor at some point. The second most popular type of non-conventional healthcare was acupuncture, with which just over five percent of the total respondents identified. Tied with acupuncture was massage therapy, with which 5.2% of all respondents identified. Finally, the health/nutrition establishment was identified by two percent of respondents. None of the respondents indicated that they had utilized a faith healer/practitioner, a homeopathic doctor/practitioner, magnetic therapy, or a nutritionist (although, as mentioned above, a small number did visit a nutritional establishment). A subsequent question on non-conventional healthcare, which was worded in a different manner than the previous general question on healthcare other than conventional medicine, received even less response.

Only 13.9% of respondents replied affirmatively when asked whether or not they had utilized alternative healthcare. At this point, if the respondent had

utilized alternative healthcare, he/she was asked to list the type rather than choose from a pre-determined set of answers (as with the question on healthcare other than conventional medicine). The answers included "back pain center," "celethcon," "chiropractor," "herbal supplements," "nutritional," "visualization," "vegan diet," "physical therapy," "exercise," and "St. John's wart." The term "celethon" was not familiar, and further research into the term turned up nothing illuminating. When asked about their level of satisfaction with alternative healthcare, respondents indicated the following: six percent of the total respondents answered that they were satisfied with the healthcare, about two percent answered that the healthcare was "okay, but nothing changed" in their health condition, and .9% (1 respondent) indicated that he/she was dissatisfied with the healthcare. Seven percent of the total respondents indicated that they used alternative healthcare regularly in the past year, while 1.7% used alternative medicine irregularly in the past year.

In order to gauge to what extent winter visitors have penetrated the cultural landscape of the Rio Grande Valley in terms of non-conventional healthcare, a section was included on the questionnaire asking about respondents' experience with cultural healthcare. Some examples were included to trigger any recognition in the respondents. These included curanderos, bone-setters, and herbal healers/yerberías. Only 1 respondent indicated any experience with this type of medicine. The respondent identified the type of cultural healthcare as ear candling. When asked about the respondent's level of satisfaction with the healthcare, he/she answered that he/she was satisfied with

the healthcare. The questionnaire included a question on whether or not respondents continue to use this cultural healthcare while away from the Rio Grande Valley, and the responded indicated that he/she does still utilize the healthcare. When asked how the healthcare is obtained when not in the Rio Grande Valley, the respondent answered that he/she obtains the healthcare (or in the case, supplies for the treatment) from a health food store.

Health Status, Depression, and Illness

When asked about physical health status, over 70.4% of respondents answered that they feel their present state of physical health is about the same compared to five years ago. Nearly 16% said that their present state of physical health is worse than five years ago, while 11.3% said that their present state of physical health is better than five years ago. When asked a similar question comparing their present physical health status to one year ago, 74.8% answered that it was about the same, 13% said it was better, and only 2.6% indicated that it was worse. Regarding surgery or testing requiring an overnight hospital stay, 41.7% answered that they had stayed overnight in the hospital in the last five years. Roughly 58% said that they had not stayed in the hospital overnight in the last five years due to surgery or testing. Of the respondents who answered that they had stayed overnight in the hospital in the last five years due to surgery/testing, 48% said that their overnight stay was at a Rio Grande Valley hospital. Twenty-five percent said that the stay was at a hospital in the location of their primary residence. Seventeen percent of these respondents said that their hospital stay was in another location, and about 6.3% said that they stayed

overnight in hospitals both in the Rio Grande Valley and in the location of their primary residence. Common reasons for staying overnight in the hospital in the last five years included knee replacement surgery, back surgery, blood clots, broken bones, heart-related surgery, and cancer-related testing or treatments.

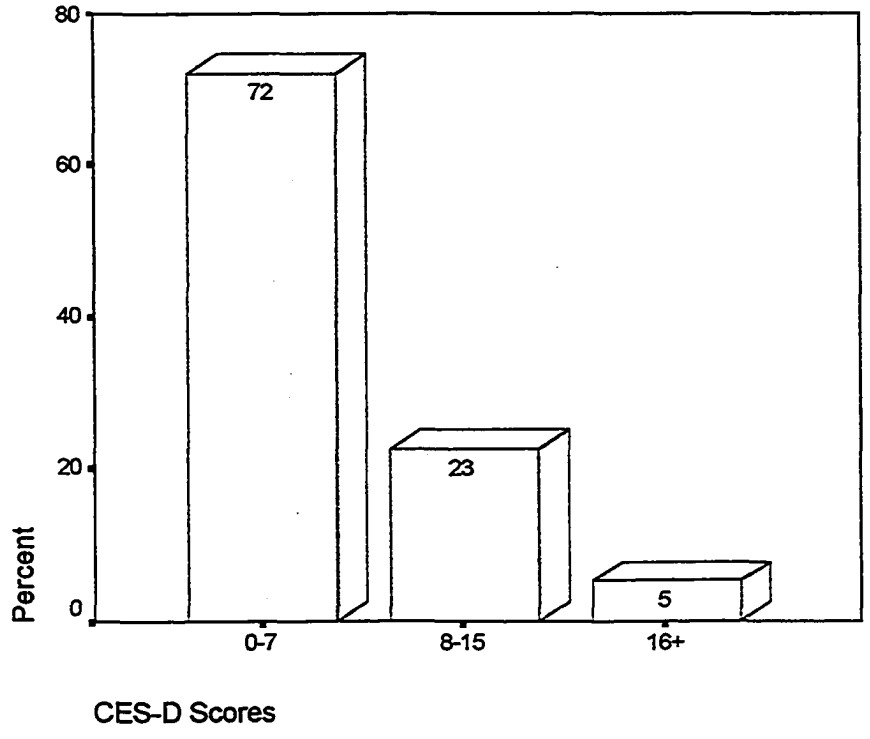
Another question regarding hospital stay prompted respondents to answer whether or not they had stayed overnight (for medical reasons) in a hospital in the past year. Only 20.9% of respondents answered that they had stayed overnight in the hospital in the past year. Out of the number of respondents who answered affirmatively to the previous question, 58% stayed overnight in a hospital in the Rio Grande Valley, 29% stayed in a hospital at their primary residence, 8.3% stayed overnight in hospitals in both locations. Only 4% stayed in the hospital overnight in the last year in a location other than the Rio Grande Valley and/or their primary residence.

As discussed above, depression is detrimental not only to the emotional/mental well being of an individual but also to his/her physical health. Part of this study involved evaluating depression levels of the respondents based on the CES-D scores from the responses to questions that the respondents answered. The questions are asked on a scaled basis with answers ranging from "rarely or none of the time" (less than 1 day per week) to "most or all of the time" (5-7 days per week). Most of the questions are asked about a negative experience (i.e., "I was bothered by things that usually don't bother me."); however, a couple of the questions are asked about positive experiences (i.e., "I felt that I was just as good as other people."). According to some scoring

standards, a score that is greater than or equal to 16 may suggest a "clinically significant level of psychological distress," and generally, roughly 20% of the population would score in this range (Huba, G.J. and Melchior, L.A., 1995).

The following table (Table 1.5) illustrates a grouped score breakdown by percentage of the respondents' CES-D scores. As illustrated, the majority of respondents score in the lower range (0-7), which would suggest no clinically significant level of depression or psychological distress. Twenty-three percent of respondents scored in the 8-15 range, which is toward the higher end, may signify some depression or psychological distress. However, only five percent of the respondents scored in the 16+ category.

Table 1.5 - CES-D Scores



After reviewing the actual scores for this group of respondents who scored in the 16+ category, further investigation seemed appropriate. Out of these six cases, three were females, two were males, and one did not answer the gender question. Three of the respondents were in the 61-70 age group, and three were more than 70 years old. One actually wrote in their age as 82 years old. All six subjects had visual impairment, with four of the six enduring cataracts, glaucoma, or both. Three of the six individuals had diabetes. Three had high blood pressure; Three had heart problems and/or hardening of the arteries. Other reported symptoms of this group of individuals included paralysis/weakness, neurosis/depression, kidney/urinary problems, nerve/muscular problems, forgetfulness, respiratory difficulty, and hearing impairment. Those respondents scoring higher on the CES-D appear to be disproportionately affected by health problems.

During the data gathering process, respondents were asked to answer multiple questions about their general health. Different ailments/diseases addressed included heart disease, high blood pressure, cancer, stroke symptoms, thyroid problems, joint/bone problems, visual impairments, hearing impairment, speech impairment, liver ailment, and kidney/urinary problems to name a few. Respondents were asked to answer whether or not they suffered from the ailment/disease, and if so, what they were doing for it. Selection responses included taking medications, engaging in exercise, eating a special diet, and/or utilizing alternative medicine. Table 1.6 illustrates the most frequently obtained results of the ailments/diseases questions.

Table 1.6 - Illnesses/Ailments

| | |
|---|---|
| Visual Impairment | 86.1 |
| Joint/Bone Problems | 48.7 |
| High Blood Pressure | 44.3 |
| Cataracts | 23.5 |
| Hearing Impairment | 18.3 |
| Heart Trouble | 18.3 |

As illustrated in Table 1.6, the most prevalent ailment in this sample of winter visitors is visual impairment, with just over 86% of respondents reporting they suffer from visual impairment. This may have included those 23.4% of respondents who subsequently answered they suffer from cataracts, as well as those 6.1% who answered that they suffer glaucoma. The second most reported ailment/disease is joint/bone problems, from which nearly 49% reported suffering. The next most reported ailment is high blood pressure, with roughly 44% of respondents reporting this ailment. Hearing Impairment and heart trouble were equally reported with just over 18% of respondents answering affirmatively. Additionally, but not displayed on the table, 15.7% of respondents indicated that they had thyroid problems, and the same number said that they forget things often. Thirteen percent of respondents reported cancer, leukemia, or malignancies. Roughly 12% of respondents said that they endure respiratory problems, and the same number reported diabetic symptoms.

When comparing the sample of winter visitors to the sample of 65+ used in the CDC's survey mentioned in the above review of literature, some similarities were present. Forty-four percent of the respondents in the present survey reported high blood pressure, which can be compared to the 47% of respondents from the CDC's survey that reported trouble with hypertension. However, when 61-70 year old cohorts were isolated for the winter visitor study, the percentage reporting high blood pressure was 29.5%. Fifty-three percent of the more than 70 cohort reported high blood pressure. On the other hand, the total sample of winter visitor respondents reported a higher incidence (49%) of joint/bone problems, which might effectively be compared to the 37% of respondents on the CDC's report who suffered from arthritic symptoms. Again, this figure changed to 59.1 when just the 61-70 year old cohort was analyzed, and 43.9% when the more than 70 years old cohort was isolated.

While only 18.3% of the winter visitor respondents reported ailing from any type of heart trouble, 31% of the CDC respondents reported that they have heart disease. When isolating by age, 15.9% of the 61-70 year old cohort reported having heart trouble, while 19.7% of the more than 70 years old cohort reported the same ailment. There was a slight difference in the percentage of CDC respondents' reports of cancer and the same reports from the total winter visitor sample; eighteen percent of the CDC respondents compared to 13%of the winter visitor respondents reported suffering from cancer. The gap was less apparent in the winter visitor more than 70 years old cohort when controlling for age, however, with 9.1% of the 61-70 year old cohort and 16.7% of the more than 70

years old cohort reporting cancer, leukemia, or other malignancies. Diabetes was almost equally reported by both samples, with 13.5% of the CDC's sample reporting diabetic symptoms while 12.2% of the winter visitor sample reported the same condition. For the winter visitor respondents, 9.1% of the 61-70 year old cohort reported diabetes, and 15% of the more than 70 years old cohort reported diabetes. The CDC survey data excludes visual and hearing impairment; thus, no comparisons are made using these two variables.

# CHAPTER 4

## *Overall Discussion & Conclusions*

### Further Discussion of the Data

More than half of the respondents participating in this questionnaire were above 70 years old, and the majority of these were female. Again, gender differential life expectancy, in general, may be applied to the particular or specific situation of RV parks, whereby there is a greater percentage of women. However, women may have been more likely to participate in the study than were men. The majority of the respondents spend from 3-5 months annually in the Valley, have a high school diploma or GED, and reported earning on average from $20,000 to $35,000 annual income in the last 5 years.

The majority of respondents are covered under Medicare, and less than four percent have Medicaid coverage. About a quarter utilize cash when paying for healthcare (out-of-pocket pay would be a necessity in Mexico for the dental and/or pharmaceutical expenditures). Of the 63% of respondents with private medical insurance, 78% of those also had Medicare coverage. Thus, of the 81% of respondents who have Medicare coverage, approximately 39% do not have private insurance coverage.

Substantially more than half of the respondents have a regular doctor in the Rio Grande Valley, and the vast majority of all respondents had seen a

doctor at some point in the last 12 months. Interestingly, although more than half felt their healthcare obtained at their primary residence was equal in price to that of the Valley, approximately a fifth of respondents felt that healthcare obtained in the Valley was more expensive. More respondents felt that healthcare obtained in their primary residence was satisfactory than did respondents answering a similar question about Valley healthcare. Nearly a quarter of respondents reported that they visit the pharmacist and/or the dentist in Mexico.

Almost a third of respondents indicated that they had utilized healthcare other than conventional medicine at some point, with chiropractic, acupuncture, and massage therapy being the most popular types accessed. Additionally, when worded slightly different calling the healthcare other than conventional medicine "alternative medicine," less individuals answered affirmatively. This may have been due to the ambiguity of the term "alternative," or it may have had more embedded reasons (i.e., alternative medicine being viewed as taboo). Alternately, it may simply be that some respondents did not view healthcare other than conventional medicine as the same thing as alternative medicine; thus, they were inclined to answer the questions differently.

It was startling to note that, even though many had tried alternative types of therapy, almost the entire sample had not utilized any type of cultural healthcare – even the less intimidating types like herbal. The majority of respondents (over 97%) spend at least 3-5 months in the Valley every season and roughly 80% have been coming to this area for a minimum of 7 years (with nearly 50% of total respondents coming for more than 12 years). However,

based on this study, only 1 out of 115 report any use of cultural or folk healthcare. Under the assumption that the respondents are answering truthfully, one might conclude that this group of winter visitors has not penetrated the cultural landscape of the Rio Grande Valley in terms of alternative healthcare. Without the assumption of honesty, one might speculate that some of the respondents may feel a negative connation with the use of such medicine, or at least, with the terminology (i.e., "folk medicine"). The question of to what extent the winter visitors penetrate the cultural landscape (all aspects) of the Rio Grande Valley would be an interesting research problem on its own.

Based on the findings, the majority of the respondents felt that their physical health was about the same at the time of the survey as it was on both 1 year and 5 years prior. However, nearly 16% felt that their physical health was worse 5 years prior to the survey compared to the less than three percent who indicated that their physical health was worse 1 year prior. This may be due to the cumulative effects of aging; thus, if one is suffering from ailments due to aging, 5 years would make a greater difference in physical health status than would 1 year. On the other hand, 13% of respondents felt their physical health was better at present than it was 1 year prior, and 11.3% felt it was better than 5 years prior. About 42% of respondents had stayed overnight in the hospital in the last 5 years due to surgery or testing, and the majority of these stayed in a Rio Grande Valley hospital. Only a quarter stayed in a hospital in the location of their residence.

If further, more representative research was done, and the findings were consistent with the findings from this study, it could have important implications for the Valley's healthcare system. Based on the figure of 120,000 (a conservative estimate in keeping with recent UTPA Tourism Center reports) winter visitors to the Valley in one season, the number of winter visitors staying overnight in the hospital in a five-year period could be around 24,000. Again, the most common given reasons for overnight hospital stay included knee replacement surgery, back surgery, blood clots, broken bones, heart-related surgery, and cancer-related testing or treatments. Likewise, when respondents answered whether they had stayed overnight in the hospital in the past year (for any medical reason), the majority of respondents answering affirmatively stayed in a Valley hospital. If further research confirmed these figures, the potential number of winter visitors staying overnight in a Valley hospital for any medical reason could be around 14,000 in a year.

Based on the CES-D scores, depression levels of among the respondents did not seem alarming. Nonetheless, because some studies have stressed a link between aging and depression, as well as an association between depression and physical health, diagnosing and treating depression is important. Low levels of depression may be a result of a continuous activity available to winter visitors. Additionally, rather than disconnecting from society, as detachment theory suggests is the case for some older adults, winter visitors continue to be socially integrated. This social integration may be supportive of the Carstensen's socioemotional selectivity model, the maturity hypothesis, and the activity theory.

Certainly, winter visitors appear to be an active, socially integrated group of cohorts. However, further research is suggested to develop more explanatory models relating to migratory seasonal status and levels of depression.

It certainly seems plausible that winter visitors would represent a healthier, more autonomous sample of seniors in the nation. This assumption might be based on the motivation that this select group of seniors feels to migrate from one place to another, as well as the physical ability the groups has to make the trips. While comparing the present data to that on the CDC's website, in some areas the assumption seemed valid, while in other areas, it did not hold. A later study utilizing random sampling and perhaps matching on some factors (i.e., age, income level, and education level) might analyze the health disparities – if any – between winter visitors and those seniors who age in place. Although exact comparisons cannot be made between the CDC's data from their website, as the CDC data was reporting for respondents solely from a 65+ cohort, and this study broke the age groups into different cohorts (i.e., 61-70 years old and more 70 years old), adequate comparisons were justifiable just to explore whether or not the current data was along the lines of the CDC's reported data.

In review, after age was controlled in the winter visitors sample, a significantly lower percentage of the winter visitors' 61-70 cohort reported high blood pressure than did the CDC's sample reporting hypertension. On the other hand, for the winter visitors' more than 70 years old cohort, the report of high blood pressure was slightly higher than the hypertension report from the CDC's data. Both the cohorts from the winter visitors sample had a higher percentage of

respondents reporting bone and/joint trouble than the CDC's data on arthritic symptoms. However, this could be because bone and/or joint trouble, unlike arthritis, is not necessarily a doctor diagnosed symptom; thus, if they had not been diagnosed with arthritis, more respondents might identify with a description of the ailment (i.e., bone and/or joint trouble) than would identify with an actual doctor diagnosis. Interestingly, a significantly lower percentage of respondents from both of the winter visitors' cohorts reported any heart trouble compared to the percentage of CDC respondents reporting heart disease. The percentage of the winter visitors' more than 70 years old cohort reporting cancer, tumors, or malignancies was in keeping with the CDC's data. However, the 61-70 years old cohort reported a significantly less percentage. When reporting diabetes, the CDC percentage was slightly less than the more than 70 years old cohort of winter visitors. On the other hand, the younger of the two winter visitor's cohorts had a lower percentage of respondents reporting diabetes than did the CDC respondents.

Conclusions

Although this study began as an exploratory project, to an extent, it has revealed some interesting conclusions. As the population of winter visitors to the Rio Grande Valley continues to grow, which one might safely predict based on population projections relating to our aging society, further research may prove essential in understanding the various social, psychological, biological, economical, and even perhaps spiritual facets of this unique group of individuals. In particular, further research might focus on how the winter visitor population

currently affects the environment (social, political, economical, etc.) of the Rio Grande Valley of Texas, and how this same growing population might subsequently impact our community in the future. This research suggestion calls for a collaboration between and across disciplines. As indicated by Bengston *et al.* (1999), in the past, there has been a focus in the study of aging only on research relating to an investigator's own discipline. Now, the authors maintain that it is no longer comfortable to analyze aging phenomenon in this manner; on the contrary, "a comprehensive account rests on the ability of researchers to traverse disciplinary lines and develop a more common language of inquiry (Bengston *et al.*, 1999, p. 15). Other areas of potential inquiry may also benefit from cross-disciplinary and interdisciplinary investigations.

In addition, the opportunity exists to begin a series of comparative studies. For example, comparative studies might investigate health and aging disparities (if any) between migratory seasonal seniors and those seniors who age-in-place. Another comparison might be made between winter visitors to an area and the residents of the community. Such factors as health, economic status, and level of education might be investigated. An investigator might want to look into what indicators affect a retired or senior individual's decision to migrate between various seasonal habitats or to remain in-place throughout his/her later years?

Drawing on findings from the previous chapter, it is apparent that in the winter visitors, there is a wealth of information just waiting to be tapped. Since the population is aging at such a rapid rate, researchers might utilize this population of 120,000 to 150,000 seniors age (the majority aged 60+) to build

explanatory data and draw conclusions that could affect the healthcare system for seniors as a whole. Regarding the relatively low rate of significant depression among the sample, for example. Further research might draw a more representative sample of winter visitors to ascertain if this study's findings are valid and reliable. Thus, researchers could compare these migratory retirees to those who stay in one place to see if there are disparities in the levels of depression and health status of the two samples, and if so, researchers might address why these disparities exist.

Further opportunities for research might include any or all of the following research questions. How do migratory seniors decide on the location(s) of residence? How do senior winter visitors to a community (i.e., the Rio Grande Valley of Texas) perceive their reception by the local residents, and what trends are evident in the local residents' attitudes toward the winter visitors? What role, if any, do networks play in the life choices (social, economical, etc.) of migratory seniors? This question might also include the inquiry into how embedded one must become to actually tap geographical and cultural resources of the communities in which he/she is temporarily residing? When looking into the networks created through the migratory processes, one might also address enclaves. For examples, one of my acquaintances was taking stained glass lessons from a fellow resident at the park that offered the lessons for a nominal charge to residents. Interestingly, as illustrated by this last example, winter visitors do engage in "place-making" (as mentioned in the literature review). Additionally, as evident in the badges they wear that list their name along with

the park name and location, this group does form identities with and attachments to their communities. Another illustration of an enclave and place-making might be the on-site store that one resident ran at the larger park. When, if ever, do these nomadic seniors stop traveling from one location to another? What percentage of migratory seniors have permanent residences, and what percentage live year-round primarily from their RVs.

Through visiting with my contacts, as well as calling around to a few parks other than those I visited, I ascertained that health promotions -- or at least some form of informing park residents about illnesses -- occur at some of the parks. However, one of my contacts said that she believes many of these are forms of advertising for specific doctors. This is where "guest speakers" come in to play, and some of the parks charge these individuals for granting them the opportunity to speak to the park residents. The health coordinator at the larger RV park noted that as well as the CPR/First Aide certification classes, other health promotion activities were available to park residents. Thus, one might conclude that some parks have an interest in promoting healthy, independent lifestyles in their residents.

With as many winter visitors and subsequent RV parks as there are in the Rio Grande Valley, health promotions targeted to these individuals seem given. However, neither the park managers nor the health coordinator from the larger park mentioned any in-depth health promotions. I suggest park-initiated health promotions (to avoid scam vulnerability) in which a series of health issues are addressed, and discounted screenings are offered on-site (if possible). Several

parks joining together and having an intra-park health fair of some sort might best meet this objective. In order to decide upon the best health topics to cover, parks might consider conducting a random sample survey in which all parks meeting certain criteria (i.e., all parks with a minimum number of residents) are used as a sampling frame. Respondents could be drawn randomly from each of the parks, and then surveyed about such items as their general health status, last visit to the doctor, types of healthcare coverage, etc. In addition, another type of health promotion (based on one of the articles in the literature review) might focus on creating and evaluating interventions that encourage maintaining old and nurturing new friendships – both within and outside the community.

In the article involving retirees and mental health, the author mentions offering potential retirees other jobs or optional opportunities promoting autonomy. Interestingly, according to the 1997 University of Texas-Pan American Winter Texan Study, 30% of winter visitors volunteer their time/services to nonprofit entities while they are in the Rio Grande Valley. Of the remaining 70%, nearly 60% would like to volunteer if they could "identify an organization that suits their interests" (Vern Vincent *et al.*, 1998, p.11). In a year like the most recent, where only about 120,000 winter visitors were estimated during the Valley's winter visitor season, the volunteer figures still translate into over 50,000 individuals who said they would be willing to volunteer if the "right opportunity presented itself" (Vincent *et al.*, 1998, p. 11). Perhaps, rather than retire completely, the growing number of seniors in our country could be recruited into a civil service type/volunteer program promoting the well-being of others,

which would also jointly promote the senior's well-being. In the Rio Grande Valley, every effort should be made by nonprofit organizations and representatives of the beneficiaries of such organizations to get the news out to winter visitors so that they can become more involved in the community.

Because winter visitors are an essential part of the Rio Grande Valley, the local towns that are affected by this population might consider policies that would attract and retain the winter visitors. While traveling around the Valley, I have seen numerous signs welcoming winter visitors and attempting to create an atmosphere of receptivity to these groups. However, I am not sure that economic-driven hospitality is in accordance with what the average Valley resident feels toward the winter visitors. The towns and businesses that benefit from this population needs to be sensitive to the dynamics between the locals and the winter visitors. Perhaps, local meet and greets (with the objective of getting both the locals and the winter visitors better acquainted) of some sort could be facilitated by local officials in the Valley.

Additionally, the Valley needs to consider how state-level and federal policy-making might affect the number of winter visitors that travel to this area every year. At the present moment, the numbers of winter visitors who do make it to the Valley have the support of a federal social security program and Medicare or HMO Medicare Plans. However, if either of these systems were jeopardized, the number of seniors able to afford the trip and the associated expenses might be drastically reduced. Overall, this could have a major economic effect on the Valley, especially for the RV parks, restaurants, and

healthcare industry. Thus, even with the baby boom generation set to enter their golden years, the number of winter visitors to the Rio Grande Valley could be reduced by economic changes coupled with governmental policy changes. Furthermore, the impending healthcare shortages imply that that places with large populations of older adults (i.e., the Valley during the winter visitor season) need to pay special attention to community healthcare requirements.

The major goals and objectives of this study were met through the data gathering and processing techniques utilized. Through the questionnaire, it was possible to investigate the general trends and attitudes of migratory winter visitors in the Rio Grande Valley regarding the local healthcare atmosphere/ options in comparison to the healthcare atmosphere/options of their primary residences away from the Rio Grande Valley. The questionnaire also allowed me to assess the general health status of migratory winter visitors. Demographic characteristics for this set of individuals were more comprehensively examined and described; thus, a descriptive exploration of this group of winter visitors was ascertained. Through the questionnaire, attitudes were obtained for this group of seasonal migratory visitors toward the use of alternative medicine. Unfortunately, there was little data to analyze regarding the extent to which the subjects have penetrated the distinct geographical and cultural landscape of the Rio Grande Valley by assessing their level of experience with local, traditional alternative therapies. During the course of collecting the data through the questionnaires, I gained an inside, observational perspective from which to view

patterns of health-related activities in the RV parks and -- to some small degree -- the presence of social networks and embeddedness.

Overall, this exploratory research project provides a new look at winter visitors in the Rio Grande Valley of Texas. In addition to general demographic information, the data from the questionnaire offers insight on the attitudes of winter visitors toward healthcare, general health status of this same group, some ideas about the extent to which this group has penetrated the alternative medicine realm, in general -- as well as the cultural healthcare realm of the Rio Grande Valley. Finally, social networks are essential to winter visitors. Through my observations, I glimpsed just a hint of the value these networks provide. Obviously, the winter visitors have a major effect on the Rio Grande Valley and vice-versa; thus, it is essential -- to both the winter visitors and the local residents -- for researchers to address this population and explore the social, economical, and cultural intricacies of the winter visitors' impact.

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# VITA

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# MEMORANDUM

To: Caprica Neal, Graduate Student, Sociology Department, College of Social and Behavioral Sciences, UTPA, Dr. Elena Bastida, Graduate Advisor

From: Dr. Bahram (Bob) Faraji, Chair, Institutional Review Board for Human Subjects in Research BF

Subject: Protocol for "Healthcare Trends and Attitudes of Migratory Winter Visitors in the Rio Grande Valley"

Date: March 21, 2003

The above referenced protocol has been:

____ Approved (committee review)
__X__ Approved (expedited review, IRB# 245)
____ Conditionally approved (see remarks below)
____ Tabled for future consideration-Re-submit with corrections
____ Disapproved (see remarks below)

by the Institutional Review Board Federal Wide Assurance Number (FWA 00000805).

As stipulated in the guidelines of the IRB, this protocol will be subject to annual review by the IRB and any deviations from the protocol or change in the title must be resubmitted to the Board.

For additional information you can contact the IRB University website at http://www.panam.edu/dept/sponpro/Policies/Policies.html

**AT THE CONCLUSION OF THE STUDY, YOU MUST FILL OUT THE ENCLOSED REPORT FORM**

cc: Dr. Wendy A. Lawrence-Fowler, AVPR