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Time Banks as Aging-in-Place Initiatives

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This is to certify that the doctoral dissertation by

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August 2018

Abstract

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MS, Iona College, 2003

MBA, Pace University, Lubin School of Business, 1994

BS, St. John's University, 1988

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

There has been growing concern over how state and federal governments can support the increasing population of aging Americans and their need for long-term care. Current insurance funding models cover acute hospitalization and skilled care only, leaving unskilled care needs and homemaker services at the full expense of those in need. Time banking allows individuals to exchange or barter time for goods or services without monetary payment. There is insufficient evidence to determine if members believe time banks to be a viable alternative to support aging-in-place care needs. This phenomenological study explored time banking as a potential vehicle for nonskilled health care support to defray health care costs as one ages. Ostrom's co-production theory provided the theoretical foundation for the research questions, which examined the participants' lived experiences with the role time banks played in their decision to age in place. Face-to-face interviews were conducted with 10 Southern California time bank participants, age 50 years or older. Using a Moustakas-modified van Kaam method and a priori coding emergent themes were extracted. Study findings illustrated that time bank participation did support aspects of nonskilled health care needs and provided members with confident options for aging in place. Study findings also indicated a need for continued collaborations between professional and managerial staff in public agencies, including California's Health and Human Services Agency and time bank users in their communities. Reducing health care costs for taxpayers in any government-funded health insurance model benefits positive social change, and nonskilled health care provider time bank initiatives may be a sustainable alternative for those wishing to age in place.

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Dedication

To Sri Sathya Sai Baba, who taught me how being a good example is the best form of service.

To my parents, who sacrificed much for their children. I stand on their shoulders.

To my husband and to my children, there are no words to describe my love and admiration.

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Appreciation and gratitude go to Dr. Edgar S. Cahn, the creator of Time Dollars and the founder of TimeBanks USA, for his seminal work on co-production and time banking.

To Dr. Ed Collom, whose research on time banking I have been following over the past 20 years. Over time, he has been gathering and measuring data on time banking in established systematic fashions that enabled him to answer research questions, test hypotheses, and evaluate outcomes. In turn, his research work inspired my research work.

To the extraordinary members and staff of CA TB 2, located in Southern California, for sharing their personal stories and experiences so that others can benefit.

Lastly, I wish to thank Dr. Lori Salgado … for everything.

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Chapter 1: Introduction to the Study

Aging in Place with Time Banking

As of 2010, there were 40 million people 65 and older living in the United States (U.S. Census, 2011). The United States' population 65 and older was the largest in terms of size and percent of population compared with any previous census (U.S. Census, 2011). Furthermore, between 2000 and 2010, the population 65 and older grew 15.1%, while the total United States' population grew 9.7%. The challenge this number of older Americans will bring to the country is unprecedented. Given the facts surrounding current economic problems, a weak health care system and the lack of local support systems needed to support older people, this is a serious national predicament (California State Senate, 2014). Most importantly, it is a big problem for number of Americans who are aging in place (or wish to do so). This number is increasing for various reasons including the impact of the Supreme Court ruling in *Olmstead v. L.C.* (1999). Under this ruling, individuals with mental disabilities have the right, under the Americans with Disabilities Act, to live in communities instead of institutions as long as a medical professional has determined that community placement is appropriate (California State Senate, 2014).

There are several options available for individuals who wish to age in place, including naturally occurring retirement communities (NORCs), home health services, and living with family members. The focus of aging in place is to help individuals ensure they can live where they choose and get help they need for as long as they can. The goal of an individual 50 years or older wanting to age in place should be to maintain and/or

improve their quality of life. To do that, a good plan that focuses on the quality of life and covers self, home, and finances should be created as early as possible. As people age, their bodies and capabilities change. Examples of some of these changes include the following: reduced vision; decreased muscle strength or endurance; reduced mental processing capabilities; increased risks of falls due to balance; increased risks of illness; reduced hearing; and decreased mobility. The impact of these changes can be seen in the daily life of an aging person. While their physical capabilities lessen and need change, this impacts many activities of daily living (ADLs) and other activities such as getting around their home as easily; driving safely; transportation; socializing; home upkeep; health maintenance; and more.

Participation in time bank systems may serve to facilitate aging in place initiatives. A literature gap exists with regards to exploring how independent (not presently involved in any long-term care [LTC] arrangements) time bank participants, 50 years or older, articulate their lived experience related to using time bank membership to facilitate their aging in place. Findings from this study should be of interest to state and federal policymakers considering strategies to decrease the rate of growth in Medicaid and Medicare expenditures for LTC individuals and to expand home and community-based services.

Time Banks

Time banks are a form of community-provided welfare system (Collom, 2014). Community members agree to trade each other their services, thereby making services and goods more accessible while creating a sense of community (Collom, 2014). Collom

asserted that there are various types of time banks (currency systems), each having its own protocols and methods of operation. However, the basic premise of each type of organization is the same. Members join and advertise services or goods they both provide and seek. A *seeker* contacts a *provider* through a group facilitator or administrator, who negotiates the transaction, and then arranges it. The seeker electronically pays with a predesignated currency (in the case of time banks, the currency is hours), and the provider electronically receives the currency (Collom, 2014).

Background

Government agencies including the Centers for Medicare and Medicaid Services (CMS) that include Medicare and Medicaid programs, private foundations, organizations, and businesses spend billions of dollars annually on social programs to help individuals in need (U.S. Department of Health and Human Services [HHS], 2015). These efforts are essentially one-way avenues rather than systems of reciprocity. Few of these programs attempt to provide communities with the necessary tools to improve their own social environment, in an economically sound fashion and through mutual efforts. Local currency systems (including time banks) can perhaps be considered such a tool. These systems have been started as formal voluntary organizations to enhance community-building for people who may not otherwise know each other and who have a wide variety of needs and interests. Specifically, this study explored whether participants viewed time bank participation as a means to allow them to age at home.

The CMS (2016) reported that from 2012 to 2013, national health expenditures (NHE) exhibited an annual increase of 3.6% to $2.9 trillion in 2013, or $9,255 per

person, and accounted for 17.4% of United States' gross domestic product. In addition, according to the same report, the combined Medicaid and Medicare expenditures during 2013 accounted for 35% of total NHE, or over $1 trillion (CMS, 2016).

Medicare, which is fully managed and paid through federal programs and administered through private insurance companies directly or through fiscal intermediaries, does not pay for long-term or custodial care in general (with the exception of end-stage renal disease and hospice). However, its acute and postacute care expenditures are much higher for LTC users (Rogers & Komisar, 2003) who experience various types of chronic illness or other limitations. These medical and nonmedical conditions can potentially compromise an individual's potential to live independently. Average expenditures for Medicare beneficiaries who cannot perform ADLs are 4 times higher than for persons with no ADL limitations (Rogers & Komisar, 2003). Activities that fall under this category include eating, dressing, bathing, toileting, and getting into and out of a chair (Wiener, Hanley, Clark, & Van Nostrand, 1990). In fiscal year 2010, total spending (public, out-of-pocket, and other private spending) for LTC was $207.9 billion, or 8% of all personal health care spending in the United States (The SCAN Foundation, 2013). Bodenheimer and Grumbach (2012) noted that individual state-run Medicaid programs are the dominant source of payment for LTC (62.2%), followed by out-of-pocket payments by individuals and families (21.9%). Medicaid is mostly a state-run program with funding and rules set forth by the CMS. However, what actually flows to the states is money that is then combined with state funds. This is why Medicaid

benefits (including LTC plus other benefits) vary by state as each state can determine the benefit amount.

Skilled services (including registered nurses, physical and occupational therapists, and speech therapists) are usually covered by Medicare (Bodenheimer & Grumbach, 2012). However, custodial services, which involve assistance with ADLs, are often not covered by Medicare as they fall under the unskilled category. Also, Medicaid does not cover 24-hour-a-day custodial services for individuals unable to take care of themselves. Most often, these tasks are left to be performed by paid nurses' aides, home health aides, or homemakers, or they are carried out by nonpaid family members. As a result, many low income disabled individuals end up being forced to go into nursing homes unless they have someone who can look after them 24 hours a day. In some instances, individuals have too much income to qualify for Medicaid (excess income). Some of these people may qualify for Medicaid if they spend the excess income on medical bills. This process is called a *spend down* (CMS, 2014). For example, a person over 65 may become disqualified for Medicaid nursing home coverage because his or her monthly income is $100 greater than the limit for Medicaid eligibility. If he or she spends $100 or more on medical bills each month, he or she may qualify for Medicaid nursing home coverage.

Ideally, a patient’s family and friends can serve as long-term (informal) caregivers. Arguably, LTC reform should help promulgate these types of informal caregivers. If these caregivers are not available, efforts should be focused on finding ways to deliver LTC in the home instead of nursing homes (Harrington, Carillo,

Woleslagle Blank, & O'Brian, 2010). As to whether the time bank concept can serve as a viable alternative to delivering LTC to individuals, U.S. Social Security Administration Historian Bortz (n.d.) noted the following:

> The vital test of the progress of a society is the degree of security it offers its members. How well a society provides for at least the elemental needs of the unfortunate is now and has always been a test of civilization. (p. 3)

My intention for this study was to take this "vital test" one step further by filling in the literature gap in regard to determining the potential for service barter (i.e., community currency, alternative currency, local currency) systems to provide an alternative to the provision of services for the unfortunate care seekers, including LTC individuals, who are presently not involved in any type of LTC living arrangements. This study built upon the work of Cahn, Collom, and the Robert Wood Johnson Foundation (RWJF) researchers by exploring the implications of time bank participation as it relates to aging in place. Time bank participation may have important implications for Medicaid, the largest funder of LTC services and supports, as it can delay the process of spending down assets to qualify for Medicaid. Furthermore, participation in time bank programs by LTC individuals may delay the need for institutional care (Fox-Grage & Walls, 2013).

Community Currencies

Community currencies (alternative currencies, local currencies) are defined as localized exchange systems based on time or unofficial equivalents as the medium of exchange (Collom, Lasker, & Kyriacou, 2012). There are three major types of community currency systems: (a) time banks, (b) localized exchange systems, and (c)

hours system. In turn, each of these three types of groups can be organized and managed in one of three ways: (a) embedded/open, (b) embedded/restricted, and (c) stand-alone. Moreover, each of the three groups differs with regards to (a) financing (supported by parent organization or by fees or donations), (b) staffing structure (volunteers or paid employees), and (c) membership type (open to all, restricted according to predesignated criteria).

Collom et al. (2012) applied McAdam, McCarthy, and Zald's (1996, p. 540) social movement organizations (SMO) framework to provide a more comprehensive view of the larger purpose of community currency organizations. McAdam et al. grouped community currency systems under the same category as other social movement concepts such as communal living (Kohn, 1982) and home schooling (Collom & Mitchell, 2005).

Throughout the world, people are creating their own local currencies or noncash exchanges as a complement to the official national currencies that people commonly refer to as real money (Collom et al., 2012). Community currency networks (local or alternative currencies) are do-it-yourself (DIY) groups established with the intention of building social ties within a community and making goods and services more accessible. People are drawn to community currency groups for a variety of reasons. For example, some people may be short on cash, friends, or have physical limitations that make everyday activities difficult or impossible. Communities attempt to meet local needs in a variety of ways. At the official level, towns, cities, counties, states, and the federal government collect taxes and use them to provide services through publicly funded systems. Nonprofit organizations raise money to provide additional services. Also,

individuals who volunteer are another well-recognized way of providing help to those in need.

Time banks are the most popular type of the three major types of community currencies (Collom et al., 2012). Although I present various types of local currencies in this study, time banks specifically have been discussed at length, including the history of the growth of this movement in the United States. Time Banks USA (n.d.) is a nonprofit organization that serves as a clearinghouse where participants enroll to provide and receive services without the exchange of currency. The organization was started in Miami, Florida during the mid-1980s by law professor and assistant to former attorney general Robert Kennedy, Jr., Edgar S. Cahn (Cahn & Rowe, 1996). Members participate both on inter- and intragenerational levels depending upon the location of the community and the organization housing the program. Hospitals, schools, places of worship, and social services agencies frequently house Time Banks USA groups (Seyfang & Smith, 2002).

As of 2014, there were approximately 100 various forms of time banks in the United States (Collom, 2014). For this study, participants were drawn from two time bank groups in Southern California (pseudonyms): California Time Bank 1 (CA TB 1) and California Time Bank 2 (CA TB 2). CA TB 1 is housed within a NORC—one of 55 similar NORCs located in California designed for people 50 years of age and older (Collom, 2012), with the goal of helping older people stay in their homes as long as possible. The chief time bank administrator receives a salary. In contrast, CA TB 2 is a

member-led time bank program that receives no funding and, as a result, all organizers are volunteers.

Problem Statement

There has been insufficient evidence on whether service barter systems (local currency groups, time banks groups) are a good alternative or complement to the provision of services for care seekers, 50 years or older, who are presently not involved in any type of LTC living arrangements. Health care services include medication reminders, meal preparation, bathing/dressing/grooming assistance, miscellaneous errands including shopping and driving to medical appointments, and friendly companionship. The current literature did not support the importance of service barter as a legitimate means to complement the availability of assisted living or nursing home care arrangements—or even to replace these arrangements (Collom, 2014). In his book on the co-production imperative, Cahn (2000) highlighted the opportunities available for converting potential beneficiaries of social welfare programs (including assisted living) into co-producers of outcomes. Much empirical research has been conducted on local currency groups; however, little of this research focused on elderly currency group members in the United States (Caldwell, 2000).

Time bank participation may have important implications for Medicaid, the largest funder of LTC services and supports, as it can delay the process of spending down assets to qualify for Medicaid. Furthermore, participation in time bank programs by older adults or other LTC individuals may delay the need for institutional care. Study findings should be of interest to state and federal policymakers considering strategies to decrease

the rate of growth in Medicaid and Medicare expenditures for elders and to expand home and community-based services. My hope for this study was to illustrate opportunities within this area and to contribute to the literature by reporting the findings of a phenomenological study involving time bank participants, 50 years or older, located in Southern California.

Purpose

This phenomenological study examined the views of time bank group participants, 50 years or older, belonging to two time bank organizations located in Southern California. Data collection included the use of a qualitative semistructured interview guide, which incorporated the public policy theoretical construct of co-production as the underlying theme of the interview questions. In co-production, the actors/participants are not merely recipients of public policy initiatives. They are participants in the design and execution of these initiatives (Bovaird, 2007). The demographic-based survey responses were used solely for descriptive and inferential purposes in this qualitative study. Furthermore, I used Collom's social outcomes study to inform my qualitative study. The underlying theme inherent in my research questions included social and health outcomes.

Nature of the Study

Phenomenology rests on the premise that reality consists of objects and events (phenomena) as they are experienced or perceived using human consciousness (Moustakas, 1994). This longitudinal experience includes not only passive experiences stemming from sensory perception but also imagination, thought, emotion, and action

(Van Manen, 1990). In phenomenological studies, the underlying principle is to use an emergent strategy to allow the method of analysis to follow the nature of the data itself (Giorgi, 1985). However, no matter which data collection and interpretation strategy is used, the researcher's goal is to obtain a deep understanding of the meaning of the description of a lived experience of a phenomenon. Study participants should be given the opportunity to give a full description of their experience, including their thoughts, feelings, images, sensations, memories, and stream of consciousness. Also, participants should include a description of the situation in which the experience manifested itself (Vagle, 2014). To get at the essential meaning of the experience, themes must be abstracted. These abstracted themes represent essential aspects that affect the personalization of the experience. Themes are then studied in context with a description of the experience to focus on a deep understanding of the meaning of the description. These implicit themes are then transformed into explicit themes using thematic analysis (Saldana, 2013). The analyses of the concrete descriptions follow four steps: reading the description to obtain a sense of the whole; establishing meaning units; changing meaning units from the subjects' everyday language into perspective language with emphasis on the phenomenon being investigated; and, lastly, synthesizing meaning units into a consistent statement of the structure of the phenomenon (Saldana, 2013).

Research Questions

The central purpose of this phenomenological study was to allow me to examine what role time bank participation played for members of two Southern California time bank groups in their decisions to age in place. This was determined by an understanding

of the articulated lived experiences of the participants. The basic research design was developed to uncover participants' experiences and the meaning the participants ascribed to those experiences. The theoretical construct for this study was the public policy-based co-production model as conceptualized by Ostrom (1999). When viewed through a co-production lens, my purpose was to determine whether time bank participation could be considered an example of a public policy process through which inputs used to provide a service or good are contributed by individuals who are not working in the same organization. In other words, I was interested in if time bank participation translated into health care for participants (as they could be considered equal partners and cocreators of the delivery of particular LTC-related public services), or if participants relied on insurance products and public service organizations to support them in old age. In turn, I determined whether time bank participation had implications for Medicaid, the largest funder of LTC services and supports, as it can delay the process of spending down assets to qualify for Medicaid. Furthermore, this study was designed to assess whether time bank participation by older adults or other LTC individuals delayed the need for institutional care. Study findings should be of interest to state and federal policymakers considering strategies to decrease the rate of growth in Medicaid and Medicare expenditures for elders and to expand home and community-based services.

The three main research questions for this study were as follows:

1. How do participants, 50 years or older, in CA TB 1 and CA TB 2 articulate their lived experience as it relates to their involvement with these time bank groups?

2. What role does time bank participation play in an individual's decision to age in place?
3. Does co-production theory, as conceptualized by Ostrom (1999), adequately explain the experiences of participants in CA TB1 and CA TB 2 groups?

Theoretical Foundation

When determining which public policy theoretical construct to use during this study, I reviewed various forms of coordination and cooperation efforts established between the public administrations and third sector organizations in the governance, management, and production of public services. The three types of coordination I considered included (a) comanagement,— defined as the collaboration of third sector organizations and other providers in the provision of public services (Pestoff & Brandsen, 2008, p. 2); (b) cogovernance,— referring to the role of volunteer and community organizations (VCOs) in policy formulation and community governance (Pestoff & Brandsen, 2008); and (c) co-production,— where citizens participate in the provision of public service either individually or through VCOs. I chose to use co-production as the theoretical construct because it is narrower in scope of involvement of the VCOs and participants.

Co-production differs greatly from the traditional model of public service production in which public officials are exclusively charged with the responsibility for designing and providing services to citizens who, in turn, only demand, consume, and evaluate them (Pestoff & Brandsen, 2008, p. 4). Co-production is therefore noted by the mix of activities that both public service agents and citizens contribute to the provision of

public services. The former are involved as professionals or regular producers while citizen production is based on voluntary efforts of individuals or groups to enhance the quality and/or quantity of services they receive (Ostrom, 1999).

Ostrom (1990), in her study of the problem of collectively managed shared services and resources (including common pool natural resources as well as co-production involving government services), supported the notion that centralized regulation or privatization was not always required in efforts to solve common resource problems. Individuals who were in an interdependent relationship could organize and govern themselves as they continued to derive mutual benefits while enforcing mechanisms to avoid overinvestment and overuse (Alford, 2014). Furthermore, Ostrom devised eight principles for managing a common resource that can be extended into co-production efforts. Included within those eight principles are tenets that form the foundation of time bank organizational structure and management: defining clear group boundaries, matching rules governing use of common goods/services to local needs and conditions, self-monitoring of member's behavior, and ensuring those individuals affected by the rules can participate in changing the rules. Because one of the desired outcomes of this study was to provide options for individuals who wish to age in place, a co-production model was a valuable component of the theoretical and conceptual foundation.

According to a recent study conducted by the California State Senate Select Committee on Aging and Long-Term Care, over 5.1 million people aged 65 and over will call California home (California State Senate, 2014). Moreover, due to aging Baby

Boomers and migration patterns, that number will grow to 8.4 million by 2030, or nearly one fifth of California's population (California State Senate, 2014). The theoretical construct (co-production) is firmly rooted in public policy. This study will support the goals of the California State Senate's Select Committee on Aging and Long-Term Care, which articulated a vision for an effective and efficient LTC system. In February 2014, the California Senate established the Senate Select Committee on Aging and Long-Term Care for this purpose. To date, since the study was completed, "California has not responded to the increase in the aging population or the rich cultural and ethnic diversity of the state" (California State Senate, 2014, p. 3). Continued reliance upon the variety of programs and services to serve the growing aging and disabled population will result in unnecessary expenditures, inequitable access, and irreverent services. Furthermore, under the existing fragmented structure, there is no leader to oversee or coordinate the entire range of services and no mechanism for accountability or improvement (California State Senate, 2014, p. 4).

One of the recommendations of the committee was to create a California Department of Community Living (California State Senate, 2014, p. 16). System fragmentation is one of the most significant issues impacting both service delivery and state leadership capacity. The committee recommended that the state administrative structure should be reorganized to establish a Department of Community Living under California's Health and Human Services Agency, replicating the federal government's Administration for Community Living (ACL) and reflecting the national trend toward service delivery in the least restrictive, most integrated community-based setting

(California State Senate, 2014, p. 16). In support of this goal, creating more local currency systems including time bank programs, especially when situated in NORCs such as CA TB1, will assist the state's efforts in this endeavor.

Time banks are an example of a form of community-provided welfare system (Collom, 2014) that shares boundaries between the public policy domain of health care (aging in place) and co-production. The study of time bank participation using a co-production lens has the potential to extend theory and improve practice as it relates to aging in place options for individuals requiring LTC.

I employed a phenomenological data collection strategy (Moustakas, 1994) to collect data. In phenomenological studies, perception is regarded as the primary source of knowledge (Moustakas, 1994, p. 52). As a result, the aim of this type of research is to seek honest self-expression on the part of the participant, with no interference on the researcher's part. In phenomenological research, a relationship always exists between an individual's external perception of natural objects and the internal perceptions, which are influenced by memories and judgments (Moustakas, 1994, p. 47). Some phenomenological data collection methods at my disposal included interviews, diaries, drawings, and observations. I worked with a semistructured interview format to gather, analyze, and interpret some of these perceptions and realities as they related to time bank participation of elderly individuals who have chosen to avoid or delay entry into nursing homes or assisted living facilities. By studying various perspectives of time bank participation through the lenses of aging in place (and possible impact on health policy) and co-production (public policy theoretical construct), researchers can begin to make

some inferences regarding what time bank participation is like as an experience from the insiders perspectives. These frameworks were chosen because they helped to answer my research questions.

Definitions

Activities of daily living (ADLs): One of two types of daily self-care activities used to determine if individual is eligible for LTC services. This group includes eating, dressing, bathing, toileting, and getting into and out of a chair (Wiener et al., 1990).

Aging in place: A term used to describe a person living in the residence of their choice, for as long as they are able, as they age. This includes being able to have any services or other support they might need over time as their needs change (Collom, 2014).

Alternative currency (community or local currency): A means through which to expand commerce by connecting a network of people (and businesses). Participants publicize the goods or services they wish to offer and/or obtain through a directory, newsletter, notice board, or website. Interested parties contact one another, negotiate the transaction, and then arrange it. The recipient "pays" and the provider receives credit that can be used for making purchases from other participants in the system (Collom, 2008).

Barter system: Also referred to as local currency group, TimeBanks.org group, and co-production effort. System of exchange where goods or services are exchanged for other goods or services (including time dollar credits) without using a medium of exchange, such as money (Cahn & Rowe, 1996).

California Time Bank 1 (CA TB 1): The CA TB 1 is housed in a NORC located in a suburban Southern California venue. It is one of the two different attributes (settings for data collection) incorporated in this research. The second attribute (setting) is the CA TB 2.

California Time Bank 2 (CA TB 2): A member-led time bank group located in an urban venue in Southern California. It is one of the two different settings for data collection incorporated in this research. The other setting is CA TB 1.

Cogovernance: One of three major forms of coordination and cooperation efforts established between the public administrations and third sector organizations in the governance, management, and production of public services. Refers specifically to the role of VCOs in policy formulation and community governance (Pestoff & Brandsen, 2008, p. 2).

Comanagement: One of three major forms of coordination and cooperation efforts established between the public administrations and third sector organizations in the governance, management, and production of public services. Refers to collaboration of third sector organizations and other providers in the provision of public services (Pestoff & Brandsen 2008, p. 2).

Community currency/alternative or local currency/complementary currency: Interchangeable generic terms for the wealth of contemporary alternative exchange systems that exist alongside mainstream money (Collom et al., 2012).

Consumer choice: How society responds in an appropriate, sufficient, and cost-effective manner to the needs of frail older adults and younger people with disabilities (Benjamin & Snyder, 2002).

Conventional bartering: Two participants trade directly with each other (Collom, 2008).

Co-production: One of three major forms of coordination and cooperation efforts established between the public administrations and third sector organizations in the governance, management, and production of public services: A public policy process through which inputs used to provide a service or good are contributed by individuals who are not working in the same organization. People who use the services deliver public services. Citizens are equal partners and cocreators of the delivery of a particular public service (Ostrom, 1999).

Core/second/household economy: Composed of social capital embedded in the everyday lives of every individual (time, wisdom, experience, energy, knowledge, skills) and in the relationships among them (love, empathy, responsibility, care, reciprocity, teaching, and learning). They are core because they are central and essential to society (Burnell & Phillips, 2015). This core/second/household economy market is presently not measured by traditional indicators that determine the value of the caring activities performed in households or communities (Eisler, 2007, p. 251).

Embedded/open to anyone: A form of embedded time bank housed within an organization. Anyone willing to pay dues can join.

Embedded/restricted: A form of embedded time bank housed within an institution; however, members must meet specific criteria. For example, health maintenance organization (HMOs) offered time bank membership to HMO members-only.

Embedded time bank: A form of time bank based in an existing organization versus being community based. Also referred to as institution-based time bank. Can be open to anyone or have restricted membership (Collom et al., 2012).

Hours: One of three basic forms of community currency systems (including LETS and time banking). Each 1 hour of work equals $10 (or some other agreed upon fixed dollar amount) no matter what type of work done. For example, 1 hour of gardening earns same rate as 1 hour of surgery. Most hours systems are stand-alone, run by volunteers, and have a mix of organizational and individual members. The challenges of retaining dedicated administrators and recruiting new participants, a shortage of useful services, and insufficient resources have hurt these systems (Collom et al., 2012).

Institution-based time bank program: Also known as embedded time bank. Functions in same way as community-based time bank; however, institution-based time bank programs are housed in existing institutions versus agencies such as hospitals, schools, churches, or social service agencies (Collom, 2008).

Instrumental activities of daily living (IADLs): Include activities that support an independent lifestyle. These activities include doing laundry, housework, meal preparation, grocery shopping, transportation, financial management, managing medications, and using the telephone or computer (Wiener et al., 1990).

Local currency group: Service recipients and volunteers (including merchants) living as neighbors (Cahn & Rowe, 1996). Usually has open memberships (not targeting specific groups) and seeks to build social capital and improve the local economy (Collom, 2008).

Local exchange trading system (LETS): One of three major forms of community currency systems that originated in British Columbia in the early 1980s. This system has been most widespread globally although it never caught on in the United States. Involves the establishment of a printed local currency system. Individuals and businesses exchange the currency, whose exchange rate is based upon services or products exchanged. These currencies are not exempt from tax and welfare benefit calculations is some countries. As a result, they are not very attractive to the poor and unemployed (Seyfang & Smith, 2002).

Long-term care (LTC): Includes various services that help meet both the medical and nonmedical needs of people with a chronic illness or other limitations to include physical, mental, or cognitive functioning, which may potentially compromise one's ability to enjoy independent living (Bodenheimer & Gumbach, 2012).

Member-led time bank: A type of time bank program that receives no funding and, as result, all organizers are volunteers (Conlan, Rooney, & Rosenheck, 2011).

Monetary economy: Capitalism (Coote & Goodwin, 2011).

Neighbor-to-neighbor: A type of community organization whose members live or work in the same neighborhood and exhibit strong social ties. Participants help one another in a spirit of give and take (Cahn & Rowe, 1996).

Service credit time bank program: A type of time bank program that is agency-based. Participants earn and spend the egalitarian electronic currency (time dollars) that is measured in the amount of time required to provide a service rather than the monetary value of the service. People volunteering to provide services to needy individuals would receive time credits in a paper bank that would entitle these volunteers to cash in these time credits in the future when and if the need arose (Dentzer, 2002).

Sociocultural health care: The interaction of culture, environment, economy and politics as they relate to health care access (Barton, 2010).

Stand-alone time bank program: A way to classify a LETS or hours community currency system. Program has broad goals and no specific constituency. Also known as *neighbor-to-neighbor* network program. According to TimeBanksUSA (n.d.), there are currently 59 of these types of time banks in the United States (Collom, 2008).

Third sector: Also known as voluntary sector, private nonprofit sector, social economy, civil society. Each term has a slightly different defining characteristic and includes large degree of overlap (Brandsen & Pestoff, 2006).

Time banking: One of three basic types of community currency systems (including LETS and hours). Also known as service credit banking. This refers to a pattern of reciprocal service exchanges that uses units of time as dollars. The currency is time—however long it takes to do something is what it is worth. A participant spends 1 hour providing a service to another and their account is credited for one Time Dollar. All types of work and all types of workers are equal in value. Most often led by volunteers. Edgar Cahn is recognized as a pioneer for his independent development of the time bank

concept and continues to be a leader in the international movement today (Collom et al., 2012).

Time dollars: What one earns upon volunteering his or her services. These time dollars can then be used as mechanism of exchange when the volunteer him- or herself needs services performed by another volunteer.

Scope

I planned to conduct my study in two time bank locations in Southern California. The first location, where CA TB 1 was located, is a NORC residing in a suburban environment. The second California location for this study included participants from the member-led CA TB 2, located in an urban environment. This time bank group originally started out with a hierarchical leadership model. However, after learning from the experiences of other time bank groups in that time banks nearly always fail at some point when they are staffed by only one person, the group transitioned into a newer Internet age team leadership model known as the starfish model (Brafman & Beckstrom, 2006). Working with this approach, the members are fully engaged and invested in the operations and management of the group.

Eligible study participants had to be 50 years or older. Participant pool included past and present time bank members. In addition to advertising within the community, I sought the assistance of the time bank administrators to find candidates who fit my participant pool profile.

Assumptions

Several assumptions were involved this research. The main assumption was that residents 50 years or older were aware of the existence of their time bank group and had chosen as to whether or not they would participate. Another assumption was that the focus of this study was not the world but instead the study participant who experienced the world. Finally, my use of semistructured interviews as the primary data collection tool was based on the assumption that the participants would participate willingly and honestly.

Limitations

Data gathered through interviews can be distorted by bias (both researcher and respondent), lack of awareness, or emotions (Padgett, 2012). The major limitations and weaknesses of research of this type were (a) it examined one geographic region and (b) it had a small sample size. These data were reduced by identifying themes, coding data elements, and creating categories. As a result, the presentation of the highly qualitative nature of the results may be difficult to present in a manner that is usable by practitioners. Also, participants may have had difficulty expressing themselves. I also collected demographic data that were used for descriptive purposes only. I relied on the credibility of Collom et al. (2012) as I used their study to inform my qualitative study. I did this by including theme questions during my semistructured interview. Finally, I made sure to adhere to HHS regulations (including 45 CFR 46.111) regarding protection of human subjects, especially because I worked with elderly research participants. A description of the justification for the methodology and protocols of this study appears in Chapter 3.

Delimitations

The delimitations resulted from decisions I made regarding population and sample. Because the location for the participant pool was chosen from both Southern California communities, CA TB 1 and CA TB 2, the demographic characteristics of the participants in these regions, particularly socioeconomic factors, may restrict generalizability or transferability to other populations throughout the state. I evaluated the risks associated with the use of a phenomenological study. Openness was encouraged through my ability to facilitate communication in the instances when the participant was hesitant or unable to communicate effectively in response to the semistructured interview questions. This openness was further facilitated by my noninterference as the researcher. I completed the process of bracketing to be aware of my own ideas and prejudices regarding issues covered in this study. No leading questions were asked during these semistructured interviews.

Significance and Implications for Social Change

The CMS (2014) found that annual NHE increased 3.6% to $2.9 trillion in 2013, or $9,255 per person, and accounted for 17.4% of gross domestic product. According to the same study, the combined Medicaid and Medicare expenditures during this year accounted for 35% of total NHE or over $1 trillion. To break it down further, in 2011 approximately 10 million elderly and physically disabled individuals received Medicaid. From this group, 4.4 million (44%) received Medicaid-financed LTC assistance (Paradise, 2015). Over 55% of these people were in assisted living or nursing homes and the rest received services in community-based settings, either through the Medicaid home

and community-based waiver services program or through a state Medicaid plan benefit, such as personal care services. In addition, an estimated 3.75 million intellectually or developmentally disabled individuals (HHS ACL, n.d.) received services while they lived at home with their families serving as the primary support system (HHS ACL, n.d.).

The United States' long-term health care industry is an important part of the costliest health care system in the world (Anderson, Hussey, Frogner, & Waters, 2005). According to the Annie E. Casey Foundation Technical Assistance Resource Center (2004), as the aging and the long-termed disabled population increases, and nursing homes and assisted living facilities have become growth industries, costs to the states and taxpayers (for traditional welfare programs) have risen in proportion. At the same time, money for social programs that would help fund or offset costs associated with nursing home or assisted living are decreasing (Annie E. Casey Foundation Technical Assistance Resource Center, 2004). The results of this study can have wide applications for social change through the creation of additional access to aging in place programs. Participation in time bank programs by older adults or other LTC individuals may delay the need for institutional care. In addition, time bank participation may have important implications for Medicaid, the largest funder of LTC services and supports, as it can delay the process of spending down assets to qualify for Medicaid. Study findings should be of interest to state and federal policymakers considering strategies to decrease the rate of growth in Medicaid and Medicare expenditures for elders and to expand home and community-based services.

Summary

California public administrators are attempting to consolidate a fragmented LTC system to both keep costs down as well as to meet the needs of the growing elderly population. People prefer to remain at home and avoid institutionalization as much as possible. This desire is reinforced by the U.S. Supreme Court's 1999 ruling in *Olmstead v. LC.*, which established the right of individuals with disabilities, of any age, to receive services in the most integrated and least restrictive setting possible (California State Senate, 2014). During the past 10 years, researchers affiliated with the International Journal of Community Research and others have found that the service barter environment can offer a sociocultural-based health care approach (versus Medicare and Medicaid involvement) resulting in cost savings to federal, state, and local governments, including individual taxpayers. This type of access (through service barter) will complement financial, geographical, temporal, and physical health care access. By investigating how CA TB 1 and CA TB 2 participants, 50 years and older, viewed their participation as it related to allowing them to age in place, this study can contribute to positive social change by informing policymakers about whether time bank use can be expanded throughout the state to advance state and local public health policy goals.

This chapter served as an introduction to the phenomenological study and provided an overview of the background, purpose, and need for this research. In Chapter 2, I present an examination of the growth of the time bank movement, followed by the history of co-production—the theoretical construct for this study of time bank participation. This construct, which involves the mix of citizen and government input in

the provision of services, served as the lens for the study. From the theoretical framework/lens, I continue the literature review by presenting an overview of LTC in the United States and the role of Medicare and Medicaid. Finally, I identify a gap in the scholarly literature.

Chapter 3 details the phenomenological research methodology for the study including the research design and the interplay between time bank participation, co-production, and aging in place.

Chapter 2: Literature Review

Introduction

The central purpose of this phenomenological study was to allow me to examine what role time bank participation within two time bank organizations located in Southern California played in the participants' decisions to age in place. This was determined by an understanding of the articulated lived experiences of the participants. The basic research design was developed to uncover participants' experiences dealing with time banks and the meaning the participants ascribed to those experiences. The theoretical construct for this study was the public policy-based co-production model as conceptualized by Ostrom (1999).

When viewed through a co-production lens, my interest was in whether time bank participation could be considered an example of a public policy process through which inputs used to provide a service or good are contributed by individuals who are not working in the same organization. In other words, I wanted to determine if time bank participation translated into health care for participants (as they can be considered equal partners and cocreators of the delivery of particular LTC-related public services), or if participants relied on insurance products and public service organizations to support them in old age. In turn, I examined if time bank participation had implications for Medicaid, the largest funder of LTC services and supports, as it could delay the process of spending down assets to qualify for Medicaid. Furthermore, this study addressed whether time bank participation by older adults or other LTC individuals delayed the need for institutional care. Study findings should be of interest to state and federal policymakers

considering strategies to decrease the rate of growth in Medicaid and Medicare expenditures for older adults and to expand home and community-based services.

The three main research questions for this study were as follows:

1. How do participants, 50 years or older, in CA TB 1 and CA TB 2 articulate their lived experience as it relates to their involvement with these time bank groups?
2. What role does time bank participation play in an individual's decision to age in place?
3. Does co-production theory, as conceptualized by Ostrom (1999), adequately explain the experiences of participants in CA TB 1 and CA TB 2 groups?

As a result, the literature review begins with an examination of the background on time banks and community currency. This is followed by an examination of co-production—the lens through which the relationship between time bank participation and aging in place was evaluated. From the theoretical construct, the literature review proceeds to an overview of the history of LTC initiatives in the United States (including aging in place) and the role of Medicare and Medicaid. As a means for comparison, an overview of government sponsored LTC programs for older adults in Canada and the Netherlands are also included.

References for this study were drawn extensively from several sources:

- Walden University Online Library, including the EBSCO, ProQuest Central, Thoreau and SAGE search engines.
- University of California Berkeley Library, A-Z Databases

- Google and Google Scholar engines
- Government, academic and other relevant nongovernment Internet websites in the public domain including the American Association for Long-Term Care Insurance, AARP, Annie E. Casey Foundation, California State Senate Select Committee on Aging and Long Term Care, Centers for Medicare & Medicaid Services, National Association for Home Care and Hospice (2010), National Institutes of Health (NIH) Human Research Protection Program, The Henry J. Kaiser Family Foundation, HHS, and U.S. Social Security Administration.

Literature Search Strategy

To thoroughly understand the time bank movement as well as the development of co-production efforts, I structured the literature search into four distinct segments: scholarly studies published since 2000 on the United States' time bank movement; historical foundations of LTC in the United States (since the 1940s); historical foundations of co-production theories (since the 1950s); and recent public policies and programs that deal with aging in place initiatives. Keywords for all search methods included terms and permutations such as *activities of daily living, aging in place*, *Canada, collaborative consumption, community, community currency, community living, co-production, family, focus group, long term care, Medicare, Medicaid, mental health, naturally occurring retirement communities (NORCs), phenomenological focus group, public health*, *The Netherlands, time bank,* and *time dollars.*

Theoretical Framework

Actively seeking time bank participation as a means to age in place is a relatively new idea. Therefore, I grounded this study in the public policy theoretical framework known as co-production to understand time banks and their use as LTC options for individuals who wish to age in place. By examining the relationship among time banks and community currency (Collom et al., 2012), the co-production model of citizen participation in the deliverance of government services (Botsman & Rogers, 2010; Bovaird, 2007; Brandsen & Pestoff, 2006), and the concept of LTC (aging in place) in health policy, I gathered information that may be useful not only to scholars, but also to practitioners and policymakers as they seek to coordinate and improve LTC options for individuals seeking to age in place.

When determining which public policy theoretical construct to use during this study, I reviewed various forms of coordination and cooperation efforts established between the public administrations and third sector organizations in the governance, management, and production of public services. The three types of coordination I considered included (a) comanagement,— defined as the collaboration of third sector organizations and other providers in the provision of public services (Pestoff & Brandsen, 2008, p. 2), (b) cogovernance,— referring to the role of VCOs in policy formulation and community governance (Pestoff & Brandsen, 2008), and (c) co-production where citizens participate in the provision of public service either individually or through VCOs. I chose to use co-production as the theoretical construct because it is narrower in scope of involvement of the VCOs and participants. Co-production differs greatly from the

traditional model of public service production in which public officials are exclusively charged with the responsibility for designing and providing services to citizens who, in turn, only demand, consume, and evaluate them (Pestoff & Brandsen, 2008, p. 4). Co-production is noted by the mix of activities that both public service agents and citizens contribute to the provision of public services. The former are involved as professionals or regular producers while citizen production is based on voluntary efforts of individuals or groups to enhance the quality and/or quantity of services they receive (Ostrom, 1999). Because one of the desired outcomes of this study was to provide options for individuals who wish to age in place, a co-production model was a valuable component of the theoretical and conceptual foundation.

Emergence of Co-production

The 2009 Nobel Prize winner for economics, Elinor Ostrom, developed the co-production theory based on a 1970 study she conducted along with several Indiana University researchers (Burnell & Phillips, 2015). The goal of this study was to determine why crime rates increased after Chicago police officers were re-assigned from walking beats to driving patrol cars to promote the safety of the communities. What Ostrom and her colleagues noted was that as the police officers became more removed from their community (patrol cars versus foot patrol), the officers lost an essential source of insider information from community members (who were supposed to be the recipients of the services provided by the police officers), which made it more difficult for the officers to do their jobs effectively. The researchers realized that services, in this instance policing, rely as much on the undesignated assets and efforts of service users as

the expertise of the professional providers. It was the informal understanding of local community members and the relationship they had developed with the police officers that had helped to keep crime down. To sum up, the police needed the community as much as the community needed the police. Ostrom (1999) went on to coin the term *co-production* and to define it as a process through which inputs used to provide a service or good are contributed by individuals who are not working in the same organization (p. 1077).

Challenges for Co-production

Percy (1984) noted that the scope of the benefits resulting from co-productive efforts may affect a citizen's decision about the types and frequency of co-production undertaken. Where the benefits of the citizen's efforts go primarily to the citizen-producers themselves, co-production is likely to be greatest. There is a direct correspondence between resources committed and benefits received. However, where the benefits are more broadly scattered among the population in general, citizens' co-productive efforts are less frequent (Percy, 1984). Here there is a "free-rider" problem that needs to be identified and analyzed.

Moreover, Percy (1984) stated that organizational arrangements could facilitate or hinder co-production. In particular, resistance to co-production strategies may be encountered in public service agencies. Service workers and public administrators may see themselves as trained workers and therefore resent or resist the intrusion of untrained and inexperienced workers. Warren, Rosentraub, and Harlow (1984) pointed out that without the tacit support of public employees, the involvement of citizens in production activities might create more problems than it solves.

Rich (1981) noted that citizens may consider the net benefits of their voluntary efforts in terms of fellowship, self-esteem, or other intangible benefits stemming from them. He emphasized the interface between the government and voluntary sectors and noted the importance of recognizing that voluntary action always takes place in a political context. The individual cost/benefit analysis and the decision to cooperate with voluntary efforts, as well as the effectiveness of these efforts, can be conditioned by the structure of the political institutions. Centralized service delivery tends to make articulation of demands more costly for citizens and to inhibit governmental responsiveness, while citizen participation seems to fare better in decentralized service delivery (Ostrom, 1999).

Co-production Resources and Examples

The U.S. economist Neva Goodwin took Ostrom's theory one step further by defining these “undesignated assets and efforts” of community members as "core economy" (Coote & Goodwin, 2011, p. 3). Burnell and Phillips (2015) expanded upon the core economy theory by noting that social capital forms its foundation as the core economy depends on the interrelationship, collaboration, trust, and engagement that exist between people in their family, neighborhood, and community groups (p. 90). Examples of contributions to the core economy include people volunteering to look after the grounds at a public park, and grandparents becoming more involved with their grandchildren's childcare responsibilities (Burnell & Phillips, 2015, p. 90). These concepts (co-production and core economy) are not necessarily new but they are enjoying a comeback as the individuals' desire to establish more meaningful personal bonds as

well as to gain control over choices increases (Burnell & Phillips, 2015). Furthermore, Coote and Goodwin (2011) noted the following about resources:

> The resources that make up the core economy are embedded in the everyday lives of every individual (time, wisdom, experience, energy, knowledge, skills) and in the relationships among them (love, empathy, responsibility, care, reciprocity, teaching, and learning). They are core because they are central and essential to society. They underpin the market economy by raising children, caring for people who are ill, frail, and disabled, feeding families, maintaining households, and building and sustaining intimacies, friendships, social networks, and civil society. (p. 91)

The core economy is seen as a viable economic approach because it is based on the premise that "people helping people" (Boyle, 2010, p. 322) has an economic value that can be exchanged. The conceptual framework of co-production relies on the understanding of what the core economy includes as the process involves mapping out how co-production can take place through the stages of service planning, design, commissioning, management, delivery, monitoring, and evaluation (Bovaird, 2007, p. 857). United States civil rights lawyer Edgar Cahn further elaborated upon the importance of co-production as a way of improving public service delivery in the 1980s. Cahn (2000) studied the underlying relationship between the principle of co-production and the concept of the core economy with regards to the provision of services. Cahn acknowledged the existence of a *second economy* referred to as the core economy (Coote & Goodwin, 2011). This second economy, according to Cahn (2000, p. 48), has never

been fully appreciated in society as a parallel economy working side by side with the traditional market economy (capitalism).

Cahn (2000) argued that the co-production imperative (another underlying lens/theory further explained in this study) forces researchers to study this second/core economy in further detail because co-production allows people's needs to be better met when the people are involved in an equal and reciprocal relationship with professionals and others, working together to accomplish what needs to be done (p. 48). For co-production to thrive, fundamental partnerships must exist between the monetary economies found in capitalist societies and the core economies of home, family, neighborhood, community, and civil society (Cahn, 2000, p. 50). As the delineation between core (secondary or household) economy and monetary (capitalist, supply/demand) economy becomes clearer, this has led to a radical reinterpretation of the role of policy making and service delivery in the public domain (Bovaird, 2007, p. 846). Bovaird (2007) noted how policy making is no longer seen as a top-down process but instead as a negotiation among many interacting policy systems (p. 846). As a result, services are no longer simply delivered by professional and managerial staff in public agencies but instead are co-produced by users in their communities (Bovaird, 2007, p. 847).

Co-production Criticisms and Responses

Co-production does have its limitations. Problems arise resulting from differences in the values of the various co-producers, incompatible incentives among co-producers, unclear division of roles, free riders and burnout of users or community members

(Bovaird, 2007, p. 857). Another concern of co-production is the possibility that public accountability may be diminished as the boundaries between public, private and voluntary sectors are obscured (Bovaird, 2007, p. 858). More experimentation is needed to show how practical co-production is. An increase in case studies examining this phenomenon will help public service professionals to determine the applicability of this theory within varied contexts (Bovaird, 2007, p. 859). Furthermore, a case can be made for the development of a new type of public servant, a "co-production development officer" (Bovaird, 2007, p. 859), who can facilitate the sharing of power between government employees and communities, and also, can design new roles for co-production efforts between traditional service professionals, community members, and the political decision-makers who have input with regards to the strategic direction of the provision of services for the society (Bovaird, 2007, p. 860).

It is very useful to study time banks through the lens of co-production. The central purpose of this phenomenological study was to allow me to examine what role time bank participation within two community-based, restricted time bank organizations located in Southern California played in the participants' decisions to age in place. This was determined by an enhanced understanding of the articulated lived experiences of the participants. Time bank participation may have important implications for Medicaid, the largest funder of LTC services and supports, as it can delay the process of spending down assets to qualify for Medicaid. Furthermore, participation in time bank programs by older adults or other LTC individuals may delay the need for institutional care. Research findings should be of interest to state and federal policymakers considering strategies to

decrease the rate of growth in Medicaid and Medicare expenditures for elders and to expand home and community-based services.

This study can serve to inform future public policy analyses as it relates to expanding LTC options for individuals. This stems from the fact that the goal of public policy analysis, no matter which model is employed, is to allow analysts to use evaluative criteria (including qualitative data emanating from this study) to judge projected outcomes (Bardach, 2012). Examples of common evaluative criteria, which are used to judge outcomes, include efficiency (considered by Bardach to be the most important consideration in cost-effectiveness and benefit-cost studies), equality, equity, fairness, justice, freedom and community (Bardach, 2012, p. 37). In addition, Bardach discussed process values as another criterion to use to judge outcomes. Bardach (2012) pointed out that "democracy values process and procedure—that is, having a say in policy issues that affect you, rationality, openness and accessibility, transparency, fairness, non-arbitrariness—as well as substance" (p. 37). Guess and Farnham's (2011) view on the process of public policy analysis involved the application of problem definition and cost benefit analysis to the policy issue. In their textbook *Cases in Public Policy*, Guess and Farnham (2011) presented a generic public policy analytic approach as follows: Identify the core issues for decision; develop a framework for analysis and data collection; identify the relevant technical concepts and methods that will be used (opportunity costs, discount rates, and break even analysis); identify relevant policy options and rank by cost/risk; recommend solutions and identify missing data that, if supplied, could lead to better analysis and better decisions (p. ix).

In summary, the basic research design attempted to uncover participants' experiences and the meaning the participants ascribed to those experiences. I attempted to accomplish this by working with the public policy framework known as co-production. When viewed through a co-production lens, can time bank participation be considered an example of a public policy process through which inputs used to provide a service or good are contributed by individuals who are not working in the same organization? In other words, does Time bank participation translate into health care for participants (as they can be considered equal partners and cocreators of the delivery of particular LTC-related public services) or do participants rely on insurance products and public service organizations to support them in old age?

Evolution of Long-Term Health Care in the United States

Throughout the ages and in various cultures, societies have attempted to assume responsibility for their weakest citizens, including the frail and aged. Initially, in the United States, these efforts were evident in poor laws, charity workshops, poor farms and the philanthropic activities of religious organizations (Bortz, n.d.). Efforts to assist older adults during their times of need also included family members, namely adult children. Private charitable, philanthropic and mutual aid societies (some ethnic-based) also provided a variety of support programs through efforts of voluntary cooperation (Bortz, n.d.) to assist this growing part of the population. Bortz's (n.d.) commentary illustrated how these family and voluntary associations took on the roles of mediators between the frail who needed looking after, and the mass society or government organizations who could provide needed services.

Country	Underlying Philosophy	Eligibility	Financing	Coverage
 USA	The federal and state governments, along with the citizens, share responsibility for LTC	Based upon income, family size (Medicaid), type of care required	Through combination of sources including but not limited to family members, Medicaid, long-term care insurance, and Medicare. Americans must use their own money for nursing homes or other long-term care until they deplete their assets (including savings, pensions, Individual Retirement Accounts and severance packages) then they can qualify for Medicaid-The Federal-state health entitlement program.	Elderly care, all chronic care, at-home care, institutional care for elderly or physically or mentally challenged
 Canada	The provinces bear responsibility for long-term care except those in special groups such as military, native Canadians and quarantine centers –in which case, the government of Canada is responsible	Based upon type of care required	Universal health insurance (subsidized in part by higher taxes). Funding for LTC facilities governed by provinces and territories, which varies across the country. There are some means tests for government aid but families are not required to sell off their assets.	Services vary across the country in terms of range of services offered and costs
 The Netherlands	The state bears responsibility for LTC	Based upon type of care required	Public LTC insurance. Algemene Wet Bijzondere Ziektekosten (AWBZ). Exceptional Medical Expenses Act (1967). Full funding for formal care and partial funding for informal care	Elderly care, all chronic care, at-home care, institutional care for elderly or physically or mentally challenged

Figure 1. Comparison of criteria for long-term care (LTC) programs in three countries.

The provision of LTC is one example of how a society can provide security to its citizens. This varies across the globe. For example, the preceding chart (Figure 1) compares four criteria with regards to LTC availability. As can be seen, both Canada (Canadian Life and Health Insurance Association, 2012) and The Netherlands (Anderson et al., 2005) place importance in providing security through their generous LTC programs that do not necessitate citizens having to sell off most of their assets.

These individuals cannot care for themselves for long periods of time. Whether or not someone requires LTC services is usually determined by evaluating the person's ability to carry out daily self-care activities.

There are two general types of daily self -care activities that are measured. The first category is known as ADLs. This group includes the tasks that are required to get going in the morning, get from place to place using one's body, and then close out the day in the evening. The tasks involve caring for and moving the body (Wiener et al., 1990). For example, ADLs include eating, dressing, bathing, toileting, and getting in and out of bed or a chair. The second category of daily care activities involves the use of slightly more complex skills. This group of tasks is referred to as *instrumental ADLs* (IADLs). To clarify, IADLs include activities that people do once they are up and dressed. These tasks support an independent lifestyle. Many people can still live independently even though they need help with one or two of these IADLs. Examples of IADLs include doing laundry, housework, meal preparation, grocery shopping, transportation, financial management, managing medications and using the telephone or computer (Wiener et al., 1990).

Medicare, Medicaid, and private insurance each play a different role in the financing of LTC. Skilled services such as those provided by registered nurses, speech therapists or physical or occupational therapists, for example, are covered by Medicare. In the United States, 25% of all Medicare spending is for the five percent of patients who are in their final year of life and most of that money goes for care in their last couple of months that is of little apparent benefit (Riley & Lubitz, 2010). However, custodial services involving assistance with ADLs and IADLs, versus treatment or rehabilitative care related to a disease process, are not covered. To illustrate, tasks such as cooking, house cleaning, laundry, shopping or helping a patient to the toilet are classified by health

policy programs such as Medicare and Medicaid as unskilled tasks able to be performed by nurses' aides, home health aides, homemakers or family members and are often not covered by reimbursement programs (Bodenheimer & Grumbach, 2012, p. 147).

Colonial America

During colonial times, the concept of long term health care was known as old age security. In general, this security stemmed from accumulated wealth (property) and/or having many children who would grow up and look after their aging parents (Stevenson, 2016). Wealthy, childless individuals were in the position of hiring help when needed (medical and nonmedical) whereas most aging individuals with large families relied on their children for care. Moreover, most families lived closely together during Colonial times for reasons such as limited transportation options because railroads and automobiles had not yet been invented (Bortz, n.d.).

The family groups were self-sufficient. The virtues of industry, of frugality, and self -help were greatly valued (Bortz, n.d.). Extended families lived together easily and cheaply. Family members worked their own farms, while local community members pooled their efforts to assume the roles of butchers, bakers, barbers, and teachers for the local children (U.S. Social Security Administration, n.d.). Cash was not required in that type of local economy (Stevenson, 2016). In other words, barter of services or goods was a predominant currency for daily functioning. During this time, it was expected that children would take care of their parents if the parents needed care; however, if the adult children could not do this, then they could board out their parents to local surrogate

families and the adult children would pay the surrogate families for this service. Poor and childless elderly people relied on charity or public welfare to survive (Stevenson, 2016).

19th Century

As the United States continued to expand geographically, families began to scatter. As transportation options were becoming more prevalent in the middle 1800s many adult children left their homes and moved. This prompted the break-up of the old family structures as the younger generations now had the ability to move from rural areas into the cities where they could find jobs and earn incomes. The United States' government's enactment of the Homestead Act of 1862 further promoted the dispersion of the old family unit structures. This legislation declared that any citizen or intended citizen could claim 160 acres of unoccupied land in public domain states, which included any part of the country outside of the original 13 colonies, Tennessee, Kentucky and Texas. Claimants had to build a home on the land and grow crops on it for 5 years.

At the end of that time, if the claimants were still living on the land, it would belong to them, without charge. As a consequence, pioneers traveled through the Oregon Trail, the Santa Fe Trail, and other major wagon routes to claim their pending homesteads. Moreover, another force that pulled young adults away from the central family unit was the fact that to earn money, often these individuals had to move away from rural areas and into cities to find work. By the 1850s railroads were making travel easier and this, in turn, facilitated individual relocations from rural to urban locations. In 1869, when the transcontinental railroad was completed, individuals now had the ability to travel coast to coast in search of their fortune (Stevenson, 2016).

1900 to 1929

Urbanization increases care needs of older adults and as a result, nonprofit old-age homes are built (Bortz, n.d.). Many of these voluntary and nonprofit old-age homes were constructed on farm lands which could help support the homes' residents. As fewer people were dying in childhood, a larger percentage of the population lived to old age necessitating the building of more living quarters for these individuals. This, in turn, increased the demand for the construction of additional buildings (hospitals, barns, and staff homes) to help meet the needs of the residents and employees (Stevenson, 2016).

It was during this period that Theodore Roosevelt first included a type of social insurance as part of the campaign platform of his Progressive Party. During 1915, the group American Association for Labor Legislation, tried to introduce a medical insurance bill to some state legislatures. Although the attempt was unsuccessful, it did bring to the national forefront the discussion of a need for a government health insurance program. Although few social welfare measures were enacted during this period, many private social welfare organizations (including the National Consumers' League, the National Conference of Social Work, the National Child Labor Committee, and the American Association of Social Workers) kept fighting for the alleviation of all types of social distress, including health care concerns (Corning, 1969).

1930 to 1939

During the Great Depression (October 1929 to March 1933) the number of unemployed was estimated to be 13 million out of a labor force of 52 million (Bortz, n.d., p. 36). Of these 13 million unemployed, the U.S. Social Security Administration

estimated that only one fourth were receiving any kind of assistance. As noted by Bortz (n.d., p. 36) between 1929 and 1932, the marriage rate decreased by 22%, birth rates dropped sharply, and suicide rates increased by 40% over previous periods. During this time, the availability of LTC services (especially homes for older adults) was greatly reduced as local charitable organizations could no longer keep up with demands for assistance (Sultz & Young, 2014, p. 352). Local governments could not care for the increasing numbers of poor people on their welfare rolls and sought help from state governments. The states could not legally operate with deficit budgets or print new money to pay their obligations however, the federal government could. As a result, the states sought help from the federal government (Stevenson, 2016).

During this same time, people who risked losing their homes to mortgage foreclosures chose to operate small private nursing homes by taking in aged and infirm outsiders and providing care for them (Sultz & Young, 2014). However, this effort was not enough to meet the growing demand for LTC services. Many World War I military personnel who had returned from the war required all types of LTC. In addition, widows and orphans required financial assistance to survive. For these reasons, the federal government became a more active participant in developing, overseeing, and paying for a variety of financial and LTC services as part of the social welfare reforms.

The federal government's participation began in earnest when President Franklin D. Roosevelt signed the 1935 Social Security Act ([SSA], Stevenson, 2016). Medical benefits however, were omitted from SSA to avoid controversy that might halt the passage of SSA altogether (LaTour, Eichenwald Maki, & Oachs, 2013). Title I of SSA

did create the Old Age Assistance (OAA) program. This program was important for many reasons including the fact that its enactment ultimately helped to give birth to the Medicaid program, which has become the primary funding source for LTC today (Stevenson, 2016). The OAA program allowed for cash payments to be given to poor older adults, regardless of their work record. Through OAA, the federal government matched state old-age assistance expenses. Also, it was during this time that SSA was expanded (in 1939) to include survivors and dependents benefits.

After WWI, the Veteran's Administration added additional benefits for newly disabled veterans or surviving spouses. As the elderly and disabled portion of the population grew, many citizens were now eligible for some type of government payments including veteran's benefits, old-age assistance, Social Security, and unemployment assistance. Some of these funds could be directed towards nursing home care. As a result, the availability of care facilities increased (Stevenson, 2016).

1940 to 1949

During World War II, many seniors came out of retirement to participate in the war effort. As noted by Stevenson (2016), their war-time earnings may have helped them to escape welfare however this was only temporary as these seniors had to retire once again when the servicemen returned home and needed jobs. As was the case with the end of WWI, the disabled population, along with that of widows and orphans, increased after WWII ended. Moreover, the nation's health care infrastructure continued to deteriorate as hospital buildings (most of which had been built by charitable organizations during the

1920s and 1930s) were falling apart and there were no funds available to either renovate the old hospitals or to construct new ones (Stevenson, 2016).

In 1943, one of the most comprehensive social measures ever introduced in Congress was presented in a bill drafted by Senator Wagner and Senator Murray of Montana and Representative Dingell of Michigan (Corning, 1969). The Wagner-Murray-Dingell bill represented the beginning of a political debate that would continue until the 1960s (Corning, 1969). This bill outlined a federally sponsored health insurance program, along with permanent and temporary disability, maternity and death benefits, full federalization of the existing Federal-State unemployment insurance, expansion of old-age and survivors' insurance, and an increase in public assistance. President Truman and other bill supporters lost the battle as the bill was attacked by the American Medical Association (AMA) because members felt that government sponsored health insurance could cause physicians' reimbursements to decrease (Corning, 1969). Simultaneously, labor unions and the insurance industry opposed the bill because they preferred that employers provide health insurance to their employees as an alternative to a government - sponsored program (Stevenson, 2016).

In 1946, the Hospital Survey and Construction Act (commonly called the Hill-Burton Act) was enacted. This Act allowed for federal funding to build new hospitals in rural and impoverished areas that had no hospitals. Also, federal funding would be provided to modernize hospitals in urban areas. Hill-Burton financing led to tremendous growth in public and nonprofit hospital development. This legislation also provided a model for federal and state standards for the design, regulation, and financing of health

care institutions that was later adapted for nursing homes (Center for Medicare Advocacy, n.d.).

1950 to 1959

Home care (provided by nonfamily members) was never really considered as an alternative to institutionalization (Stevenson, 2016). The wealthier individuals however, hired private nurses to take care of them in their homes since the late 1800s but most people could not afford this. There were visiting nurse associations and public health nurses who visited people in their homes however, these individuals focused not on elderly care but on health education in general, including disease prevention and pregnancy (Stevenson, 2016). As hospital construction advanced and care was improved, more patients began going to medical facilities to receive medical care. The administrators of these facilities noted the cost-effectiveness of having patients come to them instead of the other way around (Stevenson, 2016). In addition, an unintended consequence of the Hill-Burton legislation was that many of the old hospitals that were being replaced were converted to nursing homes (Stevenson, 2016). In addition, construction resources were still in short supply since WWII ended so in addition to the conversion of old hospitals into nursing homes, additional conversions took place to meet the expanding demand for nursing homes. Hotels, homes, and various other existing buildings were also converted for this purpose (Stevenson, 2016).

1960 to 1969

As government payments to nursing homes increased (through federal funding for construction or renovation as well as direct payments to citizens), these facilities

continued to grow. This fast growth, in turn, created situations where nursing home quality concerns were raised (Stevenson, 2016). However, in spite of these concerns, demand was greater than supply for nursing home beds (Stevenson, 2016).

Two trends impacted the increase in the number of people receiving Social Security during this time, which led to more funds being available to be spent by individuals for nursing home care. Firstly, new groups of employees were added to the program as the Kerr-Mills Act (1960) established an additional category of welfare for aged people who were not on public assistance, but who could not pay for needed medical services (medically needy). Through passage of this act, the Medical Assistance for the Aged (MAA) program was created. This program authorized states to determine which patients needed financial assistance. In turn, the federal government would provide matching funds to the states for state funds disbursed through this program.

The second trend occurred in 1961 when the retirement age was lowered from 65 to 62 and in 1965 when benefits to aged widows was increased and, divorced women were added to the list of eligible beneficiaries if they could demonstrate that they had depended on their husband's earnings to survive. This increased the pool of people who now had the financial ability to pay privately for at least some of their care needs (Stevenson, 2016).

Major Long-Term Health Care Reform Efforts of the 20th Century

The modern concept of LTC dates to the passage of the SSA of 1935. This legislation "provided coverage to replace reliance upon charity and public relief" (Bortz, n.d., p. 54). The act (including subsequent amendments to it) established the

responsibilities and the working relationship between the federal and the state governments to provide Americans security relating to old-age, unemployment and health. More specifically, SSA ultimately provided for the public welfare by establishing a system of nationally administered (federal government) provisions for old-aged benefits and for facilitating the states' individual efforts to provide assistance in the areas of aid to disabled military personnel, widows and orphans, blind, crippled or otherwise dependent individuals, maternal and child welfare, public health, and the administration of unemployment compensation laws (Bortz, n.d.).

One portion of SSA that stimulated the growth of nursing homes on a national level was OAA, added to SSA in 1935. In effect, OAA combined the 28-state old-age assistance programs that were in place at the time. These various state programs were brought in to the federal system and each state was allowed to set its own standards for determining eligibility and payments, with the federal government providing cash for a 50% match up of up to $30 a month in aid (Stevenson, 2016). Old Age Assistance recipients now had funds to spend and as a result, they became attractive for proprietary nursing home operators. Nursing homes were now becoming a for-profit industry while hospitals continued to develop under government and nonprofit sponsorship (Stevenson, 2016).

Furthermore, amendments to the SSA during the 1950s and 1960s established a form of old age and survivor's insurance that allowed workers and their employers to contribute to a fund that could supplement retirement income. This form of income security decreased the extent of poverty frequently encountered in the elderly population.

It also increased the amount of guaranteed income that older Americans could spend on services and care in later years (Sultz & Young, 2014). In 1956, an amendment to SSA authorized federal matching for state funds designated towards providing social services and, in 1962 SSA was expanded to promote the provision of social services programs for older adults. These funds were used to provide services that would permit low-income elderly people to remain in their home. Many states applied these funds towards programs that provided homemaking and other domestic services to older adults still living at home. The enactment of Medicare and Medicaid legislation in 1965 further promoted the LTC industry as government payments increased. This allowed for more consistent sources or reimbursement than were previously only available through private pay and charitable funding.

Government Financing

Medicare Part A. Only with the 1965 enactment of Medicare (for older adults) and Medicaid (for people living in poverty) did public insurance payments for privately operated health services become a major feature of health care in the United States. Medicare Part A is a hospital insurance plan for older adults paid for mostly through social security taxes from employers and employees. People who reach 65 years of age who are eligible for Social Security are automatically enrolled in Medicare Part A irrespective of whether or not they are retired. Anyone who has paid into the Social Security system for 10 years is eligible for Social Security. So is that person's spouse. Those individuals who do not meet these Social Security eligibility criteria can enroll in Medicare Part A by paying a monthly premium.

People younger than 65 years old who are completely and permanently disabled due to chronic disease or injury may enroll in Medicare Part A after they have been receiving Social Security disability benefits for a qualifying period of 2 years.

People with chronic renal disease requiring dialysis or a transplant may also be eligible for Medicare Part A without a 2-year waiting period. Individuals with a life expectancy of 6 months or less maybe eligible to receive hospice care benefits under Medicare Part A. Access to hospice benefits require physician certification for eligibility. If the individual lives longer than 6 months, hospice care is still available as long as the hospice medical director or other hospice doctor recertifies that the individual is still terminally ill with a life expectancy of 6 months or less.

Medicare funding is through the Social Security system. Both the employers and the employees each pay to Medicare 1.45% of wages and salaries. Self-employed people pay 2.9%. The 2010 Accountable Care Act increased the rate for higher income taxpayers ($200,000 for individuals or $250,000 for couples) from 1.45% to 2.35% starting in 2013 (CMS, 2014). The trustees of the Medicare program increased this percentage of wages rate to raise social security payments while reducing expenditures to avoid the estimated 2017 Part A trust fund depletion. This action has extended Medicare's solvency through 2029 (Barton, 2010). With respects to services covered by Medicare, hospitalization, skilled nursing facility, home health care and hospice care are covered to varying degrees. Unskilled nursing home care (care that is mainly custodial) is not covered.

Medicare Part B. People who are eligible for Medicare Part A who choose to pay the Medicare Part B premium of $115.40 per month are eligible to sign up for

Medicare Part B. Some low-income people do not have to pay the premium. Higher income beneficiaries (over $85,000 for person or $170,000 per couple) have higher premiums based upon their income (CMS, 2014).

Benefits are partially financed by general federal revenues (including personal income and other federal taxes) and partially by Part B monthly premiums. Services covered under Part B include various medical expenses, physician services, physical, occupational, and speech therapy, medical equipment and diagnostic services. Certain preventative care services are also covered, in addition to outpatient medications.

Medicaid. Medicaid is a special type of funding that combines federal and state dollars however, the states had, up until the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010, full jurisdiction over how those Medicaid funds are paid out (Jha, 2013). Medicaid provides insurance coverage for a prescribed scope of basic health care services to individuals who qualify based on income parameters, established on a state-by-state basis.

Unlike Medicare, Medicaid is not an entitlement program funded by payroll taxes. Instead, it is funded by personal income and corporate and excise taxes, with funds transferred from more economically affluent individuals to those in need. Unlike Medicare, which reimburses providers through intermediaries such as Blue Cross, Medicaid directly reimburses service providers. Rate-setting formulas, procedures, and policies vary widely among states and as such, Medicaid has been described as “50 different programs” (Sultz & Young, 2014, p.270).

The federal government pays between 50% and 76% of total Medicaid costs; the federal contribution is greater for states with lower per capita incomes. Although designed for low-income Americans, not all poor people are eligible for Medicaid. In addition to being poor, Medicaid has required that people also meet categorical eligibility criteria such as being a young child, pregnant, elderly, or disabled. The PPACA included a large increase of Medicaid disbursements that began in 2014, eliminating the categorical eligibility criteria and offering the program to all citizens and legal residents with family income below 133% of the federal poverty line.

In 2012, The National Federation of Independent Businesses (NFIB) a 350,000-member lobbying organization representing the interests of small firms (Sultz & Young, 2014) brought a lawsuit against the federal government challenging the constitutionality of PPACA. Enacted in 2010, the PPACA affects a wide variety of topics including health insurance, Medicaid, Medicare, LTC, and public health. The two main provisions at issue in *NFIB v. Sebelius* (2012) were the individual mandate and the Medicaid expansion. Under the individual mandate, most Americans must purchase minimum essential insurance coverage or face a penalty in the form of a tax assessment. Under the Medicaid expansion, state Medicaid programs must cover most individuals below 133% of the federal poverty level. States that do not comply with the Medicaid expansion could lose all of their federal Medicaid funding (*NFIB v. Sebelius*, 2012). Because the states originally had jurisdiction over how the Medicaid funds (which the federal government would match) were paid out, PPACA matching requirements varied from state to state.

In 2012, some groups sued the federal government claiming it was infringing upon the states' authority to continue to determine what these matching requirements are. For example, the plaintiffs in *NFIB v. Sebelius* (2012) alleged that both the individual mandate and the Medicaid expansion exceeded the federal government's constitutionally enumerated powers. These powers include The Commerce Clause, which grants the federal government the power to regulate interstate commerce and prohibits the states from regulating the same; The Taxing and Spending Clause, which grants the federal government the power to levy taxes and spend federal funds (including attaching conditions to the receipt of such funds) and The Necessary and Proper Clause, which grants the federal government the power to enact laws that are necessary and proper for carrying out its other enumerated powers (*NFIB v. Sebelius*, 2012).

In response to the plaintiff's claims, the federal government claimed that the individual mandate was justified by three of its enumerated powers: The Commerce Clause, the Taxing and Spending Clause, and the Necessary and Proper Clause. A majority of the Court ruled that the federal government does not have the authority to force people to buy a product under the Commerce Clause or the Necessary and Proper Clause. However, a majority of the Court upheld the mandate under the Taxing and Spending Clause because the sole consequence for failing to purchase insurance is a tax; in other words, the PPACA can be read as taxing people who fail to buy insurance, which is within the authority of the federal government.

With regards to the Medicaid expansion, a majority of the Court ruled that threatening states with the loss of all Medicaid funding if they do not comply with the

Medicaid expansion is unconstitutional. According to the Court, the potential loss of such a large sum of federal money essentially deprived states of the option not to comply with the expansion. A majority of the Court ruled that the remedy for this constitutional violation is to preclude the federal government from withdrawing existing federal funding to states that do not comply. In other words, the Court ruled that states that do not comply with the Medicaid expansion would only lose the matching funds for the newly eligible population; existing Medicaid funding would not be affected. States that elect to proceed with the Medicaid expansion would presumably be unaffected by the ruling (*NFIB v Sibelius*, 2012). The additional 16 million people on Medicaid will be financed largely by the federal government at a cost of over $40 billion per year in new dollars (CMS, 2014). According to federal government requirements, a broad set of services must be covered under Medicaid, including hospital, physician, laboratory, x-ray, prenatal, preventative, nursing home, and home health services, although these services can be restricted through federal waivers.

Informal (Family/Friend) Caregiving

According to a 2009 study conducted by the American Association of Retired Persons (AARP) Public Policy Institute, people needing LTC services receive them mostly from their family and friends (AARP, 2011). The study found that the support of family and friends was a major factor in determining whether or not an individual needing LTC remained in one's home and community. The study noted that if family care-givers were no longer involved in the process, the economic cost to the United States' health care system would rise sharply. For example, in 2009, it was estimated that

42.1 million family caregivers in the United States provided care to an adult with limitations in daily activities at any given point in time, and about 61.6 million provided care at some time during the year (AARP, 2011).

The estimated economic value of their unpaid contributions was approximately $450 billion in 2009, up from an estimated $375 billion in 2007 (AARP, 2011, p. 1). If family care-giving were no longer available according to this study, the increase in economic cost to the United States' health care system would be "astronomical" (AARP, 2011, p. 3). To put things in perspective, the estimated $450 billion approaches the total 2009 expenditures ($509 billion) for the Medicare program (AARP, 2011, p. 1).

In addition, it is the wives who often provide LTC for their husbands, and for women, it is their daughters who are frequently caregivers (Bodenheimer & Grumbach, 2012). Levine (1999) reported that on average, informal (family or friends) caregivers provide 20 hours per week of care. It was estimated that 37% of informal caregivers to individuals age 50 or older reported resigning from their job or decreasing their work hours to assist their family members (Levine, 1999). Overall, according to Levine (1999), the informal care received by these individuals resulted in shorter hospital stays, fewer readmissions, and lower inpatient expenses, demonstrating that unpaid caregivers create a great deal of value for the health care system.

Institutional Based

Nursing homes. The history of the growth of nursing home care in the United States includes the use of a variety of organizations to take care of older adults including poorhouses and homes supported by immigrant or philanthropic organizations (Eskildsen

& Price, 2009). The SSA of 1935 was passed following the Great Depression that began in 1929, and with SSA's cash assistance program for older adults, sped up the downfall of poorhouses and propelled the growth of for-profit nursing homes. Nonprofit nursing homes also increased in number however at a slower rate than for-profit facilities due to strict operating restrictions imposed on the nonprofit facilities by many religiously-based sponsoring organizations (Eskildsen & Price, 2009).

After WWII, nursing home growth was stimulated with the passage in 1946 of the Hill-Burton Act. The goal of this legislation was to improve the country's hospital system however an unintended consequence arose in that nursing homes were expanded as former hospital buildings were converted for extended care (Eskildsen & Price, 2009). Finally, in 1965, President Lyndon Johnson signed into law two amendments to the SSA of 1935. Title VXIII, which became known as Medicare, provides hospital insurance for the aged and supplementary medical insurance. Title XIX, which became known as Medicaid, provides for the states to finance health care for individuals who are close to the public assistance level and in turn, the federal government would help with matching funds. These programs continue to be the main source of health insurance for adults over 65 years of age, with Medicaid being the primary payer of long-term nursing home benefits and Medicare paying for skilled short stays in nursing homes (Eskildsen & Price, 2009).

Today, there are approximately 18,000 nursing homes in the United States, each with an average of 106 beds (Fisher & Castle, 2012). Residents usually arrive at a nursing home as a result of an acceleration of care from either their home or an assisted

living facility, as a step down in treatment intensity from a hospital, or when transferred from another nursing home (Fisher & Castle, 2012). Medicaid covers 46% of the nursing home industry's revenue (Fisher & Castle, 2012). Any nursing home that chooses to accept Medicare or Medicaid residents is subject to inspection by the CMS. These inspections take place every 9 to 15 months and the nursing homes are subject to fines if any violations occur. To keep costs down, most care in nursing homes is provided by nurse's aides, who are paid very little, receive minimal training, are inadequately supervised, and are required to care for more residents than they can properly serve (Fisher & Castle, 2012). The job of a nursing home aide is very difficult, involving bathing, feeding, walking residents, cleaning them when they are incontinent, lifting them, and hearing their complaints.

Assisted living facilities. Assisted living, which provides housing with a ranked intensity of services depending on the functional capabilities of its residents, has been growing rapidly. However, the average annual cost in 2009 was $34,000, most of which comes from out-of-pocket payments, and as a consequence, prices assisting living out of the reach of low- and moderate-income families (Bodenheimer & Grumbach, 2012). These facilities are deemed appropriate for people who do not require skilled nursing services and whose needs lie more in the custodial and supportive sphere. Members are provided with daily meals, personal and other supportive services, health care and 24-hour oversight to persons residing in a group residential facility who need assistance with ADLs (Barton, 2010). Many assisted living facilities contract with home health agencies to provide skilled nursing care and with hospice service providers when such services are

needed by individual residents. States carry out oversight and regulation of assisted living facilities at various levels (Stevenson & Grabowski, 2010).

LTC: Current Policies, Programs, and Systems

Community Based

Community-based LTC is delivered through a variety of programs, such as home care, adult day care, assisted living settings, home-delivered meals, board and care homes, hospice care for the terminally ill, mental health programs, and others. During the 1970s, the independent living movement among disabled people created a strong push away from institutional (hospital and nursing home) care toward community-based and home care that fostered the greatest possible independence (Bodenheimer & Grumbach, 2012). During the 1980s, acquired immunodeficiency syndrome (AIDS) activists furthered the development of community hospice programs that provided intensive home care services for people with terminal cancer and AIDS. In addition, the Medicaid provision of LTC services expanded from home health care and nursing home care to HCBS with the passage of the 1981 Omnibus Budget Reconciliation Act (OBRA). This expansion occurred for several reasons (Barton, 2010):

- State Medicaid programs, because they reimbursed for few HCBS, created perverse incentives for people to use more expensive nursing home care when available.
- Both federal and state government wanted to reduce their expenditures for nursing home care and restrain expansion of nursing home bed supply.

- Enrollees wanted to obtain services in their homes or communities rather than being institutionalized. (p. 356)

The HCBS provisions of Section 2176 of the 1981 OBRA allowed states to produce waivers authorizing community-based LTC services to be provided for elderly people, those with developmental disabilities, and other disabled and chronically ill people who would otherwise require nursing home or other forms of institutional care. The Medicaid law (Title XIX of the SSA) authorizes these waivers under its section 1915(c). The 1981 OBRA created another waiver program to deal with the unique requirements of the growing elderly population (frail elderly) who were at risk for seeking nursing home care. These waivers allow states to provide medical and medically related benefits and to include a range of nonmedical, social, and support services that are essential in permitting people to stay in the community (Barton, 2010).

Home care. Because a reasonable quality of life and personal independence, within the limitations imposed by a patient's illness, are so difficult to achieve in the nursing home environment, LTC reformers often advocate that most LTC be provided at home (Bodenheimer & Grumbach, 2012). The first step toward deinstitutionalizing LTC is a financing mechanism that pays for more comprehensive community based and home LTC services. Home health care services include performing blood pressure checks and other monitoring activities, starting intravenous therapies, checking surgical wounds, and administering immunizations or other injections (Barton, 2010). A limited home health care benefit was included with the passage of Medicare legislation in 1965 and the

Medicaid legislation provided for the coverage of personal care services prescribed by a physician.

From one of the smallest expenditure categories to one of the fastest growing ones, Medicare home health care expenditures grew from $2.7 billion to $12.7 billion between 1989 and 1994, and they reached $ 19.8 billion in 2009 (Barton, 2010). Many experts and advisors in the field of LTC consulting feel that the ideal long-term caregivers are the patient's family and friends; as a result, an argument can be made that LTC reform should support, assist, and pay informal caregivers, not replace them (Bodenheimer & Grumbach, 2012). Teams of nurses, physical and occupational therapists, physicians, social workers, and attendants can train and work with informal caregivers, and personnel can be available to provide respite care so informal caregivers can have some relief from the 24-hours-a day, 7 days a week burden. If informal caregivers are not available, all possible efforts can still be made to deliver LTC in people's home's homes rather than in nursing homes (Bodenheimer & Grumbach, 2012).

Money follows the person initiative. This initiative helps states rebalance their Medicaid LTC systems by providing funds to help people transition back into their communities **(**Watts, 2013). The Affordable Care Act of 2010 strengthened and expanded the program allowing more states to apply. Currently, 44 states and the District of Columbia participate in this program. The goals of the Money Follows the Person Program include the following (Watts, 2013):

- Increase the use of HCBS and reduce the use of institutionally-based services

- Eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get LTC in the settings of their choice
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions
- Put procedures in place to provide quality assurance and improvement of HCBS. (p. 6)

NORCs. The term *NORC* is often used to describe apartment buildings where most residents are 60 years of age or older (Sultz & Young, 2014). Programs that include NORCs use a blend of services such as case management, nursing, social and recreational activities, health education, transportation, nutrition, and referral linkages to enhance quality of life and safety for adults who wish to remain in their homes during their aging process. The NORC living arrangement appears to hold much potential to serve as a positive alternative to institutionalization and to provide possible cost savings for individuals and government (Sultz & Young, 2014). Beacon Hill Village, located in Boston, serves as a prototype of how a successful NORC operates (Gross, 2006). Here, NORC community members must pay dues and must live in either the storied Beacon Hill or Back Bay neighborhoods. The United States Administration on Aging pays for service coordinators at NORCs and a few Medicaid programs are giving older adults vouchers to buy home care services—not just to pay for nursing home care (Gross, 2006).

On Lok Senior Health Service (aging in place). An innovative LTC program that has achieved great success is the On Lok program started in San Francisco's

Chinatown in 1971. Translated from Chinese, On Lok means *peaceful, happy abode*. The On Lok set up is similar to that of NORC communities however, this program differs from NORCs in that most of the On Lok residents are less independent and as a result, may require more assistance with day to day living. The program relies on adult day care to monitor the health of frail, elderly people at risk for nursing home care and to make sure that the members have access to required services. Consequently, On Lok merges adult day services, in-home care, home-delivered meals, housing assistance, comprehensive medical care, respite care for caregivers, hospital care, and skilled nursing care into one program. Persons eligible for On Lok have chronic illness sufficiently severe to qualify them for nursing home placement, but only 15% ever spend time in a nursing home (Bodenheimer & Grumbach, 2012). Services for each resident member are organized by a multi-disciplinary team, including physicians, nurses, social workers, rehabilitation and recreation therapists, and nutritionists.

In 1983, On Lok became the first organization in the United States to undertake full financial risk for the care of frail elderly population, receiving monthly capitation payments from Medicare and Medicaid to cover all services. Whereas 45% of personal health care expenditures in the United States go to hospital and nursing home services, On Lok spent only 16% on these items, making 83% of the health care dollar available for ambulatory home and community-based services (Bodenheimer & Grumbach, 2012). While its services are far more comprehensive, On Lok's costs are no higher than for those for a similar frail elderly population under traditional Medicare and Medicaid (Barton, 2010).

Background on Time Banks and Community Currency

Because one of the desired indirect outcomes of this study is to increase consideration of options available for individuals who wish to age in place or wish to receive a variety of LTC services in a home environment, various types of community currency models (including local exchange trading systems [LETS], hours systems, and time banks) were studied. Ultimately, the community currency model referred to as time banking was selected as the most appropriate for this study because use of this model's design takes into consideration the complexities of participant factors, including psychological, sociological, and economic, all of which impact health care access (Collom, 2014). Surrounding this list of complex participant factors are a variety of environmental factors that influence the process, the most pertinent of which I will discuss in greater detail later in this chapter. As a result, the time banks community currency/time barter model is one of the few barter models to successfully merge elements from both co-production and aging in place initiatives.

Because the time bank model is designed to facilitate the exchange of services among individuals who participate in particular time bank networks, the process is contingent upon community involvement and thus is relevant to this study of aging in place options for seniors and others needing LTC. In all instances (time bank participation, aging in place, co-production), the thread of active citizen participation in the delivery of LTC (and other government services) is evident.

Scholars and policymakers are finding value in the time banks model for their research and policy initiatives. In a study on aging and LTC, members of the California Senate Select Committee tasked with looking into this matter concluded the following:

> A person-centered, culturally responsive LTC system would enable individuals to receive services in the most affordable, home-like settings available. California was once a leader in providing services to support the full integration of older adults and persons with disabilities into community life. Over the past several years, however, the LTC system has been adversely impacted by system fragmentation, a lack of usable data, poor planning, unaddressed workforce issues, capacity issues, and of course, devastating budget cuts during the recessions. (California State Senate, 2014, p. 7)

Advocates claim that local currency systems (such as time banks) can generate a variety of beneficial outcomes (Cahn, 2000; Collom et al., 2012; Meeker-Lowry, 1995; Seyfang & Smith, 2002). The major types include: economic, social, health, ideological, and environmental. Individual members, participating organizations and the wider community can all potentially experience positive gains (Collom et al., 2012). Community-provided welfare (such as time banks) that are the result of grass-root activists' efforts can help build solutions to contemporary social problems stemming from limited incomes, inadequate health care, expensive housing, assistance with daily activities and social isolation (Collom, 2014). Important public policy issues emerge from community currency efforts. How can local, state and federal officials play a role in and support these movements? Should scarce government resources be channeled toward

them? Might these movements be counter-productive, absolving authorities of traditional responsibilities (Collom, 2014)?

Time banks are the most popular type in the United States of what has been called *community currencies*, that is, localized exchange systems based on time or unofficial dollar equivalents as the medium of exchange (Collom, 2007). An amalgam of components of various community currency models and theories, the time bank model is rooted in alternative social movement ideology that emphasizes bottom-up initiatives to empower the marginalized (Collom, 2014). It is an example of communities engaging in do-it-yourself (DIY) efforts to increase access to resources-including health care. Through use of this model, individuals become less reliant upon mainstream governmental and social institutions and are creating local alternatives to complement or replace local, state and federal initiatives.

The growth of the Time Banks movement. Time banks are service-exchange networks that utilize an alternative, local currency to make services and goods more accessible and to create community. Though there are various models, and each system tends to have its own dynamics, the basic premise of these networks is similar. Participants join and publicize the services or goods that they wish to offer or obtain in an online or printed directory. A member desiring something contacts the provider (or a staff person in some instances), negotiates the transaction, and then arranges it. The recipient pays with, and the provider receives the local currency (including hours), which acts as a mechanism to store the value of the transaction so that the credit can be used later with others in the network. The general idea underlying local currencies is to decrease the

need for conventional money by increasing access to resources in the community (Cahn, 2000).

Since the early 1980s there have been three types of community currency systems in operation across the world: LETS; hours systems, and time banks (Meeker-Lowry, 1995).

LETS. Locally initiated, democratically organized, not for profit community enterprise that provides a community information service and records transactions of members exchanging goods and services by using the currency of locally created LETS Credits. The value of these virtual currencies is usually pegged to the national currency. Participants exchange services with one another—not with the group. Participants report their exchanges to an administrator who tracks circulation in a database. Tax and welfare benefit calculations do not allow for LETS exemptions (Seyfang & Smith, 2002).

Hours system. Each one hour of work is valued according to agreed-upon amount. Participants earn fake paper money for performing services for one another. They are free to spend this fake paper money to purchase services from other local community hours group members (Collom, 2007).

Time bank. A time bank is a community of people who have agreed to trade each other their services, or their time. In a Time-Bank, time itself is currency, and no one person's time is deemed to be more valuable than another's. For example, an uneducated person's services are judged to be equal to the services of a PhD. Services are traded on an hour-for-hour basis.

Time Banks USA (formerly known as the Time Dollar Network) was started in Miami in the early 1970s by law professor Edgar Cahn. A staff is required to recruit participants, provide orientation, match providers and recipients as needed, track the hours, and distribute statements to members. The earliest time banks were service credit banking programs. These agency-based programs were mostly intergenerational, recruiting older people to help other older people remain independent and in their homes (Lasker et al., 2011). Today, most time banks continue to be based in existing institutions (hospitals, schools, churches, or social service agencies) and target the socially and economically marginalized—the young, elderly, poor, and disabled (Seyfang & Smith, 2002).

Cahn, an attorney, economist, and long-time social activist (Cahn, 2000) began the program to mobilize people so that citizens “not only notice that the poor old lady across town can't get out of bed, they take the next step and hop into their car and drive across town to take out her garbage, hold her hand or rake her leaves" (Dentzer, 2002, p. 79). Initially, Cahn searched for a way to link the following phenomena: there were many people in the world who needed help; helping these people could in some ways disenfranchise them; and to help keep these needy individuals feeling empowered and engaged, a way had to be found to enlist them in helping themselves (Cahn, 2000, p. 24).

Cahn studied time banking from a social justice perspective. His thinking evolved during the 1980s to the point where he was supporting time dollars and time banking from a public choice and co-production theoretical perspective (Cahn, 2000, p. 181). The early motto of Cahn's TimeDollars.org program was "Help somebody. Give an hour, get

an hour. One hour equals one service credit" (Cahn, 2000, p. 80). In the 1980s Cahn changed the term *service credit* to *Time Dollars* (Cahn, 2000, p. 81).

One of the early challenges of Time Dollar.org groups included trouble recruiting both volunteer service providers as well as recipients of these volunteer services (Cahn, 2000, p. 82). In addition, a large administrative staff was needed to recruit and manage volunteers and to keep tabs on those who needed services and those who could provide these services through volunteer efforts. In addition, an administrator was needed who knew how to run the computer software system that contained data used to keep the program running smoothly (Cahn, 2000, p. 82).

The RWJF has been particularly involved with funding projects that encourage people to volunteer their services to the needy (Benjamin & Snyder, 2002). The foundation has made it a priority to expand and improve LTC services for elderly people, especially those who are frail (Benjamin & Snyder, 2002, p. 75). At one point, the foundation donated up to $100 million on a program called Faith in Action to help religious institutions of various faiths to support their own members who needed LTC (Benjamin & Snyder, 2002, p. 81). Eventually, RWJF expanded into supporting programs service credit programs in two phases (Benjamin & Snyder, 2002). Phase 1 was the authorization of $1.2 million in grants under a program called *Service Credit Banking for the Elderly*. Six health care organizations were involved with the program. This included two hospitals, one nursing home, a senior center, a community service center, and a social health maintenance organization (SHMO). The program ran from 1987 to 1990 under the leadership of Cahn (Benjamin & Snyder, 2002).

At the end of 3 years, a study was conducted by RWJF to determine if a program of service credits could attract senior volunteers to serve elderly people. Precisely, how important were credits themselves in this process, and could the concept increase local capacity to provide supportive services to frail elderly (Dentzer, 2002, p. 81)? The study results were mixed. As noted by Dentzer (2002), a big weakness of the program dealt with the number of people needed to administer it. At the time, the technology was not available to run the organization efficiently but thanks to new technological advancements, this is no longer the case (p. 86).

One of the most successful service credit programs associated with SHMOs was Elderplan, a service credit banking group specifically set up for elderly grantees (Dentzer, 2002, p. 85). It was based in Brooklyn, New York. Elderplan was one of the original SHMO demonstration projects created by the federal government in the 1980s. The concept behind SHMOs was to help frail elderly people stay out of nursing homes. To do this, SHMOs were given waivers from the traditional Medicare and Medicaid programs, in return for which they would offer supplemental services beyond the normal benefits that these programs typically offered. The concept provided a kind of natural home for a service credit program in that SHMOs tended to attract both enrollees and staff members attuned to the importance of providing more than just standard medical services to the aged (Dentzer, 2002). An SHMO is more expensive, but enrollees are covered for more services than original Medicare (Medicare Resource Center, 2016). The personal care services include, but are not limited to, homemaker, adult day care, respite care, and medical transportation. This made the SHMO operating environment conducive towards

the service credit banking program because there were many personal services needed by SHMO members that were not necessarily covered by the SHMO plan. As of 2015, the Elderplan SHMO is still in operation, however the service credit banking group was abolished after several years of operation. The service credit banking concept was widely applauded however, the group had become too expensive and difficult to manage from an administrative standpoint (Benjamin & Snyder, 2002).

In 1992, RWJF set up a national program office for what would become the second phase of its experiment—the Service Credit Banking in Managed Care Program (Dentzer, 2002, p. 85). The program was housed at the University of Maryland Center on Aging located in College Park, Maryland as part of the Family Medical Group, a primary medical-care group practice located in San Fernando Valley, California. All was going well until the Family Medical Group was accused of delivering inadequate care to patients. In an episode that foreshadowed later volatility at other managed care organizations, Family Medical Group lost a large HMO contract and one half of its patient base. It was then sold to a medical management organization that discontinued the service credit banking project.

A prototype service credit banking program for HMOs was instituted at the Rocky Mountain HMO in Grand Junction, Colorado. The RWJF signed a 3-year contract with Rocky Mountain in 1993 to develop a time bank (Dentzer, 2007, p. 87). Within the first 3 years, RWJF contributed $50,000 towards this effort. The time bank program was housed within Rocky Mountain HMO's home health care department, and would work, where

possible, to provide services for the agency's clients. Although volunteers did not need to belong to the HMO, only HMO members would receive services.

The larger goal of the HMO was to take the time bank program to the community. The foundation set up an additional five service credit banking replication projects at other managed care organizations however most of these projects were unable to meet either of the challenges that prompted RWJF to launch the program: financial sustainability and information management. Facing decreasing profits and in some cases, organizational upheaval, four of the five managed care organizations abandoned their service credit banking projects. Only the Rocky Mountain HMO and Blue Shield of California maintain their service credit banking operations to this day. As of 2015, RWJF studies have not been able to determine whether earning service credits is a meaningful incentive for volunteers or whether credit banking programs can produce savings that offset their administrative costs (Benjamin & Snyder, 2002).

Public Policy Interactions

In this study I wove together elements of co-production theories, LTC (including aging in place) policies and options, and the growth of the time bank movement to more fully understand how individuals perceive time bank participation with regards to using it as an aging in place option (Figure 2).

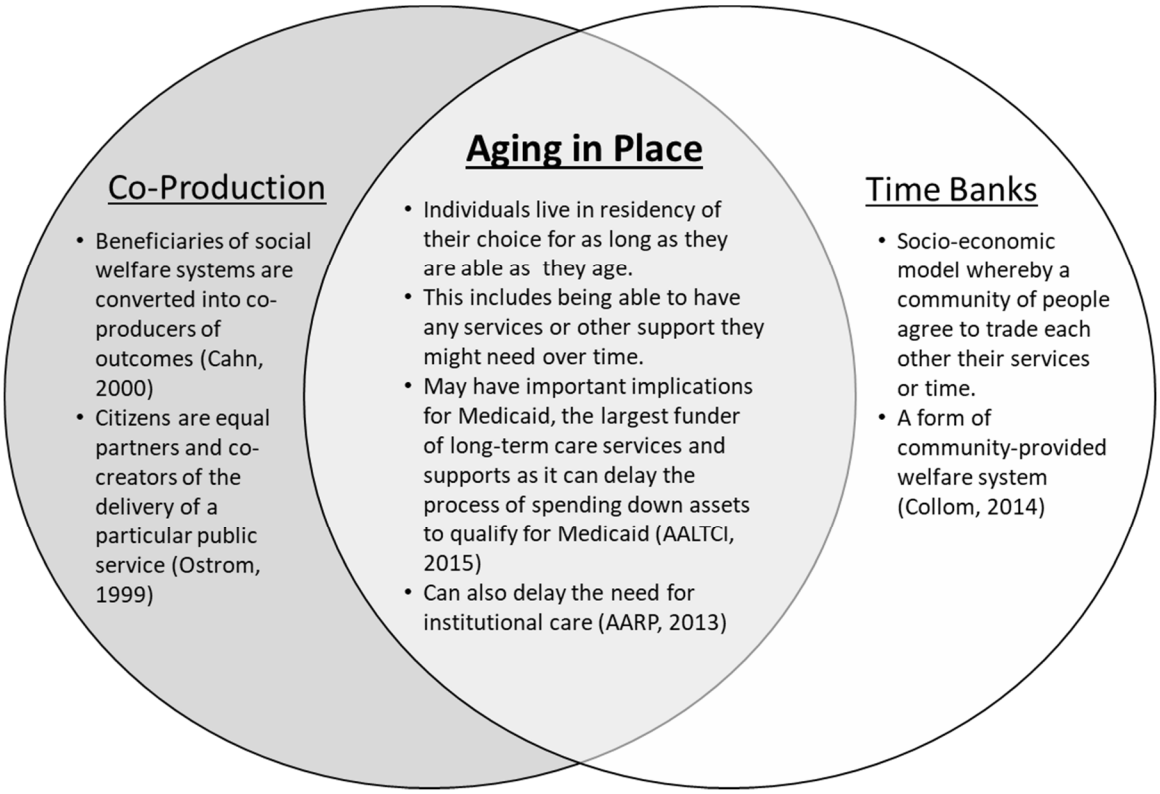

Figure 2. Comparison between time banks, co-production, and aging in place.

In addition, I also explored how public policies, programs, and systems interact in this process to impact both desire for people to age in place. Furthermore, I explored the availability of community currency programs (such as time banks) in order for them to consider this as an option. The use of time banks is being legitimized through calls to action from government task forces and proposed legislation. For example, the California Senate Select Committee on Aging and Long-Term Care (California State Senate, 2014) has acknowledged that elders and persons with disabilities prefer to remain as independent as possible, in their own homes with support from home and community-based services. In the committee's 2014 report, it presented over 30 legislative recommendations for immediate action and provides a strategy to achieve improved

coordination and a high functioning comprehensive system (California State Senate, 2014).

The stated goal of the committee was to design a "person-centered, culturally responsive LTC system which would enable individuals to receive services in the most affordable, home-like settings available*"* (California State Senate, 2014, p. 7). The California Senate Select Committee on Aging and Long-term Care (California State Senate, 2014) defined LTC as follows:

> Long-term care (LTC), also referred to as Long-Term Services and Supports (LTSS), refers to a broad range of services delivered by paid or unpaid providers that can support people who have limitations in their ability to care for themselves due to a physical, cognitive, or chronic health condition that is expected to continue at home, in the community, in residential settings, or in institutional settings. (p. 7)

Summary and Conclusion

According to a recent California government study (California State Senate, 2014), access to and quality of LTC service in California are unsatisfactory. That same study indicated that comparable expenditures in other states have also increased and deficits in access to quality care are increasing. NHE increased 3.6% to $2.9 trillion in 2013, or $9,255 per person, and accounted for 17.4% of the Gross Domestic Product (CMS, 2014). Although Medicare does not pay for LTC, its acute and postacute care expenditures are much higher for LTC users.

A variety of factors influence an individual's decision to age in place or to move into an assisted living or nursing home. Time Barter enrollment may exert influence in this decision-making process. Findings from this research should be of interest to state and federal policymakers considering strategies to decrease the rate of growth in Medicare and Medicaid expenses for elders and to expand home and community-based services.

This chapter provided a review of existing literature on co-production, long-term health care delivery history (including aging in place), and time banks. Chapter 3 introduces the research design and approach for this study.

Chapter 3: Research Method

Introduction

In this chapter, I have specified my research design and approach for the exploration of the central purpose of this phenomenological study dealing with the role time bank participation within two Southern California time banks played in an individual's decision to age in place. This chapter is organized into five major content areas: (a) a description of the phenomenological design and the research questions, (b) the logic behind the selection of the population and the sample, (c) components of the instrumentation, (d) data collection and analysis procedures, (e) threats to validity and issues of trustworthiness, and (f) measures taken to ensure the protection of participant rights.

There has been insufficient evidence on whether service barter systems (including time banks) are a good alternative or complement to the provision of services for care seekers 50 years or older not presently involved in LTC living arrangements. The basic research design was an attempt to uncover participants' experiences with the time bank relationship and the meaning the participants ascribed to those experiences. These lived experiences were examined using co-production (as conceptualized by Ostrom, 1999) as the theoretical framework/lens. When viewed through a co-production lens, I was concerned with whether time bank participation could be considered an example of a public policy process through which inputs used to provide a service or good are contributed by individuals who are not working in the same organization. In other words, this study addressed if time bank participation translated into health care for participants

(as they can be considered equal partners and cocreators of the delivery of particular LTC-related public services) or if participants relied on insurance products and public service organizations to support them in old age.

I used Collom et al.'s (2012) social outcomes study using a retrospective membership survey (Appendix A) to inform the semistructured interview guide portion of my qualitative study. I used the categories from his study to guide my interview protocol. Collom et al. created their social outcomes survey from previous community research on motivations (Appendix B) and outcomes (Appendix C), which included a total of 21 studies. Themes resulting from the study were used to inform questions I included in my semistructured, phenomenological-based interviews. I did this to determine if service barter systems served as a viable alternative and/or complement to the provision of services for elderly care seekers who are presently not involved in any type of LTC living arrangements.

Research Design and Approach

In this phenomenological study, I explored and explained the views of time bank participants as they articulated their lived experience as related to their involvement with this group. The research would uncover whether their experiences affected their decisions to age in place. I attempted to answer my research questions while working with the co-production theoretical framework as conceptualized by Ostrom (1999).

Using the semistructured interview format, I collected qualitative data and performed a thematic analysis. The data were coded to keep responses at a level where they could be easily separated to examine any differences in philosophy or responses

between the two locations. Further analysis will be provided in Chapter 5 as to whether time banks can be considered a good alternative or complement to the provision of LTC services for care seekers who are not presently involved in any type of LTC living arrangements.

Rationale for a Phenomenological Methodology

Which methodology to use for this study was based not only on the research questions but also upon my assumptions about what constitutes human knowledge (Crotty, 1998, p. 2). Based upon the research questions, I considered the following four basic elements of research: method, methodology, theoretical perspective, and epistemology (Crotty, 1998, p. 3). My decision to work with phenomenology as the research paradigm emerged from my constructivist worldview as I sought to explore the trends as well as the stories and personal experiences of the participants. My epistemological position regarding this research can be described as follows: (a) data are contained within the perspectives of people who are involved with the CA TB 1 and CA TB 2 groups, and (b) because of this, I engaged with the participants in collecting the data.

Justification for the Methodological Paradigms

For this study, I worked with a phenomenological design during the data collection, analysis, and reporting phases. This research paradigm was appropriate because the main purpose of the study was to investigate and understand the common experiences of time bank participants, 50 years or older, to determine how they viewed their participation as it related to access to LTC and ultimately, did their experiences

impact their decisions as to whether they chose to age in place. I studied their perceptual processes through semistructured interviews.

During the selection of the qualitative methodology, I evaluated four qualitative research paradigms to select the approach that would be best suited for this study. Initially I had planned to employ a case study approach for this research whereby I would develop in-depth descriptions and analyses of several cases. I rejected use of this qualitative approach because I was interested in studying several individuals who have shared the same experience over a long period of time. This contrasts with studying an event or activity. Furthermore, as noted by Yin (2014), "The essence of a case study, the central tendency among all types of case study, is that it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented, and with what result" (p. 15).

Case study differs from a phenomenological study whereby the aim of phenomenology is to determine what an experience means for the individuals who have had the experience and are able to provide a comprehensive description of it (Giorgi, 1985). Furthermore, Husserl (1982) did not believe that objects in the external world exist independently and, as a result, information about these objects is not reliable. He noted that individuals can be certain about how things appear in or present themselves to their consciousness. As a result, individual, personal realities were to be treated as pure phenomena, or absolute data. He coined this philosophical method *phenomenology* and referred to it as the science of pure phenomena (Moustakas, 1994, p. 26). Holloway (1997) noted that Husserl studied under Franz Brentano, who provided him with the

foundation for phenomenology. Brentano stressed the "intentional nature of consciousness' or the 'internal experience of being conscious of something" (Holloway, 1997, p. 117). In turn, Husserl's student, Martin Heidegger, took the phenomenological paradigm one step further by introducing the concept of *being there* and the conversation between an individual and the world within which he lives (Holloway, 1997, p. 117). Narrative research, which explores the life of an individual, is too detailed. This research method would not have allowed me to answer my research questions. I also evaluated use of an ethnographic qualitative approach; however, my research questions, which do not involve studying a group that shares the same culture, would not have been answered through my study. As a result, given the importance of understanding the shared, lived experiences of a variety of participants (Moustakas, 1994), the best fit for this research study proved to be a phenomenology.

Phenomenology. A phenomenological inquiry allows individuals to articulate their interpretations of perceptions of the meaning of an event or experience (Van Manen, 1990). The philosophical assumption is that the individual is "being, becoming, and moving through the life world in intersubjective relationships with others" (Vagle, 2014, p. 23). The main objective of a phenomenological study is to answer the question "What is it like to experience xyz" (Van Manen, 1990, p. 36)? It helps to understand how people construct meaning (Moustakas, 1994). By looking at multiple perspectives of the same situation, a researcher can start to collect some ideas of what something is like as an experience from the insider's perspective (Vagle, 2014). Ultimately, through creative synthesis (Moustakas, 1994), perspectives can be brought together to show patterns and

relationships to capture the essence. The major data source for this inner perspective was interviewing. Patton (1990) stated that the purpose of interviewing is to find out "what is in and on someone else's mind" (p. 71).

I constructed the protocol for the phenomenological study around the four steps in Husserl's (1982) descriptive phenomenological research model, specifically (a) epoche, (b) phenomenological reduction, (c) intuiting, and (d) synthesis of meanings and essences. In the epoche, the researcher identifies and holds in abeyance any preconceived beliefs and opinions about the phenomenon that is being researched (Moustakas, 1994). This first step was particularly important due to my personal experiences with the phenomenon of dealing with two parents who required LTC. In effect, as noted by Giorgi (1985), the researcher uses acts of consciousness to study human consciousness and must bracket past understandings and knowledge to be able to analyze data being collected with a new outlook. During the phenomenological reduction stage, the task was to describe and record what was observed. The reduction of the data took place to collect that which was most relevant to the study. With this reduction, the objects of experience were reduced to phenomena as presented; however, the researcher's acts of consciousness correlated with such objects must be bracketed. During the intuiting stage I remained open to the meaning attributed to the phenomenon by those who had experienced it. I kept an open mind to note any emerging themes. Finally, in the final stage of synthesis of meanings and essences, I attempted to determine the essence of the experience (Moustakas, 1994).

Research Questions

The central purpose of this phenomenological study was to allow me to examine what role time bank participation within two Southern California time bank groups played in the 50 years or older participants' decisions to age in place. This was determined by an understanding of the articulated lived experiences of the participants.

The three main research questions for this study were as follows:

1. How do participants, 50 years or older, in CA TB 1 and CA TB 2 articulate their lived experience as it relates to their involvement with these time bank groups?
2. What role does time bank participation play in an individual's decision to age in place?
3. Does co-production theory, as conceptualized by Ostrom (1999), adequately explain the experiences of participants in CA TB1 and CA TB 2 groups?

Phenomenological Methodology

The purpose of this study was two-fold. The first was to explore and understand (a) co-production, the public policy based theoretical construct, (b) the contextual perspectives of both the history and development of long-term health care/aging in place, and (c) the growth of the socioeconomic phenomenon of time banking and its impact on communities and individuals participating in CA TB 1 and CA TB 2. The second purpose was to evaluate further how these factors (aging in place, time banking, and co-production), when combined, facilitated the development of the consideration of time bank participation as a viable resource to facilitate aging in place. My goal was to focus

on exploring and explaining how time bank participants, 50 years or older, articulated their lived experience as it related to their involvement with this group. Further analysis will be provided in Chapter 5 as to whether time banks can be considered a good alternative or complement to the provision of LTC services for care seekers, 50 years or older, who are not presently involved in any type of LTC living arrangements.

These findings should be of interest to state and federal policymakers considering strategies to decrease the rate of growth in Medicaid and Medicare expenditures for elders and to expand home and community-based services. According to a recent study conducted by the California Senate Select Committee on Aging and Long-Term Care (California State Senate, 2014), "Older adults, their families, caregivers, and state and local government suffer from a costly and fragmented 'non'-system of long-term care services and supports because California has not made development of an efficient and effective LTC system a priority" (California State Senate, 2014, p. 3). The Select Committee concluded that a need exists for a person-centered system that provides individualized care in accordance with needs is easy to navigate, facilitates transitions from levels of care, and overall maximizes the ability of people to age and receive care in their homes and communities rather than in institutions (California State Senate, 2014).

Furthermore, the Committee noted that California is plagued by a lack of capacity—especially in the rural areas—in services, supports, and workforce across a range of disciplines (California State Senate, 2014, p. 6). The study noted how programs to assist dependent adults are spread across at least six major state departments (California State Senate, 2014, p. 8). There is no statewide leader to champion a

statewide vision, develop a statewide plan, or implement a statewide strategy. Best practices (such as time barter groups, for example) are under-valued and not shared across agencies, departments, and programs. I intended that the results of this research study dealing with CA TB 1 and CA TB 2 could provide another approach for the provision of LTC for its elders and persons with disabilities.

Research Design

I used a phenomenological approach framed within a co-production lens to explore the process of how CA TB 1 and CA TB 2 participants, 50 years or older, articulated their lived experience as it related to their participation within these groups. Did their experiences impact their decisions to age in place?

Moustakas (1994) stated that phenomenological data analysis proceeds through the method of reduction, the analysis of specific statements and themes and a search for all possible meanings. The researcher needs to set aside all prejudgments by bracketing his or her experiences. In addition to the semistructured interview, I used Collom's social outcomes study using a retrospective membership survey (Appendix A) to inform the semistructured interview guide portion of my qualitative study. I used the categories from his study to guide my interview protocol.

Collom created his social outcomes survey from previous community research on motivations (Appendix B) and outcomes (Appendix C), which includes a total of 21 studies. Themes resulting from his study were used to inform questions I included in my semistructured, phenomenological-based interviews. The Collom survey was carried out at Hour Exchange Portland (HEP), a stand-alone community-based time bank group

located in Maine. They generated and fielded 14 relevant outcome items representing three broad categories suggested by the previous research including: wealth, social, and finally, work (Collom et al., 2012, p. 147). The data collection process for my study included the following: a screening phase (Appendix D), a preinterview questionnaire and survey (Appendix E), and a face-to-face semistructured interview (Appendix F). Each of these phases helped me to elicit responses that enabled me to explore the research questions and sub-questions.

Once again, to avoid field complications due to the vulnerability of the older adult participant pool, Walden University's Institutional Review Board (IRB) prescreened data collection methods and approaches. In addition, Walden University's IRB reviewed and approved the proposal prior to execution of the study.

Although several other researchers have conducted studies on the benefits of service barter participation, there is a literature gap with regards to how time bank participation impacts an individual's decision to age in place as viewed through the lens of co-production. Using co-production as a framework for understanding time bank participation, the possibility exists that this study can be replicated throughout the United States.

A multiple case (multiple location) methodology would be far more intensive and logistically difficult to conduct at this time due to my current geographic location. These findings should be of interest to state and federal policy members considering strategies to decrease the rate of growth in Medicaid and Medicare for elders and to expand home and community-based services.

I was aware that there were limitations, advantages, and disadvantages with utilizing a phenomenological research approach. Moustakas (1994) has noted several of the traditional prejudices to phenomenological research pointing out the following: the subjectivity of data leads to difficulties in establishing reliability and validity of approaches and information; difficulty in detecting or preventing researcher bias; sample size is small making it difficult to say that experiences are typical. Holloway (1997) noted that researchers who use phenomenology are hesitant to offer up techniques. Hycner (1999, p. 143) agreed with Holloway in that when conducting a phenomenological study, it is difficult to focus too much on specific steps because one cannot impose method on a phenomenon "since that would do a great injustice to the integrity of the phenomenon" (p. 144). I acknowledged that phenomenological studies are difficult to conduct. My personal tactics for overcoming some of these prejudices are discussed further in the section of this chapter on trustworthiness.

Role of the Researcher

The role of the researcher in data collection, and in structuring this study and for organizing its conclusions, was in accordance with Patton's (2002) dimensions of fieldwork variations:

- The author is the sole researcher.
- The researcher's role will be as observer.
- The researcher's role and observation will be overt; with full disclosure to participants.

- The researcher will have no personal or professional relationships with the participants.
- An insider (emic) viewpoint will underlie the research. (p. 277)

As the only researcher conducting semistructured interviews, collecting data on a questionnaire and reporting data for this study, a form of bias that could materialize during this study was related to my having first-hand knowledge of other time bank organization participants and their experiences with participation. To eliminate this bias from affecting both the interview process and my interpretation of data, I reverted to my professional training as a journalist in remaining impartial in emotionally charged situations. I also relied on my own self-discipline and role as a researcher and scholar to maintain my focus. I used bracketing as an approach to differentiate my personal feelings and perceptions (Moustakas, 1994).

Finally, as I had to interview elderly individuals, it was possible that I could encounter participants who revealed to me sensitive information that was not in line with the questioning in this study. Every effort was made to avoid this subject matter.

There were no additional team members for this study. No translators were used for conducting interviews. I conducted all observations and interviews myself. I used transcription services. The transcriber signed a confidentiality agreement. All interviews were coded to protect identity of participant during transcription. This particular issue will be discussed further with regards to validity or trustworthiness of data collected.

Data Collection Procedures

Identification of Target Group

When it comes to selecting the subjects for phenomenological research, the question the researcher has to ask is: "Does the potential participant have the experience I am looking for" (Englander, 2012, p. 19)? For this particular study, I used purposive sampling, considered by Frankfort-Nachmias and Nachmias (2008) as the most important kind of nonprobability sampling, to identify primary participants. Initially, participants were recruited with the help of the organizations' chief administrators (CAs). The CA's only role was to post the study recruitment flyer on a public bulletin board located on time bank premises, and to also distribute this flyer to time bank members through their internal e-mail listservs, a database held by time bank administrative staff. Potential participants were asked to contact me through telephone or e-mail. The CAs had no knowledge as to who responded to my invitation. In this manner, I identified participants, 50 years and older, from the CA TB 1 and CA TB 2 groups. These potential participants were asked to go through a short telephone screening session (Appendix D). The screening questionnaire included the three study participant thresholds which had to be determined before participation in the study was permitted. The participant thresholds were as follows: must be a member of time bank group; at least 50 years of age and lastly, not participating in any LTC programs. As discussed below, a snowball sampling technique was used to expand the initial pool of potential participants. Snowballing is a method of expanding the sample by asking one participant to recommend others for interviewing. This nonrandom form of sampling is effective in identifying hidden

populations (Atkinson & Flint, 2001) including those who are not listed in publicly available sources. Snowball sampling is advantageous to use when conducting qualitative, descriptive studies where some degree of trust is needed to access participants (Atkinson & Flint, 2001). Because of past RWJF studies dealing with failed service barter groups, it is believed that some of the participants may have been reticent to be interviewed by the researcher without being identified as an *insider*.

Recruiting Process for Participants

Upon receiving approval from Walden University IRB, I contacted time bank CAs so I could post my study recruitment folder on public bulletin boards located on time banks' premises. I also forwarded my flyer to CAs for member e-mailing to time bank membership lists. Potential participants were asked to contact me through telephone or e-mail. The time bank CAs did not learn who responded to my invitation. I responded to potential participant phone calls or e-mail. I introduced myself and provided a brief summary of the study I was conducting. I asked potential participants if they were willing to go through a short screening (Appendix D) session. I provided my contact information, and potential participants were then invited to contact me to set up interviews at their convenience. I called a second time to follow up with each of the individuals. During the interview process I asked each of the potential participants to identify other individuals in the population (snowball sampling) who might be good participant candidates to approach for this study. This snowball sampling technique, whereby existing study subjects recruit future subject from their acquaintances, resulted

in the identification of additional potential participants who added value to the study based upon their particular circumstances.

There are pros and cons to snowball sampling. The pros include having access to a group of people who are difficult to get in contact with. The major con is that it is not a representative sample. As a result, there is a potential bias of a sample because of how the sample was recruited into the study (Atkinson & Flint, 2001). However, I believe this bias was overcome by the initial sampling coming from several groups of potential participants (for example, participants who sought the performance of various services in exchange for service they provided) rather than from one particular group of individuals (for example, all recruits obtained meal preparation services through service barter) and that this resulted in an adequate representation of the service barter participants. This technique was dependent in large part on the level of cooperation of the initial and subsequent participants. However, another possible downside to snowball sampling was that I may have inadvertently or purposefully been isolated from some potential participants (Atkinson & Flint, 2001). I requested purposive sample interviewees to give, at their discretion, the names and contact details of persons associated with CA TB 1 and CA TB 2 who (a) presently participated (b) chose not to participate (c) participated at one time but dropped out, and (d) never considered participating in the time bank program.

Interview Process

In order for phenomenological research to achieve the same rigorous quality as natural scientific research, it is important that the research process be methodologically articulated in such a manner that the data collection and data analysis are both seen as

part of a single unified process with the same underlying theory of science (Moustakas, 1994). Also, there must be an essential relationship between the overall research questions and the data collection procedures. I interviewed the participants over a 6-week period to learn their perceptions and beliefs. I hired a transcriptionist who transcribed each in-depth, anonymously-labeled interview tape after she signed the confidentiality agreement. I conducted interview sessions until a sample size of 5 to 10 was obtained. I asked the same questions during each session. I verified the validity of the responses using the member-checking technique by e-mailing password-protected transcripts of the interview to the participants and asking if it was accurate or if they wanted to change or add any information.

Moustakas (1994) and Vagle (2014) cautioned that the researcher must allow the data to emerge. For this reason, the actual research questions that I put to the participants were in the form of semistructured in-depth interpretive phenomenological interviews. When preparing interview questions, I incorporated themes (based upon my main research and sub questions) for interview. A general focus or theme could have been further narrowed down during the interview (Vagle, 2014). The questions were directed to the participants' experiences, beliefs, feelings, and convictions about the themes in question (Vagle, 2014). Giorgi (1985) recommended that questions be broad and open-ended so that the participant has enough opportunity to express his/her viewpoint at length. Giorgi (1985) also recommended that the phenomenological interview approach be a two-tiered method of obtaining descriptions of context followed by an interview for obtaining meaning.

Seidman's (2006) phenomenological interview approach requires three interviews per participant. The first interview is a focused life history that provides context, followed by an interview aimed to reconstruct the experience with its relationships and structures and lastly, an interview that allowed the respondent to reflect on the meaning of his or her experience in context. I interviewed participants in the vocabulary and language they were comfortable with (Bevan, 2014). In addition, as Vagle (2014) noted, the researcher must bracket his/her own preconceptions and enter into the participants' world. I listened very actively to note areas of clarification or probing. I remained open to conducting more than one interview with each participant if clarification was needed. Moustakas (1994) stated that the researcher should keep in mind that it is not enough to know what a participant's opinion on something is. The important thing to learn is the participant's experience or experiences that led him/her to this opinion. Notes comprised of direct observations will be maintained.

Once the consent form (Appendix E) was reviewed and discussed by the researcher and signed by the participant, a copy of this signed consent form was provided to the participant. Next, the semistructured phenomenological interviews (Appendix F) were conducted at a time and location that was mutually agreed upon. Private meeting rooms in local public libraries and other public, semiprivate venues were used to conduct the interviews. According to Giorgi (2009), there are two ways of collecting data if one wants information about the lived experience of phenomenological study participants. The first way involves a traditional face-to-face interview. The second way involves asking the participant to provide the researcher with a written or recorded account of the

experience. Giorgi (2009) noted "What one seeks from a research interview in phenomenological research is as complete a description as possible of the experience that a participant has lived through" (p. 122). The face-to-face interview is often longer and thus richer in terms of nuances and depth.

It was possible to have a preliminary meeting with participants prior to the actual interview. Englander (2012) suggested holding the preliminary meeting roughly 1 week before the interview. This preliminary meeting was supposed to establish trust with the participants, review ethical considerations and complete consent forms (Appendix E). In addition, the participants were asked if they would like to complete a questionnaire (Appendix E), which included voluntary demographic responses aligned to my research interest. The responses to this voluntary demographic information will be discussed in Chapter 5. Englander (2012) suggested that during this initial meeting with the participant it is useful to review the research question. This gives the participant time to dwell on the experience. In this manner, the researcher can get richer description during the interview without the researcher having to ask too many questions. The standard objection to this suggestion is that the participant will start to self-interpret the event and the description will lose its raw, spontaneous nature.

Beginning with a set of established questions, the semistructured phenomenological interview allowed me to include new questions that came up during the study. This particular type of interview was suitable for this study because it was based upon established questions, but it was not so strict with the order in which questions had to be asked or how answers could be provided. It allowed for interview

questions to be asked in different ways while maintaining the focus of the interview. Semistructured interviews allowed new ideas to be brought up during the interview as a result of what the interviewee said. The researcher was able to ask additional questions necessary to clarify points and to explore responses while allowing the participant to choose how to respond to the question (Barriball & While, 1994). Personal opinions and biases were gathered in an effort to elicit respondent's true experience with service barter based upon how he or she viewed it.

Before interviews were conducted, the consent form was reviewed with and signed by each participant. I provided a copy of the signed consent form to the participant prior to the start of the interview. Participants were given the chance to ask questions before signing the consent form. It was also restated that they could choose to leave the study at any point in time with no negative impact on their time bank membership. I planned to record how many participants chose to leave the study and why.

I expected to interview 5 to 10 individuals initially, leaving room for the possibility that one or two participants may choose to withdraw from the study. According to Giorgi (2009), the phenomenological method in human sciences recommends that the researcher work with at least three participants. Although researchers sometimes are not interested in how many have had a particular experience, for the purposes of comparison, "we could take note on how many times the phenomena makes its presence in the description" (Giorgi, 2009, p. 198). Furthermore, according to Giorgi (2009), research based upon depth strategies should not be confused with research based upon sampling strategies. Moustakas (1994) explained that having a small number

of participants is essential when the goal is to obtain extensive information regarding the lived experiences of a group. Saturation will be obtained when the data being collected and analyzed becomes repetitive and contains no new information.

Semistructured face-to-face phenomenological interviews (Appendix F) were conducted. I took notes by hand. In addition, a digital tape recorder was used to capture verbatim interview content for transcription. Affirmative consent was obtained at the start of audio recording of interview. If permission for audio recording was not granted, then manual note-taking was to be used. At the conclusion of the interview, I offered each participant a $15 gift card as a token of appreciation for their time.

All interview guides, field notes, consent forms, and all other written records of this study were scanned and saved in PDF format. Original hard copies were destroyed after scanned copies were verified. These records, along with digital recordings and transcriptions, will be maintained on a password-protected external device and stored in a fireproof safe for a minimum of 5 years, after which time the documents will be shredded and the digital storage media will be physically destroyed.

Interview guide questions. The interview was semistructured, using an interview guide (Appendix F) which included thematic questions that were informed by the Collom study (Appendix A). Collom's research (Appendix A), in turn, was informed by earlier motivations studies (Appendices B, C). As recommended by Englander (2012, p. 26), phenomenological research requires the asking of two distinct questions and the remaining follow-up questions will be determined by participants' responses to the two distinct questions. This will result in a semistructured interview. In this study, the first

question was to ask for a description of the situation in which the participant experienced time bank participation. The follow up question was to determine what the lived effect of this experience was. The questions that are part of the phenomenological interview should meet the criteria of being descriptive (Giorgi, 2009). Asking for a situation in which the participant has experienced the phenomena being studied is important because the description of the phenomena needs to have been connected to specific context in which the phenomena was experienced.

It is essential that the researcher keep track of three dimensions of time present in the interview situation. The participant is in the present describing a memory of an experience, which took place in the past. Simultaneously, the researcher is in the present listening intently to make sure theme questions have been asked and answered by the participant (Englander, 2012). The interviewer must know when to move from the initial question where the phenomenon was first encountered by the participant. Next, the interviewer must ask further questions to determine how experiencing this phenomenon impacted the participant's life.

Data Analysis

Qualitative Analysis

My research produced lengthy interview transcripts and I utilized both manual coding and computer-aided qualitative analysis software (CAQDAS). NVivo coding (inductive) was used (Saldana, 2013). Manually coding the information as it was being collected in the participant's own language allowed me to gain insight into the perspectives of my research subjects. This also allowed me to adjust my interview guide

as needed. Manual coding combined with qualitative analysis software increased the accuracy of my findings as well as offered me a means of verifying the reliability of the Moustakas-modified van Kaam analytical method (1994).

Manually coding interview transcripts calls for assigning labels to pieces of data as a means of assigning meaning to the information collected (Bazeley & Jackson, 2013). Coding activities, as described by Bazeley and Jackson (2013), allowed me to rearrange data in a meaningful way to facilitate further analyses. Boyatzis (1998) pointed out that "one of the benefits of thematic analysis is its flexibility" (p. 78). I started by designating codes in relation to my research questions. As recommended by Bazeley and Jackson (2013), I created a "Start List" (p. 13) of codes guided by my research questions. A limitation associated with utilizing a Start List for coding is that it has the potential to limit the results because the researcher is only looking for specific thematic pieces of data. This can be addressed by adjusting the coding as each transcript is manually coded as necessary.

I explored two CAQDAS programs, NVivo and ATLAS.ti, for use to derive thematic elements from participant interviews. I elected to use NVivo v. 11 for Windows because it will allow me to manage documents, code those documents and analyze data in a variety of ways. It also was the most cost-effective software available to me. I was able to purchase a 6-month student license for a minimal cost as compared to the cost of a full license. In making my decision, I reviewed several reviews and opinions of the software and completed a tutorial. Based upon reviews and my own personal practice with the software, I felt it would significantly aid my analysis of the data. The demographic-based

survey responses were used solely for descriptive and inferential purposes in this qualitative study. Furthermore, I used results from Collom's social outcomes study (Appendix A) to inform questions included in my Interview Guide (Appendix F). The underlying theme inherent in my research questions included social/health outcomes.

The Moustakas-modified (1994) van Kaam method was used to analyze the data. Using this approach, the goal was to reveal and explain the experience as perceived by the participants. Thus, the researcher discovers the undisclosed makeup of an experience by recording and interpreting the originally given descriptions of the set of circumstances in which the experience occurred. This was accomplished through the use of the following eight steps (Moustakas, 1994, p. 120):

Step 1: Horizonalization: Used to inventory and assemble initial expressions relevant to the experience. I interviewed the participants over a 6-week period to learn their perceptions and beliefs. I transcribed each in-depth interview. Every statement was treated as having equal value.

Step 2: Reduction and elimination: Categorizes the constant components by testing for necessity to understand the experience and the ability to conceptualize into a characterization. I tested each comment for two requirements as follows: Does remark include a moment of the experience that shows relevance to the experience being studied and, is it possible to abstract and label this moment of the experience? I eliminated duplicate or vague comments.

Step 3: Clustering and thematizing: Groups the constant elements of experience in themes. I listed all remaining comments and grouped them into theme categories.

Step 4: Final identification of the invariant: Identifies where themes are fully expressed constituents and where themes are applied in the participant's transcript through a compatible or validating experience. I organized the themes with participant's corroborating statements related to theme.

Step 5: Creating individual textural description: Encapsulates each participant's experience using verbatim examples from the transcription. I created a textural description of the participant's experience. I include verbatim examples from the transcribed interview to determine what happened in each of the experiences.

Step 6: Creating individual structural description: Involves developing a vivid explanation of the underlying factors of experience, and the connection to themes, feelings, and thoughts. In other words, I captured how the participants experienced the phenomenon – how they felt during their experiences.

Step 7: Creating textural-structural description: Entails developing a description of the core meaning of the experience incorporating the constant elements and themes. I combined steps 5 and 6 where I intuitively-reflectively integrated the composite textural and composite structural descriptions to develop a synthesis of the meanings and essences of participation in time bank groups and effect on decisions to age in place.

Step 8: Composite description of the meanings and essences: Combines the identified belief of the participants to identify common meanings using qualitative data analysis software to assist in the analysis of the data for qualitative research purposes. I repeated step 7 above for all of the participants and then I integrated all individual textural descriptions into a group textural description (Moustakas, 1994, p. 121).

Ethical Considerations

To protect the confidentiality of my participants, I assigned to them a unique identifier to ensure that the participants could not be personally identified. An assigned letter and number identified the participants. All sources used for the collection of data, including researcher journal notes, were identified in a similar manner. This allowed the participants to feel comfortable answering questions openly and honestly without fear of being identified. The transcriptionist was required to sign a confidentiality agreement. As noted by Stake (1995), research participants have much to lose with regards to embarrassment and loss of public standing based upon responses they provide during interviews. As a result, caution should be practiced during this data collection phase of the study (Stake, 1995, p. 459). Participants were advised that they could choose to withdraw from the study at any time. In addition, they were offered the opportunity to review interview transcripts for accuracy.

Consent forms, which were distributed to the participants to read and sign, clearly described the nature of the study and their role in the process. Participants were informed that the interview process (Appendix F) may cause them to feel tired, stressed or emotional. I took steps to minimize potential risks and ensured that the benefits of the research outweighed these risks. These steps included the following: Consistently monitoring the participants' emotional reactions, providing frequent breaks and identifying in the early stages any potential participants who might be vulnerable through the use of a Screening Questionnaire Guide (Appendix D). In addition, to protect participants' human rights, I obtained approval from the IRB of Walden University. This

study presented five areas of potential concern, which are listed under the *Ethical Protection of Participants* section in this chapter. Lastly, I have completed the National Institutes of Health (NIH) web-based training course *Protecting Human Research Participants* (certification number 2385143).

Trustworthiness

Trustworthiness is a concept parallel to the quantitative research concepts of reliability and validity (Frankfort-Nachmias & Nachmias, 2008). It is primarily focused on demonstrating qualitative rigor to establish the credibility, transferability, dependability (auditability) and confirmability (2008) of the study. Frankfort-Nachmias and Nachmias (2008) supported the use of member checking data as a method for increasing credibility of a study. Participants were asked to review the transcripts of their own interviews for completeness and correctness, allowing the participant to offer any additional clarification upon review and reading how they responded to specific questions. Participants were asked to review the findings of a final analysis to offer final validity to the findings of the study.

Transferability/external validity is concerned with the extent to which the findings of one study can be applied to other situations. External validity is not a priority because the focus of this study is on subjective meanings and depth over breadth (Padgett, 2012). To capture depth, thick description was used during this study. Thick description refers to the process of describing a phenomenon in great detail to clearly articulate the specific contexts to a reader (Lincoln & Guba, 1985). This contextual information about the study and the fieldwork will enable the reader to make such a transfer.

Frankfort-Nachmias and Nachmias' (2008) third framework for ensuring rigor, dependability (auditability), is focused on making sure that the findings of a study could be repeated—if the study were repeated in the same context with similar methods and with the same participants, similar results would be obtained. The study procedures should have a logic that can be followed by other researchers (Padgett, 2012). The procedures do not have to lead to the same conclusions but should have a logic that makes sense to others (Lincoln & Guba, 1985). To directly address the dependability (auditability) issue, I reported all the processes within the study in detail so as to allow future researchers to repeat the same work. This detail will also allow readers to assess the extent to which proper research practices have been followed. For example, triangulation, peer review, and the use of field journals are all techniques that aid in recording the methods of a study (Lincoln & Guba, 1985). The primary method for establishing dependability (auditability), however, is the process of establishing an audit trail that describes the details of the processes followed in the study, so the study could be repeated by another researcher (Padgett, 2012). All documentation, data, and notes were maintained in an organized manner so that the processes that were carried out, and changes to these processes during the study, and observations and impressions of the researcher are clear.

Lastly, confirmability will be achieved by showing that the study's findings are strongly linked to data. The study results must be based on the experiences of the participants. Results should not stem from researcher characteristics or fabrication of data (Padgett, 2015). Methods that have already been discussed, such as triangulation and

audit trails, are essential to establishing confirmability in any study. Triangulation of data and debriefing offer an ongoing evaluation of data collected and allow other researchers to come to the same conclusions. My field journal and personal notes provide a clear path to follow should another researcher seek to validate findings of my study. Lastly, I have investigated and documented my predispositions and possible bias regarding these two issues.

Ethical Protection of Participants

Informed consent and assured confidentiality of participants was of primary importance to me due to the personally sensitive information participants may disclose. I included a prepared script in my semistructured interview guide (Appendix F) stating that any time a participant disclosed actual or potential elder abuse, I would ask if they had reported this concern to local authorities including but not limited to law enforcement, clergy members, medical professionals, or mental health professionals. In the event a participant asked me for recommendations or advice related to time banking or health related questions, I had a prepared script to explain why I could not provide recommendation or advice. The script indicated I was a journalist by trade and by education and that time banking and health care were not my areas of professional expertise. The subject matter of time banking as an alternative funding mechanism in health care in aging individuals interested me from a public policy perspective. I also recommended that the participant speak with an individual in their time bank organization if they had any questions.

To protect the participants from any violations of their human rights, I obtained approval from Walden University IRB (12-07-17-0278583). The participants were also advised, in the consent form, that they could contact the University's Participant Advocate, Dr. Leilani Endicott, at any time to voice concerns or to inquire further about their participation and how the participation results may be used. To further protect study participants their names were not be revealed; interview scripts and audio tapes were archived using assigned pseudonyms and placed under secure storage by the researcher for 5 years (after which time documents will be shredded) and will not be released to third parties; and data collection (outside of the interviews and survey) will be restricted to information in the public domain.

Summary

Chapter 3 includes an introduction to the research methodology that was used in this study. The justification for the use of a phenomenological approach was also presented here. This was followed by a discussion on the role of the researcher. Issues of trustworthiness, a concept parallel to the qualitative research concepts of reliability and validity, were also discussed. Finally, tactics for ensuring that data were collected, stored, and analyzed in a way that will ensure the findings are not compromised, were included in this chapter. In summary, use of the phenomenological approach for this study permitted me to obtain answers for my research questions. Specifically, the study focused on how this participation can facilitate aging in place initiatives for individuals who are not presently involved in any LTC living arrangements. The themes and patterns that

emerged as study participants shared their experiences will form the foundation of Chapter 4.

Chapter 4 will report the findings of the study, including the systems to be used for recording and analyzing the data. This will include the data from semistructured interviews, observations, and other documents and notes created throughout the study. Chapter 4 will also address the patterns, relationships, and themes emerging from the data.

Chapter 5 will summarize and present a critical analysis of the study including an interpretation of findings. Conclusions based upon the research questions will be offered. Finally, implications for social change will be presented and recommendations for further studies will be offered.

Chapter 4: Results

Introduction

This phenomenological study examined what role time bank participation within a Southern California-based time bank organization played in 10 participants' decision to age in place. This was determined by understanding the meaning ascribed by the participants to lived experiences relating to time bank membership, as viewed through a co-production lens (Ostrom, 1999) focused on health-related services. When viewed through this lens, my purpose was to determine whether time bank participation translated into an option to support aspects of health care delivery for some of the participants or if the participants relied on insurance products and public service organizations to support them in old age.

The research questions which informed the study were as follows:

Research Question 1: How do participants, 50 years or older in the CA TB 1 and CA TB 2 groups articulate their lived experience as it relates to their involvement with these time bank groups?

Research Question 2: What role does time bank participation play in an individual's decision to age in place?

Research Question 3: Does co-production theory, as conceptualized by Ostrom (1999) adequately explain the experiences of participants in the CA TB 1 and CA TB 2 groups?

In Chapter 4, I include an explanation of the following study attributes: The research environment (setting), demographics, data collection approach, analysis of data,

and proof of trustworthiness and quality. I summarize findings gleaned from the data using inductive reasoning.

Setting

I conducted primary research for this study in January and February 2018 using a descriptive, phenomenological, qualitative approach. The 10 volunteer participants, ranging in age from 50 to 89, were interviewed in their natural settings. The semistructured, face-to-face interviews took place at the times and semiprivate public locations of their choosing to minimize distractions and to enable them to focus on the substance of the interview. In addition to audio recording the interviews, I documented the participants' interview question responses to make certain I captured everything they said. I obtained preliminary contact from 10 individuals who expressed interest in participating in the study; eight of these 10 individuals met the study eligibility criteria. I then recruited an additional two eligible participants through use of the snowball technique. I obtained consent to participate in the study from all participants. A private conference room at a local library was used to conduct five of the interviews. The remaining five interviews took place at various public venues in city government buildings. The longest interview lasted for 95 minutes while the shortest interview lasted for 42 minutes. The average time for the in-depth interviews was 68 minutes. I documented contact information for the participants in an interview log that I maintained to note dates and times of communication. Pseudonyms were assigned to the participants to protect their identity. The interview log contained pseudonyms only. No personal or organizational conditions during the time of this study were present that might have

affected the participants and, in turn, influenced the conclusions or the interpretation of the study.

Demographics

The participant makeup included a variety of religions, ethnicities, and self-identified genders. No consideration was given in study participant selection to gender, race, political or religious affiliation, or any other demographic. None of the participants had any personal experience with LTC for themselves. Table 1 shows additional relevant characteristics and demographics of the 10 participants: Age, annual income, proximity to other family members or close friends, and if they shared housing arrangements with nonspouse/partner.

Table 1

Participants' Demographic Information

Participant	Age	Income	Proximity	Share
Bill	50-59	$21-60,000	Y	Y
Sally	60-69	$100,000+	N	N
Cynthia	80-89	$21-60,000	Y	N
Mary	60-69	$21-60,000	Y	N
Karen	60-69	$21-60,000	N	Y
Bud	50-59	$21-60,000	Y	Y
Amy	70-79	-	N	Y
Carolyn	50-59	$100,000+	Y	N
Michelle	50-59	-	Y	Y
Teresa	50-59	$100,000+	Y	Y

Notes. Proximity = Live near family or close friends. Share = Share residence with other than spouse. Dashes indicate information was not disclosed.

All of the participants indicated they were able to perform the ADLs in the self-care category, as well as the following three IADLs: Laundry, housework, and preparation of meals. Table 2 records participants' abilities to perform other IADLs.

Table 2

Ability to Perform Instrumental Activities of Daily Living

Participant	Grocery	Transportation	Financial Management	Managing Meds	Phone/PC
Bill	Y	N	N	Y	Y
Sally	Y	N	Y	Y	N
Cynthia	N	Y	N	Y	N
Mary	Y	Y	Y	Y	Y
Karen	Y	Y	Y	Y	N
Bud	Y	Y	Y	Y	N
Amy	Y	Y	N	N	N
Carolyn	Y	N	Y	Y	Y
Michelle	Y	Y	Y	Y	Y
Teresa	Y	Y	Y	Y	Y

Notes. Managing medications includes tasks such as taking oral or injectable medications. Phone/PC = Using a telephone or personal computer.

Data Collection

Data collection for this phenomenological study consisted primarily of 10 semistructured, face-to-face, audio-recorded interviews, supplemented by my observations and notes. I conducted this study between January and February 2018 (6 weeks). After having received permission from the participants, I documented their responses to the semistructured, open-ended interview questions as I simultaneously audio recorded the interviews. Initially, 10 potential participants volunteered to participate, and eight participants (80%) met the participant requirements. During the interview process, each of the eight eligible participants was asked to identify other individuals in the population who might be good participant candidates to approach for this study. This snowball sampling technique resulted in the identification and recruitment of two additional eligible participants. This brought the total number of eligible participants up to 10.

The initial eight participants were recruited with the help of the time bank's chief administrator whose only role was to distribute the recruitment flyer through the organization's internal e-mail listserv. Potential participants contacted me by e-mail, and I followed up each e-mail with a phone call to determine potential participant eligibility (Appendix D). Eligible participants were interviewed during days and times of their choosing. Interview locations included mutually agreed upon public meetings at venues having provisions for private conference spaces to minimize distractions and to enable participants to focus on the substance of the interviews. Husband and wife study participants were interviewed during the same time after they both signed the consent form (Appendix E) including the *Further Consent* section on the same form agreeing to be interviewed in front of specified family member. Interviews lasted an average of 68 minutes each and were audio recorded and I took handwritten notes, with the participants' permission. Participants were provided with a $15 gift card upon conclusion of the interview. The interview recordings were then transcribed into Microsoft Word 2010 maintaining a standardized format. The transcriptions were sent to the participants for member checking using encrypted e-mail. Once the transcripts had been validated by the participants, they were then uploaded into QSR International's NVivo 11 for subsequent automated coding and analysis.

Initially, my goal was to select participants from two time bank organizations including CA TB 1 and CA TB 2. I chose not to include the CA TB 1 recruitment setting because it was the retirement community (NORC), not the time bank associated with the community, that was meeting the needs of members to age in place.

As the interviews progressed, it became apparent that not all interview questions would be necessary. Table 3 shows the disposition of the various questions.

Table 3

Reasons for Discarded Questions

Research / Interview Questions	Disposition & Reasons
RQ1: How do participants, 50 years or older in CA TB 1 and CA TB 2 articulate their lived experience as it relates to their involvement with these time bank groups?	Retained but modified. CA TB 1 is not included as recruitment setting because it is the retirement community (NORC), not the time bank associated with the community that is meeting the needs of members to age in place.
RQ2: What role does time bank participation play in an individual's decision to age in place?	Retained
RQ3: Does co-production theory as conceptualized by Ostrom (1999) adequately explain the experiences of participants in CA TB 2?	Retained
IQ1: Why did you join time bank?	Retained
IQ2: How does time bank membership help you obtain goods/services you normally would or could not pay cash for?	Retained
IQ3: Describe incident where you experienced an emergency. How did membership status help?	Retained
IQ4: What is greatest benefit you derive from membership?	Discarded, already discussed in IQ1
IQ5: Negative experiences with membership?	Discarded. Only one.
IQ6: Present quality of life?	Discarded, already discussed in IQ1
IQ7: Family friends-how do they view your membership?	Discarded, already discussed in IQ1.

Data Masking

To protect the identity of the study participants, I masked any of their identifiable personal attributes and facts. I randomly employed pseudonyms to signify sources of collected data. All participants were informed regarding the strict confidentiality and protection of privacy as it related to all the data I collected from them in accordance with Walden University ethics for human research. Information regarding privacy and

confidentiality was included in the required consent form for the participants to read and sign (Appendix E). All data I collected were stored on my computer and further protected with a secure password. The transcriptionist who transcribed the audio interviews signed a confidentiality agreement. The hard copy of the transcripts did not include names of participants, only assigned pseudonyms. All interview guides, field notes, consent forms, and all other written records of this study have been scanned and saved in PDF format. These records, along with digital recordings and transcriptions, are maintained on a password-protected external device and will be stored in a fireproof safe for a minimum of 5 years, after which the documents will be shredded and digital storage media will be physically destroyed.

Collom et al.'s (2012) social outcomes study using a retrospective membership survey (Appendix A) was used to inform the semistructured interview guide portion of the qualitative study. Categories from their study (health, social, work) informed the interview protocol. Collom et al. informed their social outcomes study from previous community research on motivations (Appendix B) and outcomes (Appendix C), which included a total of 21 studies. Themes resulting from Collom et al.'s study were used to inform questions included in the semistructured, phenomenological-based interviews. I built upon the study by Collom et al. They focused on the relationship between older people and time bank membership. I fine-tuned their study by focusing on older people, timebanks, and aging in place. The underlying themes inherent in my semistructured interview questions included health outcomes (Appendix G), social outcomes (Appendix H), work outcomes (Appendix I), instrumental outcomes (Appendix J), altruistic

outcomes (Appendix K), needs outcomes (Appendix L), social capital outcomes (Appendix M), and economic instrumental outcomes (Appendix N).

These themes formed the foundation for the creation of frames of analysis. I manually coded the data as they were being collected in the participants' own language. This allowed me to gain insight into the perspectives of the research participants. This also facilitated the adjustment of interview questions to probe. I also imported the data (10 interview transcripts) into QSR International NVivo 11. I coded each sentence with one or more codes. The codes were derived from each study participant's words. Codes were added/modified as necessary as new meanings/categories emerged (emergent codes). Manual coding combined with NVivo 11 analysis increased the accuracy of my findings as well as provided a means of verifying the reliability of the Moustakas-modified van Kaam analytical method (Moustakas, 1994). Using this approach (both a priori and emergent coding) the body of evidence for prior research can be built. Also, this approach helps to identify themes that are not conforming, that is, those that require further investigation.

Profiles

While incorporating data gathered during the interviews, I designed a collective profile of all the participants instead of writing individual profiles. I did this to avoid placing participant confidentiality at risk. Participants ranged in age from 50 to 89; income level ranged between $21,000 to $100,000 plus, included a variety of religions and ethnicity. Several of the participants were caregivers for elderly parents, participants were employed in a variety of occupations and fields.

Data Analysis

The analyses of the interview data were conducted by using the Moustakas-modified van Kaam method (Moustakas, 1994), which is an appropriate tool for phenomenological analysis. I outlined in Table 4 the eight steps of the analysis aligning the data first to (1) inventory and assemble initial expressions relevant to the experience; (2) categorize the constant components by ensuring participant understands and discusses the relevant experience and that the experience can be labeled; (3) group the constant components of the experience into themes; (4) organize the themes with participant's corroborating statements related to theme; (5) encapsulate each participant's experience using verbatim examples from the transcription; (6) capture how the participants experienced the phenomenon—how they felt during their experiences; (7) combine steps (5) and (6) in an intuitive and reflective manner as I integrate the composite textural and composite structural descriptions to develop a synthesis of the meanings and essences of participation in time bank groups and effect on decision to age in place; (8) combine the identified belief of the participants to identify common meanings using NVivo 11 qualitative data analysis software to assist in the analysis of the data for qualitative research purposes.

Table 4

Alignment of Moustakas-Modified Eight-Step Data Analysis Method to the Study

Step	Action	Data Analysis Process
1	Horizonalization	• Interview participants over a 6-week period and transcribe each interview. Establish triangulation of the interview data collected. • Read each transcription at least twice. Begin preliminary coding and grouping by listing every quote relevant to the experience. • No quote or excerpt is more important than any other.
2	Reduction and Elimination	Test each quote by asking two questions: (1) Is this quote important to participant's lived experience of time banking? (2) Can this quote be reduced to a theme or code? If answer is no, vague or duplicate information is eliminated. This helps separate the invariant constituents of the experience from redundant and ancillary information.
3	Cluster and Thematize	• Take all excerpts and quotes that passed the two question criteria and determine latent meanings. • Group these excerpts and quotes according to latent meanings to create themes for each of the 10 participants.
4	Check Themes Against the Data	• Test to see if themes generated in Step 3 are supported by a compatible or validating experience (quote or excerpt)? • Perform this test for each of the 10 participants.
5	Create Individual Textural Description	Create individual textural descriptions that incorporate verbatim excerpts and quotes from the participants.
6	Create Individual Structural Description	• Use imaginative variation to seek possible meanings/explanations of the underlying factors of experiences (how participants experience the time bank relationship) and how these experiences connect to the themes, feelings and thoughts. • Primary interpretation of the data begins here.
7	Create Composite Textural/Structural Description	Create a table outlining all the themes (recurring and prominent) from each participant to relay what participants said during the interview. In this manner, common themes of the lived experience will be noted.
8	Create a Composite Description of Meanings and Essences	• Combine the identified beliefs of the participants to identify common meanings.

Notes. Steps 1-6 repeated for each of the 10 transcriptions. The steps in the *Action* column were from *Phenomenological Research Methods*, by C. Moustakas, 1994, p. 120-121.

The manual portion of my coding includes eight major themes (forms of analyses) also referred to as a priori codes, which have been informed by Collom et al.'s (2012) Social Outcomes Study survey, with Dr. Collom's permission. I also imported the data

(10 interview transcripts) into NVivo 11. I coded each sentence with one or more codes. The codes were derived from each study participants' own words (emergent codes). Codes were added/modified as necessary as new meanings/categories emerged.

The first step, inventory and assemble initial expressions relevant to the experience, was conducted during the 6-week data collection period (Moustakas, 1994). During this time, participants were interviewed to learn their perceptions and beliefs. Each in-depth semistructured interview was transcribed and read from start to finish, in a systematic manner, without coding. On the second read, codes derived prior to data collection served as a frame of analysis—the a priori codes were informed by Collom et al.'s (2012) study (Table 5).

Table 5

Frames of Analysis (a priori Codes) for Participating in Time Bank.

Comments relating to	Grand Totals Summary
Health Outcomes	(Appendix G)
Social Outcomes	(Appendix H)
Work Outcomes	(Appendix I)
Instrumental Outcomes	(Appendix J)
Altruistic Outcomes	(Appendix K)
Needs	(Appendix L)
Social Capital Outcomes	(Appendix M)
Economic Instrumental	(Appendix N)

I used Collom et al.'s (2012) retrospective membership study (Appendix A) to inform the semistructured interview guide portion of my qualitative study. I built upon Collom et al.'s (2012) study by working with a different population and other refinements which allowed me to explore time banks as aging in place initiatives. The underlying theme inherent in my research questions includes social/health/work outcomes. Collom et

al. (2012) created their retrospective membership study from previous community research on motivations (Appendix B) and outcomes (Appendix C), which includes a total of 21 studies. Finally, themes from the a priori coding (manual coding method) were compared to themes sourced from emergent codes generated through NVivo 11 analysis. Any deviations were noted.

In the second step, the constant components of the data were categorized into domains by testing for the necessity to understand the experience and the ability to conceptualize it into a characterization. I tested each comment for two requirements as follows: Does the remark include a moment of the experience that shows relevance to the experience being studied? And, is it possible to assign a code name to this occurrence? I eliminated indistinct comments. These codes, which represent the breadth of the data, were then read again and clustered (categorized) and thematized (step three). The interview transcripts were manually coded as labels were assigned to the information collected. I designated codes in relation to my research questions. I created a *start list* (Bazeley & Jackson, 2013) of codes guided by my research questions. In turn, my research questions were based on an interview guide (Appendix F) which included thematic questions that were informed by the Collom et al. (2012) study (Appendix A). Collom et al.'s (2012) research (Appendix A), in turn, was informed by earlier motivations studies (Appendices B; C).

My goal was to determine not only how many participants experienced a coded incident as indicated in each of the eight frames of analysis (Appendix P), but also how many times (frequency) a coded incident appeared in each participant description. In this

manner, I was able to build a body of evidence for the prior research from Collom et al.'s (2012) study. Also, I was able to identify themes that are not conforming, that is, new themes that may require further investigation.

The fourth step, final identification of the invariant (uniform, fixed), themes were identified and fully expressed constituents by applying them in participant's transcript through a comparable or validating experience. I organized the themes with participant's corroborating or validating experience related to the theme.

The fifth step involved the creation of a textural description of the participant's experience. I included verbatim examples from the transcribed interview to determine what happened in each of the experiences. Transcripts were analyzed to ensure there was enough data in the textural descriptions that supported inclusion of this text under specific categories. Also, textural descriptions were analyzed which did not agree with relationships expressed in the current categories. The goal here was to ensure the coded segments were assigned to appropriate categories so that accurate themes could be developed. This would allow for a collection of themes that are appropriate for reporting a description of articulated lived experiences as they occurred with respects to time bank membership and participation.

During the sixth step I completed an analysis within categories, looked inward at the data, and discovered new links, new relationships, and new categories. Individual structural descriptions, involving developing a vivid explanation of the underlying factors of experience, and the connection to themes, feelings, and thoughts, were completed. In

other words, I captured how the participants experienced the phenomenon—how they felt during their experiences.

The seventh step involved combining steps 5 and 6 to develop a synthesis of the meanings and essences of participation in time banks and the effect on the decision to age in place. It was at this point that coded data were reread and a process of searching the coded data began whereby coded data were tested to see if they could be categorized within Collom's (2012) eight frames of analysis (Appendix P). Once completed, this allowed for further analysis and interpretation of the data as they related to answering the three research questions.

The eighth step involved the combination of the identified beliefs of the participants through the use of NVivo 11 to assist in the analysis of the data for qualitative research purposes. Individual textural descriptions were combined into a group textural description (Moustakas, 1994, p. 121).

In addition to manual coding, QSR International's NVivo 11 was the sole software program used for analyzing (emergent themes) participant interviews. The use of NVivo 11 assisted in compiling the themes by creating nodes and conducting queries using text search and word frequency. Data analysis proceeded in five steps:

1. I imported the data into NVivo 11 program.
2. I coded each sentence/passage of the text with one or more codes. The codes were derived from participants' words. Codes were added or modified as necessary as new meanings or categories emerged.

3. Once the codes were established, each piece of text was systematically compared and assigned to one code.
4. I rechecked the codes and assigned text to assess coding consistency.
5. I identified themes and sub-themes.

The results of steps one, two, three and four are presented below.

Results

Three research questions (RQ) and seven interview questions (IQ) originally guided the study, aimed to provide a more in-depth understanding of the lived experiences of time bank members age 50 and older. Interview questions 4, 5, 6, and 7 were discarded for various reasons. In Table 5 I exhibit how each research question was handled during the study, including explaining why certain questions were modified or eliminated. The participants provided responses to the questions in a random order, not necessarily according to the specific sequence of the question. I arrived at the emerging themes after fine-tuning Collom et al.'s (2012) Social Outcomes Study. I used their eight outcome categories (Appendix O) by coding responses from the participants and grouping key terms and concepts into themes. The emerging themes were as follows: vulnerability is inevitable; I am needed; explore alternative health therapies; fill gap caused by medical coverage, and co-production in action. I offer an interpretation of the results in Chapter 5.

Interview Question 1

Tell me why you decided to join CA TB 2 and what other options you had available to you in order to meet similar objective(s). The intent of this question was to

determine whether the participants joined specifically with the intention of using goods and services that would allow them to age in place. Probing the participants about their reason for becoming members provided data on various motivating factors. The data collected from this probe provided supporting information about what thoughts, if any, the participants had regarding aging in place.

Findings from Interview Question 1. All of the participants reported their main motivating factor for joining the time bank group was based on health outcomes and social outcomes (Appendix P). These were the most common motivating factors based upon the number of participants who responded (code frequency) and the number of times in the interview the participant mentioned incidents which referred to these two codes (references). Exploration of this overarching interview question resulted in the emergence of five themes due to the fact that participants were answering several of the interview questions out of sequence as a natural thought progression of responding to interview question 1. The following five essential themes developed during the course of the entire study: (1) Vulnerability is inevitable (2) I am needed (3) Explore alternative health therapies (4) Fill gap caused by weak medical coverage (5) Co-production in action.

Theme 1: Vulnerability is inevitable. The participants varied with respect to which part of the interview they disclosed the fact that, although they could now perform ADL and IADLs, they might not be able to do so in the future. This worried them. They did not want to be burdens of family and friends. As a result, this theme surfaced throughout the interview, in response to questions 1, 2, 3, 4, and 6 (Appendix F).

Four of the 10 participants described circumstances which started them thinking about their loss of functionality as they aged. Two of these four participants started perceiving patterns of functional decline in themselves such as forgetting things (Cynthia), or not being able to climb steps as easily as in the past (Karen). This started them thinking more about aging, which led to a sense of fear and depression. A third participant (Bill) was taking care of an invalid relative and wondered who would take care of him if he became an invalid too. Another participant (Mary) found herself becoming more depressed after her husband passed on and she worried about who would take care of her in the same way that she took care of her husband.

Cynthia described the onset of forgetfulness and how this served as a "wake-up call" for her. "I started learning about things I could do to keep my memory strong. I felt very vulnerable at first so I learned about what I could do to help me to retain my memory — to keep my brain healthy. My time bank friends were very helpful in sharing tips and helping me."

Karen was more alarmed when she began to notice a deterioration in her health almost overnight. "One day I could climb steps easily — and then the next day, I could not. I can still climb but it takes more effort on my part." She has been a member of the CA TB 2 group for several years and she stated that due to this "I know I have help available if I need it."

Theme 2: I am needed. Seven of the 10 participants mentioned how good they felt about themselves after helping others (time bank members) in need. This forced them to look beyond themselves and their self-perceived "problems" which the participants

believed contributed to their negative thinking—including depression. Several participants mentioned how socializing with others and feeling needed had direct health benefits for them. For example, Bob noted an improvement in his mental health as a result of time bank participation: "My [parent] died and I realized I needed help — I became depressed. I got headaches all the time. As I became more involved helping others in the time bank, I started to feel better — happier." Cynthia described a sense of purpose, "I want to give back to the community by helping my fellow time bank members in need. I feel useful, like I am contributing." Mary recounted that "After my husband died, I had no one to talk with on regular basis but now I have developed a stable relationship with a time bank member. I do her grocery shopping each week and we drink tea and talk when I drop her grocery off. I look forward to our visit." Amy's comments summed up this theme: "It feels wonderful to be needed!"

Interview Question 2

How does time bank participation help you to obtain goods or services that you normally would not or could not pay cash for? The intent of this question was to ascertain whether participation in a time bank group complements existing funding systems including self-pay, private insurance, Medicare and Medicaid. This question resulted in the following two themes: Theme 3 and Theme 4.

Findings from Interview Question 2. Several participants noted that they presently required help with performing ADL and IADL-type activities (Table 2). Although the participants did not use this terminology, the services they sought from other time bank members fell under these categories. It is interesting to note, that several

participants were planning ahead for when they would need this type of assistance when and if the time came where they could not perform ADLs or IADLs.

Theme 3: Explore alternative health therapies. As a result of responses to IQ2, the following was noted: four of the 10 study participants (Mary, Karen, Carolyn, Michelle) explored the use of alternative therapies (which their insurance would not cover) because they did not have to pay for these sessions (Appendix G and Appendix L). Two participants (Mary, Karen) could not pay for the sessions, two could pay (Carolyn, Michelle) but did not want to. Time members offered reflexology, energy healing, meditation, massages, yoga lessons, and anger management workshops.

Mary described her experiences with exploring alternative therapies through her time bank membership. She explained "I have slight anxiety issues – I have been exploring how to control my anxiety through meditation. A friend of mine who is a time bank member runs meditation workshops." Because there were no costs involved, this was a contributing factor which prompted Mary to explore this alternative therapy.

Theme 4: Fill gap caused by weak medical coverage. Cynthia shared how she received support from Time Bank members during the pre- and postoperation visits required for her wrist surgery. Her insurance did not cover transportation or escort services and she could not afford to have both. Karen injured her ankle and after she returned home from hospital, Time Bank members shopped for her groceries, cooked her meals and did her laundry weekly until she was able to walk again on her own. Mary had to go to hospital for an undisclosed health condition. Although she received good care for her condition, Medicaid and Medicare did not pay for what was not directly medical. As

a result, she needed someone to help her fill her prescriptions, buy groceries and ensure she took her meds. Time Bank members filled this need. Karen described her time bank "helpers" as "angels — they went beyond the call of duty. There is no way a stranger could have, even if my insurance covered it, given me such personal care."

Interview Question 3

Describe an incident where you experienced an emergency and your time bank membership status came to your aid. The intent of this question was to determine what type of emergency services (especially health related) members felt comfortable seeking.

Findings from Interview Question 3. The data obtained from IQ3 produced strong comments from two of the 10members who did indeed have an emergency and chose to seek help from time bank members instead of seeking aid available through public service avenues. The most common words used in answering this question connoted fear via the following responses (i.e.: very scared, and frightened) strangers, emergency room, hospital, more responsive, faster, and cheaper. Karen recalled, "I cut my finger pretty deeply while slicing a frozen chicken. I called my time bank buddy who came immediately and drove me to the emergency room." Mary recounted how frightened she was during the recent wildfires in Southern California. She did not know if she would have to evacuate or not. She made arrangements in advance with another time bank member to evacuate her from her home and allow her to stay with the member until it was safe for Mary to return to her home.

Theme : Co-production in action. Responses to IQ3 indicated that there was an element of co-production present in the time bank relationships among and between

members. Time bank members sought and received services that are normally considered to be a part of public service production (including ambulance, fire department, and local emergency services).

Negative Cases and Unexpected Findings

During the interviews, there were two instances where respondents provided atypical comments regarding their experiences with time banking. The comments are recorded below.

1. Experience dissatisfaction with provision of service. One participant who requested help with her computer was not pleased with the results of the service provided to her by another time bank member. As a result, she had to request help a second time from another time bank member. She chose not to officially complain to anyone about the poor service. She did note however, that the first time bank member who tried to help her was not used to working with "older" people. Amy described, "She tried her best to help me, I know she did, but she didn't have the patience to answer all of my questions. I didn't complain for several reasons including the fact that I didn't want to get her into any trouble plus, it was my first time bank request and – I didn't want to get known as a trouble-maker."
2. Experienced disappointment in that they could not convince friends to join Time Bank. Two participants tried to get their friends, age 60 years plus who lived locally, to join the Time Bank. They were unsuccessful. In both cases, the friend and the neighbor were hesitant to meet and socialize with new

people (Time Bank members). Sally recalled, "My friend said she sought any help she needed for the past 10 years from her local church group. She saw no need for joining the time bank." Judy mused, "My neighbor was open to joining it but her husband thought it was a waste of time. He is a bit anti-social. They have one adult child living nearby who helps them out. I wonder what they will do if he decides to move away after he completes graduate school?"

Evidence of Quality and Trustworthiness

Trustworthiness of a research study requires rigor to ensure the validity or accuracy of the study results to determine the study's worth. The level of trustworthiness can be established by taking into consideration the following four criteria: Credibility, dependability, confirmability and transferability (Lincoln & Guba, 2007). Credibility was established through member checking, negative case analysis, and prolonged engagement. Dependability was established by a variety of methods including the maintenance of an audit trail of the data collection process. I achieved confirmability by ensuring the accuracy of the data collected and ensuring I kept any bias out of the data collection or interpretation stages. Finally, transferability was ensured through the collection of rich data, a study audit trail, and a consolidation of the research results (in tables) which could be disseminated to interested individuals including individuals or researchers with an interest in time banking or LTC.

Credibility

Credibility relates to confidence in the *truth* of the findings (Lincoln & Guba, 1985). To promote credibility of the results, I executed the study action plan presented in Chapter 3. This included member checking to ensure the validity of the interview procedure. In Chapter 4, I relied on quotes from participants that exemplified the findings. I also reported a systematic analysis process to obtain a variety of divergent patterns, rival explanations, and negative cases during the discovery of the themes. Prolonged engagement yielded interview transcripts that were rich with thick descriptions. Throughout the data collection process, I adhered to lessons learned from training techniques taught by the National Institutes of Health Office of Extramural Research to protect human research participants. Finally, I sought and obtained permission from study participants before conducting any audio recording or taking notes during the interview.

Dependability

Dependability, or consistency, involves showing that the research findings are consistent and could be repeated (Lincoln & Guba, 1985). Dependability was maintained by keeping field notes and journals and using an interview guide to ensure consistency among the interview process. I audio recorded the interview, took notes, and compiled the data analysis that supports the conclusions of the result. I used triangulation in the data analysis process with the Moustakas-modified van Kaam eight-step method and NVivo software to enable an analysis of the codes, categories and themes.

Confirmability

I achieved confirmability and neutrality of this study by checking transcriptions several times including using member checking of individual transcripts with the interviewed participant. I used the Moustakas-modified van Kaam method to analyze the results of the data collected. I kept personal bias out of the research process during the data collection and interpretation stages. I wrote down what bias I may have and paid attention not to let it impact my study.

Transferability

The qualitative research method (phenomenology) and the small participant size presented me with a challenge to show that the findings can be applicable in other contexts. Consequently, I established several results summary tables (Appendix G through Appendix N and Appendix P) for possible dissemination of this study to health services, health care administrators and others involved with LTC. In addition, I collected detailed, rich, and thick data by utilizing open-ended, semistructured questions to capture in-depth outlooks and insights from the time bank participants of this study.

Results

Although this study began with three research questions, supported by seven interview questions, due to the nature of how people's thinking processes work, many of the participants responded to the questions out of sequence and/or combined responses in conjunction with other interview questions. This led to having to abandon four of the seven interview questions (Table 3). As a result of examining the remaining three research questions and the three interview questions through in-depth interviews with 10

time bank participants obtained through a combination of purposeful and snowball sampling, five essential themes emerged that comprised the essence of the phenomenon.

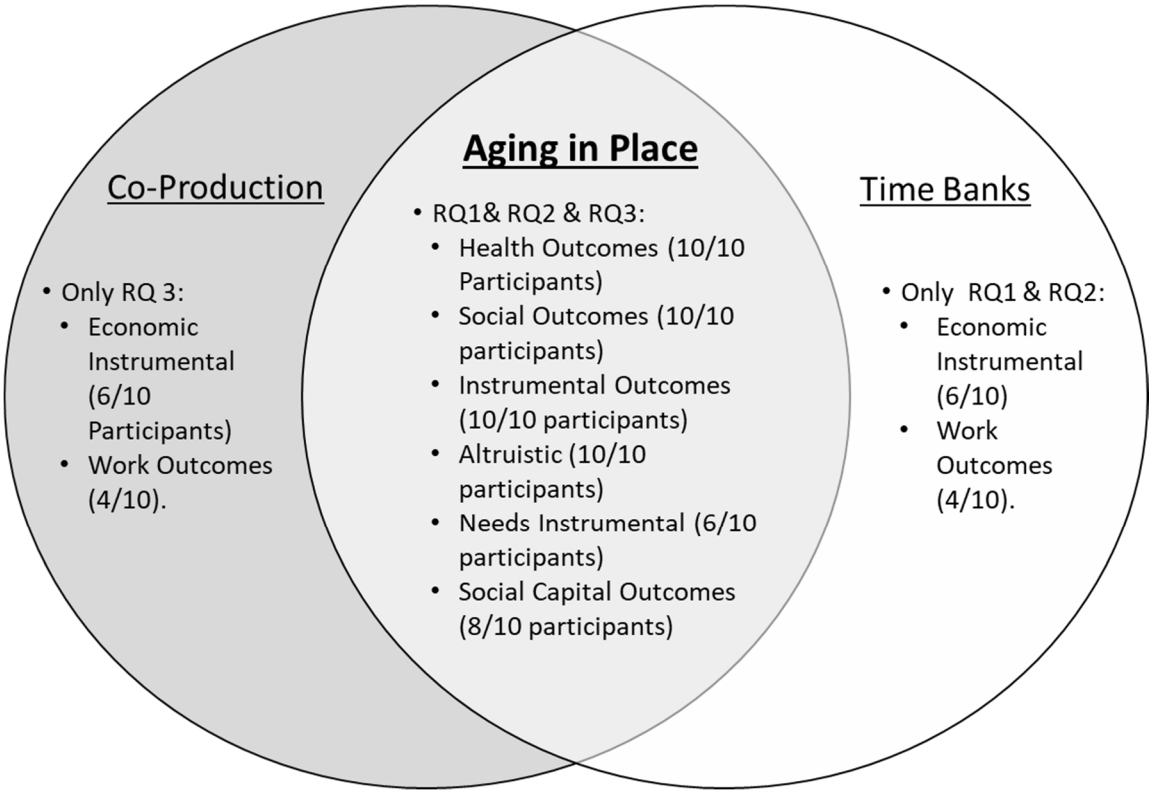

Figure 3. Aging in place/o-production/time banks Venn diagram with alignment of research questions to the conceptual framework.

To analyze the data while going from many codes to few themes, I took into consideration the blended attributes of co-production (public policy theoretical framework/lens), aging in place, and time banks as illustrated in Figure 3 and aligned the research questions to the conceptual framework as shown in Figure 3. The framework of this study was designed to investigate and explore time bank participants perception of aging in place based on their experiences as time bank members. I bracketed the results of the data collected in this study by constructs aligned with the theoretical foundation and framework related to co-production, time bank membership, and aging in place, and

coded the data by the eight categories within the interview questions and reported common themes and clusters that emerged during the interview process with the participants (Appendix P).

As illustrated in Figure 3, the results of the study are organized within the theoretical foundation and framework related to co-production, time banking, and aging in place. I expanded upon the results, clustered the results, and reported the top five themes that emerged. Although the interview questions were presented in order (Appendix F) during the semistructured interview process, many of the participants provided answers to Interview Questions 2 and 3 while in the process of responding to question 1. As a result, I am including an overview of the main In Vivo codes repeated during the interviews. The main In Vivo codes are as follows: help, trust, availability, useful, scared, sad, depressed, lonely, emergency, friends, rides, burden, doctor, support, exercise, local, strangers, emergency room, hospital, faster, cheaper, reflexology, reiki, meditation, yoga, communication, medication, walk dog, take pet to veterinarian, gardening, take trash out, companionship and shopping. More detailed coding is provided in Appendices I through P.

The findings of this study illustrate that these time bank participants experienced the essence of the phenomenon of their time bank relationship as a means of supplementing health care services (dealing with ADLs and IADLs) in conjunction with other closely linked, derived benefits. Their lived experience involved giving and receiving services that in one way or another were able to allow them to feel more confident about aging in place. The health and social outcomes benefits derived from

time banking ranked the highest in the experiences of these participants (Appendix P). These findings closely mirrored and advanced Collom et al.'s (2012) study. In addition, increased social outcomes resulted both directly and indirectly in improving the mental state of several of the participants who indicated symptoms of depression lessened the more they interacted with the group. Social outcomes impacted the confidence and positive attitudes of these participants. This, in turn, helped the participants to stay emotionally stronger, and recovery more quickly, when facing periods of stress or physical injury.

Research Questions, Themes, Aspects, and Correlational Patterns

RQ1: How do participants, 50 years or older, in CA TB 2 articulate their lived experience as it relates to their involvement with the time bank group?

Theme 1 - Vulnerability is inevitable.

Aspects - Although they could now perform ADL and IADLs, they might not be able to do so in the future; Noticing some decrease in their physical abilities; did not want to be burden on family or friends.

Theme 2 - I am needed.

Aspects - Feeling needed forced participants to look both inside and outside of themselves. They learned the value of services they could perform-which they initially took for granted or undervalued. Feeling needed gave them a sense of accomplishment and increased self-esteem. Some reported decrease in depression symptoms.

Theme 3 - Explore alternative health therapies.

Aspects - Because no costs were involved, participants felt free to explore other therapies. Time banks also supplemented insurance plans that did not cover these therapies.

RQ2-What role does time bank participation play in an individual's decision to age in place?

Theme 4 - Fill gap caused by weak medical coverage.

Aspects - Medicaid and Medicare did not pay for what was not directly medical. Participants received help with filling out prescriptions, grocery shopping while healing, etc.

RQ3: Does co-production theory, as conceptualized by Ostrom (1999), adequately explain the experiences of time bank participants in the CA TB 2 group?

Theme 5 - Co-production in action.

Aspects - Time bank members performed some services for each other that are normally considered to be a part of public service production (including ambulance, fire department, and local emergency services).

Summary

This phenomenological study examined what role time bank participation played in participants' decisions to age in place. This was determined by an understanding of the meaning ascribed by the participants to lived experiences relating to time bank membership, as viewed through a co-production lens.

In Chapter 5 I connect the study results to the contents of the literature review to show how my study results impact the stream of knowledge. I then discuss the limitations

of this study, implications for practitioners and policymakers, and I include recommendations for further research. Finally, I discuss implications for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

To explore what meaning time bank members 50 years or older ascribed to their lived experiences relating to their time bank membership, I analyzed qualitative data from a series of in-depth interviews with 10 time bank members located in Southern California. The resulting transcriptions were member checked and then both hand coded and coded using NVivo 11 software. This inquiry was undertaken to examine the relationship between co-production and aging in place and what impact, if any, time bank membership has on LTC options (including the access to the provision of custodial services involving assistance with ADLs and IADLs) for participants. In other words, my purpose was to determine whether time bank participation translated into an option to support aspects of health care delivery (ADLs and IADLs) for some of the participants or if the participants relied on other means (including out of pocket, individual private insurance, employee- based group private insurance and government financing) to support them in old age.

I discovered that time bank membership did play a role in seven of the participants' decisions to age in place presently and/or in the future. I will interpret the findings using the themes presented in Chapter 4, examine the limitations of this study, and offer recommendations for future action and research. This chapter will close with some suggestions to promote positive social change.

Interpretation of the Findings

The results of this study contribute to the knowledge base by providing analysis of the relationship of time bank membership and aging in place. The results also enhance the understanding of the potential for time bank membership to serve as vehicle for the provision of health care delivery. Yet at the same time, the results give rise to new questions. To interpret the findings of this study, I used Ostrom's (1999) co-production model as the framework, and three overarching research questions as a guide.

Research Question 1

How do participants 50 years or older in the CA TB 2 group articulate their lived experience as it relates to their involvement with this time bank group?

Theme 1: Vulnerability is inevitable. The three aspects of this theme confirmed and augmented findings in the literature. These aspects are as follows: fear, self-esteem, and burden (which is tied to self-esteem).

Fear. Participants mentioned experiencing initial feelings of fear inherent with the aging process, stemming from anticipated loss of physical and mental capacities that may accompany aging. Although this was not the main reason they joined the time bank, they acknowledged the potential for their membership (accumulated service hours to spend) to come to their aid if and when they needed help with ADLs or IADLs. This expectation alleviated some of their fear and anxiety. In addition, participants noted how friendships were built over the years with other members. In one case, the friendship was so close that the time bank service provider stopped logging in the 1 hour he earned for grocery shopping for another time bank member who had been incapacitated for an entire

month due to injury. This result paralleled and extended the results of a similar study conducted on elderly Korean subjects by Kim, Choi, Cho, Cho, and Kim (2015). Kim et al. found that individuals who perceived that their family or close network of friends were more supportive had increased self-esteem and a more optimistic outlook on extending their capability of maintaining daily life activities, including mental and physical functions, and were more likely to perceive their aging as successful. The researchers concluded that improving self-esteem and increasing interactions with family or a close network of friends can help elderly patients age successfully.

Self-esteem/burden. Using a sequential longitudinal study, Orth, Trzesniewski, and Robins (2010) found that there was continual growth in self-esteem as people aged, but as they approached retirement age this began to decline. They concluded that there is a circular connection between better health and higher self-esteem, and higher self-esteem continues to promote the maintenance of better health. Likewise, Kim et al. (2015) discussed the connection between ability to perform the eight ADLs and eight IADLs to maintaining higher self-esteem, which in turn affects overall health.

Along the same lines of the Kim et al. (2015) study, several participants in my study observed how it bothered them when they had to keep asking family, friends, and neighbors for "favor" such as driving them to the doctor's office or helping them with grocery shopping. One participant in my research study described how in the past, her neighbor had become her unofficial chauffer as the neighbor drove her to weekly doctor's appointment. Although the neighbor was very gracious about it, the participant felt like she had become a burden to her neighbor. Since joining CA TB 2, she no longer felt as if

she were "using" people because she, through her time bank membership, had another time bank member drive her weekly to the doctor's office.

Increase in self-esteem appeared to be a strong component of time banking relationships. A reason for this can be provided by Collom's (2008) explanation in that time banking attempts to transform models of passive recipients consuming services of charities or professionals or over-burdened family members, into models of reciprocal, relationships. Furthermore, Collom (2008) offered that older adults are more likely to avoid seeking help from those they cannot help in return; they value reciprocity.

Theme 2: I am needed. Two aspects of this theme confirmed and augmented findings in the literature. One aspect comprised the feelings of increased self-esteem through helping others and feeling needed. The second aspect involved the connection between feeling needed, increased self-esteem, and better physical and mental health for the helper.

***Self-esteem/better physical and mental health*.** The feeling of an increase in self-esteem, as described within Theme 2 (I am needed), aligned with and expanded upon the results of a study conducted by Brown and Brown (2015) in which they presented an elaborated neurobiological caregiving system model. Their model included elements that may reduce chronic inflammation and highlighted potential interactions of oxytocin and progesterone. The researchers noted the abundant amount of growing evidence suggesting that helping others is linked to better health and longevity for the helper; however, little is known about causal mechanisms (Brown & Brown, 2015). In their model, Brown and Brown identified possible neurophysiological mechanisms linked to

maternal care and how these mechanisms, once activated by helping others, in turn trigger neurohormonal circuitry. These hormones are known to have stress-buffering and restorative properties that can lead to better physical and mental health.

Through volunteering their time (in return for time bank hours), most of the participants experienced a sense of helping themselves as they helped others. Three participants reported feeling a sense of greater self-worth and confidence, whereas four participants felt a sense of purpose. All participants reported experiencing an increase in social ties that helped them to fight feelings of isolation.

Interview Question 2 (IQ2)

How does time bank participation help you to obtain goods or services that you normally would not or could not pay cash for?

Theme 3: Explore alternative health therapies. This finding showed that, because there were no costs involved, participants were willing to explore time bank member-provided alternative therapies, which they believed had positive impact on the quality of their lives. Davis and Weeks (2012) examined the distribution of out-of-pocket expenditures on complementary and alternative medicine (CAM) health services in the United States. According to a report released by the HHS (2016), in 2012 Americans spent $30.2 billion out-of-pocket on complimentary health approaches. These approaches include a group of diverse medical and health care systems, practices, and products such as herbal supplements, meditation, chiropractic, and yoga (Johns Hopkins Medicine Health Library, n.d.). This amount represents 9.2% of all out-of-pocket spending by Americans on health care and 1.1% of total health care spending. Davis and Weeks

concluded that as health care reform proceeds, in light of the strong demand for U.S. CAM services, the field needs to develop a better understanding of spending patterns on CAM services to inform policymakers' decisions in their consideration of CAM services during national health care reform efforts.

Theme 4: Fill gap caused by weak medical coverage. In my study, many time bank study participants provided and sought ADL and IADL-type services. For these individuals, help with these tasks would have involved the payment of out-of-pocket costs, which they could not or did not wish to pay for because most, if not all, insurances do not cover these costs. There are four basic modes of paying for health care including out-of-pocket, individual private insurance, employee-based group private insurance, and government financing. People purchasing LTC insurance may find it to be a poor investment. Some private policies specify that a policy holder must be dependent in three or more ADLs before receiving benefits for home health services (Bodenheimer & Grumbach, 2012). Skilled services (registered nursing, physical and occupational therapists, speech therapists, for example) are usually covered by Medicare so long as a skilled need has been assessed, determination has been made that progress is obtainable, and the skilled services have been prescribed by a licensed practitioner. Custodial services, which often involve assistance with ADLs and IADLs rather than treatment or rehabilitative care related to a disease process, are not covered by Medicare. These services are usually provided by nurses' aides, home health aides, homemakers, or family members who are considered unskilled workers.

Furthermore, Medicaid differs from Medicare in paying the costs of nursing home care. For home health care, however, Medicaid generally does not cover 24-hour-a-day custodial services for people unable to care for themselves. The completeness of Medicaid's nursing home coverage, in contrast to the limited nature of Medicaid financed home health care, forces many low income, disabled people to go into nursing homes unless they have someone capable of providing 24 hours per day of custodial care (Bodenheimer & Grumbach, p. 147).

Theme 5: Co-production in action. This theme was brought up during Interview Question 3 (IQ3) where participants were asked to describe an incident where they experienced an emergency and their time bank membership came to their aid. Responses to IQ3 indicated that there was an element of co-production present in the time bank relationships among and between members. Time bank members sought and received services that are normally considered to be a part of public service production (including ambulance, fire department, and local emergency services). Time banking is an example of co-production, the idea that all people are assets and can contribute to society's needs (Cahn, 2000). By earning credits and using them for services they need, members are empowered through co-production as they overcome some of the stigma associated with traditional charity. Supporters of co-production efforts have proposed going so far as to socialize the means of distributing welfare services through greater involvement of the recipients of such services (Pestoff & Brandsen, 2008). Others have called for devolving as many of the functions of the state as possible to civil society while retaining public funding (Pestoff & Brandsen, 2008, p. 498).

Relationship Among the Five Themes

As mentioned in Chapter 4, although the study participants were somewhat worried and afraid of what their aging process would bring on, aging in place was not the main goal of any of the 10 study participants when they joined CA TB 2. It was only after being members for various lengths of time for each participant, that the thought occurred to them that they might be able to consider incorporating time bank membership as an aging-in-place initiative for themselves. The longer they participated with the group and started building bonds with the members, the better they understood both the present and potential future benefits from membership. Socializing, networking, and the ability to help others impacted most of the participants in ways they could not have imagined before they became involved with the time bank group. Through this study, some of these impacts have been recorded in the tables located in Appendices I through P.

Additional Findings

Contrasting the themes derived from the quantitative-based Collom et al. (2012) study with this CA TB 2 qualitive study revealed some interesting differences in the value that participants placed on the outcome categories. The Collom et al. study used a quantitative Likert-scale survey involving 235 randomly-selected participants from a location in Portland, Maine. Those participants ranked the economic, instrumental, and altruistic outcomes as the most important. My study of CA TB 2, which used a phenomenological methodology and purposeful sampling for 10 participants in a California time bank location, found that participants considered social and health outcomes to be more important.

This may be due to the different research methods (quantitative study using Likert-scale survey versus qualitative phenomenological study using semistructured interviews) or to the nature of sampling techniques (random sampling versus purposeful sampling that included time bank members 50 years old or older). Also, further research should be conducted to determine if geographic location plays any role in the participants' time bank outcomes, because these diverse social systems depend on various shared characteristics such as location, socioeconomic status, race, religion, societal function, and other distinguishable features (Lee & Brosziewski, 2009).

Limitations of the Study

Limitations of the study include (a) examination of one geographic region, (b) small sample size, (c) purposeful sampling strategy (integrated with snowball sampling), (d) gathering of data through interviews, and (e) offering $15 gift card upon completion of the interview. Because participants from only one Southern California time bank were included in my study, the results may not be representative of other time bank members located in other parts of California or throughout the United States. The transferability of the findings of this study were affected by the integration of the snowball sampling method with the small sample size and the purposeful sampling strategy. Furthermore, data collected through interviews can be distorted by bias or recall error on the parts of both the researcher and the respondent (Padgett, 2012). Member checking was conducted with the completed interview transcripts to examine for content clarity and accuracy. Finally, incentivizing study subjects can affect the moods of the subjects and this, in turn, can impact study results (Meloy, Russo, & Gelfand Miller, 2006). To counteract this

possibility, I was careful to make sure the participants were not telling me what I wanted to hear. If I had a doubt, I probed in depth to obtain corroborating facts and experiences.

Recommendations

The public policy goals of the California State Senate Select Committee on Aging and Long-Term Care inspired this exploratory study. Therefore, the recommendations for action will likely be of most interest to public administrators in the fields of health (especially LTC) and social work, specifically in the state of California (California State Senate, 2014). These public officials, along with scholars, would also benefit from the recommendations for future research.

Recommendations for Action

Through my research I identified expanded opportunities for the creation and further development of time banks to support the goals of the California State Senate's Select Committee on Aging and Long-Term Care, which articulated a vision for an effective and efficient LTC system. One of the recommendations of the committee was to create a California Department of Community Living (California State Senate, 2014, p. 16). The Committee recommended that the state administrative structure should be reorganized to establish a Department of Community Living under California's Health and Human Services Agency, replicating the federal government's ACL and reflecting the national trend toward service delivery in the least restrictive, most integrated community-based setting (California State Senate, 2014, p. 16). In support of this goal, creating more local currency systems including time bank programs, will assist the state's efforts in this endeavor. Furthermore, time bank administrators should consider actively

recruiting members who have specific skill sets or are willing to be trained to offer ADL and IADL-type services in exchange for hours.

My findings also illustrated a need for continued LTC partnerships between professional and managerial staff in public agencies and users in their communities. The goal of such collaborations would be to (a) promote user co-planning and co-delivery of professionally designed LTC services (such as those available through time banks); (b) facilitate the alliance among public service professionals, LTC recipients and their communities; and (c) encourage the development of a new type of public service professional, the co-production development officer, who can help to overcome the reluctance of many professionals (public and private) to share power with LTC users and their communities (Bovaird, 2007).

Furthermore, as health care reform continues in the United States, CAM services (Johns Hopkins Medicine Health Library, n.d.) should be considered in health policy decisions relating to cost containment. The CA TB 2, for example, includes several members who are trained and certified to provide a variety of CAM services, which fall under one of several modalities in exchange for service hours. In my study, there were participants who explored these services because they did not incur any out-of-pocket expenditures.

Another recommendation driven by the results of my study is to determine how local state and federal officials can play a role in and support the growth and development of time banks. Should scarce government resources be channeled towards time banking as a viable and sustainable source of aging in place care options? Might the

growth of time banks be counterproductive through mechanisms of absolving authorities of traditional LTC help provided under established Medicare and Medicaid individual and tax supported programs?

Time banks are reliant on supportive legislation to operate (Collom, 2014). They are still hindered by some federal laws and would benefit from better legal environments. Funding, and in some cases governmental loans would also be beneficial and contribute to the sustainability of these alternatives. Policymakers need to be persuaded to support the growth and development of time banks. Time banks empower participants by giving them a voice in the economy and providing potential to increase their standard of living. Not only can they serve older adults now, their expansion may help avoid some of the larger social problems associated with an individual's future aging.

Recommendations for Further Research

My study should be continued throughout the state of California, to include a more racially, ethnically and socioeconomically diverse participant group that is more reflective of the state demographics. Additionally, studies that explore what services are sought after and what services are provided by time bank members age 50 and older, would provide valuable understanding for public officials on how to craft effective policies and programs to meet LTC needs of a growing segment of the population. Lastly, larger, widespread quantitative studies would be of benefit to increase generalizability and transferability of findings.

Implications for Positive Social Change

As of 2010, there were 40 million people 65 and older living in the United States (U.S. Census, 2011). The United States' population 65 and older is the largest in terms of size and percent of population compared with any previous census (U.S. Census, 2011). Furthermore, between 2000 and 2010, the population 65 and older grew 15.1%, while the total United States' population grew 9.7%. The challenge this number of older Americans will bring to the country is unprecedented. Given the facts surrounding current economic problems, a weak health care system and the lack of local support systems needed to support older people, this is a serious national predicament (California State Senate, 2014). Most importantly, it is a big problem for number of Americans who are aging in place or wish to do so.

There are several options available for individuals who wish to age in place, including NORCs, home health services, and living with family members. The focus of aging in place is to help individuals ensure they can live where they choose and get help they need for as long as they can. The goal of an individual 50 years or older wanting to age in place should be to maintain and/or improve their quality of life. To do that, a good plan that focuses on the quality of life and covers self, home and finances should be created as early as possible.

My research findings indicate a need for continued network governance collaborations including California's Health and Human Services Agency and LTC partnerships between professional and managerial staff in public agencies and users in their communities. The California State Senate's Select Committee on Aging and Long-

Term Care articulated a vision for an effective and efficient LTC system. Time banking should be a fixed part of this system. Together, public health agencies, LTC users and their communities can spearhead positive social change to expand home and community-based services.

Conclusion

How can communities respond to the LTC needs of their aging population in ways that are helpful, sufficient, and cost-effective? In the past, the extended family unit made it possible for older adults to maintain a way of life that few people in modern societies can count on. Elders and others with LTC needs were cared for in multigenerational units, often with three generations living under one roof. Today, whether by choice or by circumstance, our aging population finds themselves living alone as they age in place. Although modern scientific advances are allowing people to live longer and better than at any other time in history, these scientific advances have narrowed down the processes of aging into medical experiences managed by health care professionals. This has tremendous impact on public health care spending. Based on the results of my study, time banking can support the creation of a different kind of health care system for individuals who wish to age in place, or who require certain types of LTC. This new health care system will be less focused on high-tech medicine and doctor's expertise and more focused on addressing patients' human and social needs.

Time banking, as a contributing factor to community co-production, can promote aging in place, lower the health care cost burden, encourage less reliance on federal and state funded health insurance (Medicare and Medicaid respectively), expand ownership in

health care decision making and finally, promote a revival of societal obligation for family care of older adults, something that is deeply entrenched in other cultures today (Japan, Thailand, Canada). As discussed in my study, both the existing and the future benefit potential of time banking are great, especially as they relate to facilitating aging in place through the provision of nonmedical health care delivery. The time has come to upgrade the concept of time banking from being considered a social experiment to serving as a nonmedical LTC insurance option.

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Appendix A: Retrospective Membership Survey (Preexisting Survey Instrument)

(Collom et al., 2012, p. 147)

The Outcomes of Time Banking

Table 6.3 Additional HEP outcome items (14) and scale (4-point Likert Scale: Strongly disagree to Strongly agree)

	Mean	SD
Health Outcomes		
Health Outcomes Scale (a = .89):	*2.48*	*.76*
Improve your standard of living	2.80	.89
Get help from others	2.72	.90
Learn about sources of support and advice in the region	2.53	.94
Enabled you to feel less financially stressed	2.50	.97
Improved your mental health	2.23	.95
Improved your physical health	2.09	.98
Social Capital Outcomes		
Social Capital Outcomes Scale (a = .86):	*1.78*	*.67*
The frequency with which you volunteer	2.08	.93
Your involvement with community, civic, or political groups	1.93	.90
Your political activism	1.79	.84
The frequency with which you attend non-time bank social, political, or community events	1.61	.78
The frequency with which you entertain guests at your home	1.51	.71
Work Outcomes		
Work Outcomes Scale (a = .73):	*1.56*	*.69*
Enabled you to learn new job-related skills	1.73	.85
Provided you with the opportunity to work	1.62	.95
Helped you to find a job	1.32	.74

Appendix B: Community Currency Motivation Research

(Collom et al., 2012, p. 57)

Study	Population	Methods[a]	Motivating factors
Williams et al. (2001a, 2001b)	26 U.K. LETS	1999 Survey; n=810; RR=37%	Economic (42%); Ideological (25%); Social/Community (23%)
Birch and Liesch (1998)	50 Australian LETS	1995 Survey; n=371; RR=37%	Build community; Encourage local initiative
Gran (1998)	4 Norwegian LETS	1995 Survey; n=165; RR=64%	Short-term altruistic
Thorne (1996)	6 English & Scottish LETS	1993 Interviews; n=13	Community building; Social networking
Williams (1996b)	U.K. LETS Case Study	1995 Survey; n=63; RR=25%	Economic (52%); Social (31%); Ideological (31%)
Williams (1996c)	U.K. LETS Case Study	1994 Survey; n=46; RR=38%	Economic/Ideological (24%); Economic/Skills (24%); Economic/Social (22%)
Williams (1996a)	U.K. LETS Case Study	1995 Survey; n=109; RR=22%	Economic (82%); Community building (50%)
Pacione (1997)	Scottish LETS Case Study	1996 Survey; n=22; RR=63%	Economic (52%); Community solidarity (35%); Ideological (25%)
O'Doherty et al. (1999)	U.K. LETS Case Study	Survey; N=96; RR=32%	Attachment to Community (33%); Save cash (25%); Ideological (20%)
Caldwell (2000)	U.K. LETS Case Study	Survey; n=51; RR=54%	Ecological altruism (N=33); Ecological self-interest (N=25); Economic altruism (N=25); Economic self-interest (N=16)
Seyfang (2001a, 2001b)	U.K. LETS Case Study	1996 Survey; n=64; RR=60%	Economic (60%); Social/Community (40%)
Seyfang (2002, 2003)	U.K. Time Bank Case Study	2002 Survey; n=18; RR=28%	Help others (78%); Community involvement (72%); Improve neighborhood (56%)

[a] n = Number of cases in sample; RR = Survey response rate

From *Equal time, equal value: Community currencies and time banking in the U.S.* (p. 57), by E. Collom, J. N. Lasker, and C. Kyriacou, 2012, Surrey, UK: Ashgate Publishing Limited. Copyright [2012] by Ashgate Publishing Limited. Reprinted with permission.

Appendix C: Scholarly Research Supporting Use of Preexisting Research Instrument

(Collom et al., 2012, p. 144)

Study	Population	Methods[a]	Outcomes
Williams et al. (2001a, 2001b)	26 U.K. LETS	1999 Survey; n=810; RR=37%	Developed help network (75%); New friends (55%)
Birch and Liesch (1998)	50 Australian LETS	1995 Survey; n=371; RR=37%	Personal development; Economic benefits
Williams (1996b)	U.K. LETS Case Study	1995 Survey; n=63; RR=25%	Developed help network (68%); New friends (46%); Use skills (38%)
Williams (1996a)	U.K. LETS Case Study	1995 Survey; n=109; RR=22%	Helped improve standard of living (48% of low-income, 44% of unemployed)
O'Doherty et al. (1999)	U.K. LETS Case Study	Survey; n=96; RR=32%	Sense of belonging to community (84%)
Seyfang (2001a, 2001b)	U.K. LETS Case Study	1996 Survey; n=64; RR=60%	New income opportunities (48%); More community involvement (43%); Build self-confidence (23%)
Seyfang (2002, 2003)	U.K. Time Bank Case Study	2002 Survey; n=18; RR=28%	New friends (72%); Better neighborhood (56%); Help others (50%)
Jacob et al. (2004b)	Ithaca Hours (U.S.) Case Study	2002 Interviews; n=42	Able to help others (88%); Improved quality of life (84%); New friends (68%); Developed new skills (43%); New access to goods (41%)
Stern, Cherry, and Oberlink (2009)	U.S. Time Bank Case Study of Older (60+) Members	2009 Survey; n=61; RR=81%	New friends (86%); Sense of belonging to community (85%); Mental health/well-being (72%); New health information (66%); Increased trust (66%); Self-confidence/self-esteem (64%); Save money (51%); Physical health/well-being (48%)

[a] n = Number of cases; RR = Response rate

Appendix D: Screening Questionnaire Guide

Screening Questionnaire

Name: _____ Date: _____

Note: If the answer to questions numbered 1 or 2 is "No", or if the answer to question number 3 is "Yes", the respondent does not meet the eligibility requirements. Inform them, thank them for their time and ask them if they would let others who might qualify know about this opportunity.

- [Ice breaker] Thank you for inquiring about this research study. I am curious to know how you found out about it?
- If you do not mind, I have a few questions for you, to make sure you are eligible to participate. Is that alright? Y/N

1. Are you a member of CA TB 1 or CA TB 2 group? Y/N
2. Are you at least 50 years of age? Y/N
3. Are you participating in any long-term care programs? Y/N

*** *** *** *** *** *** *** *** *** *** *** *** *** *** *** ***

You meet the eligibility requirements for the study.

Let me tell you about the details then. If you have questions at any time, please let me know.

The purpose of this study is to understand the experiences of mature time bank participants in their roles as members of these groups. I also hope to learn if membership in these groups impacts in any way a person's choice to age in place.

This study will take place in two parts. The first part involves a face-to-face interview, and will take place at your convenience. Although we will take as much time as you group like, I do not expect us to devote more than one hour for the interview portion of this study. During that time, I want to hear about your specific experiences of how you engage with the time bank organization and what services you contribute as well as request from the group. I will be asking your permission to record the conversation.

The second part of the study involves the voluntary completion of a paper and pencil survey questionnaire which will be used for demographic purposes only- and may take up to 30 minutes.

Do you have any questions at this point? Would you like to schedule a time for the interview? Y/N

Let me get your contact information, and then we will set a date and time for the interview.

- Confirm your name:_____
- Would you prefer to receive the study questionnaire (Part 2 of study) by email, fax, or regular mail?
    - Email address:
    - Fax#:
    - Mailing address:
- What are the best phone numbers for me to reach you?

  _____
- If you have an alternative phone number to be kept on file as a backup contact number, please provide that number here: _____What would be the best dates, time, and location for you to participate in an interview?
    - Date_____
    - Time_____
    - Location_____
    - I am flexible with dates and times: Y N

Appendix E: Voluntary Demographic Survey

Voluntary Demographic Survey

Please place a check mark next to your response.

Age

- ❑ 50 -59
- ❑ 60 - 69
- ❑ 70 - 79
- ❑ 80-89
- ❑ 90 or over
- ❑ Prefer not to state

Self-identified Race (Select all that apply)

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White or Caucasian
- ❑ Other _____
- ❑ Prefer not to state

Self-identified Ethnicity

- ❑ Hispanic or Latino/a
- ❑ Not Hispanic or Latino/a
- ❑ Prefer not to state

Continued on next page

Select your Self-Identified Gender

- ❑ Male
- ❑ Female
- ❑ Transgendered
- ❑ Prefer not to state

Annual Household Income

- ❑ Below 20,000
- ❑ $21,000- $60,000
- ❑ $61,000-$100,000
- ❑ Above $100,000
- ❑ Prefer not to state

Prior Experience with Long Term Care

1. Have you received any long term services or supports in the past?
   - ❑ Yes
   - ❑ No
   - ❑ Prefer not to state

2. Other than your spouse/committed relationship partner do you share your residence with any other individual(s)?
   - ❑ Yes
   - ❑ No
   - ❑ Prefer not to state

3. If you answered yes, please elaborate:

Continued on next page

4. Do you live near family members or close friends (not including others living in your home)?
   - ❑ Yes
   - ❑ No
   - ❑ Prefer not to state

5. Are you able to perform Activities of Daily Living (ADL)? Check all that apply.
   - ❑ Eating
   - ❑ Dressing
   - ❑ Bathing
   - ❑ Toileting
   - ❑ Getting into and out of chair
   - ❑ Self-administration of medications (oral or injectable)
   - ❑ Other _____
   - ❑ Prefer not to state

6. Are you able to perform Instrumental Activities of Daily Living (IADLs)? Check all that apply.
   - ❑ Laundry
   - ❑ Housework
   - ❑ Meal preparation
   - ❑ Grocery shopping
   - ❑ Transportation
   - ❑ Financial management
   - ❑ Managing medications such as taking oral or injectable medications
   - ❑ Using the telephone or computer
   - ❑ Other _____
   - ❑ Prefer not to state

Appendix F: Semistructured Interview Guide

Date:_____ ID#_____

Introduction:

Thank you for your help with this study. My name is Calli Sajnani and before we begin the interview I would like to talk to you all about your participation in this research study. Its purpose is to understand how CA TB 1 and CA TB 2 participants view their membership and what effect this time bank participation may have on their decision to age in place. I hope to better understand your experiences and your points of view regarding your desire to participate in a time bank program.

I want to make sure you understand that participation in this study is voluntary, and that you may stop your individual participation with the interview at any time.

The interview should take about one hour, and we will be reviewing a lot of information, all of which is important for this research project. Since I do not want to miss any of your comments, would it be alright if our conversation was audio recorded? I will also be taking some notes during the session, but I can not possibly write fast enough to get it all down.

During this interview, you may feel tired, stressed, or emotional, but beyond that there should be no other risks to your safety or well-being. All of your responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you. Remember, you do not have to talk about anything you do not want to disclose and you may ask questions or end the interview at any time.

As a token of gratitude for sharing your time and experiences, I will offer you a choice of a $15 gift card to a local supermarket or discount retailer.

Are there any questions about what I have just explained?

Are you willing to participate in this interview ?

Semi-Structured Interview Guide Notes/Counters

1. Tell me why you decided to join CA TB 1 or CA TB 2, and what other options you had available to you in order to meet similar objective(s).

2. How does time bank participation help you to obtain goods or services that you normally would not or could not pay cash for? (note: ascertain whether participation in a time bank group complements existing funding systems including self-pay, private insurance, Medicare, and Medicaid)

3. Describe an incident where you experienced an emergency and your time bank membership status came to your aid.

4. What do you feel is the greatest benefit you derive from being a CA TB 1 or CA TB 2 member?

5. Have you had any negative experiences stemming from your time bank membership? Please give examples.

6. How would you describe your present quality of life? Please give examples. (note: ascertain whether time bank participation delays the need for institutional care)

7. Please describe how your family and friends view your membership in CA TB 1 or CA TB 2. Give examples.

This concludes the interview--thank you for sharing your experiences. Do you have any questions for me?

As I review the tapes and my notes, I may need to clarify some things. May I contact you with questions? [confirm contact data…phone, email, address]

Footnote: Any time a participant discloses actual or potential elder abuse, I will ask participant if they reported it to local authorities including but not limited to law enforcement, clergy members, medical professionals, mental health professionals.

Appendix G: Frame of Analysis 1—Health Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Improve Standard of Living	Code 2: Get Help from Others	Code 3: Learn About Support/ Advice/ Sources	Code 4: Improve Mental Health	Code 5: Improve Physical Health	Total Codes 1-5
Bill	1	2	1			4
Sally	2	2	1	2	1	8
Cynthia	1	4	1	2	1	9
Mary	1	3	1	1		6
Karen	1	3	1	2	1	8
Bud	1	2	1	1	1	6
Amy	1	2	1	1		5
Carolyn	1	3	1		1	6
Michelle		1	1			2
Teresa		2	1	1		4
Totals	**9**	**24**	**10**	**10**	**5**	**58**

Appendix H: Frame of Analysis 2—Social Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Spend More Time with Friends	Code 2: Experience Good Times in Social Settings	Code 3: Meet New People	Code 4: Feel useful	Code 5: Increase Self-Esteem	Code 6: Be with Like-Minded People	Code 7: Feel Less Lonely	Total Codes 1-7
Bill	1	3		1			1	6
Sally	1	1	2	3	1	1	1	10
Cynthia	1	2	2	1	1		1	8
Mary		1	1	1	1		1	5
Karen	1	1	1	2	1	1	1	8
Bud	1	1	1	3	1			7
Amy		1		2	1	1		5
Carolyn	1	1	2	1	1	1		7
Michelle	1	1	2	3	1			8
Teresa	1	1	2	4				8
Totals	**8**	**13**	**13**	**21**	**8**	**4**	**5**	**72**

Appendix I: Frame of Analysis 3—Work Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Learned New Job Skill	Code 2: Provided Job Opportunity	Code 3: Helped You to Find a Job	Total Codes 1-3
Bill			4	4
Sally	3			3
Cynthia				
Mary		1		1
Karen				
Bud				
Amy	1			1
Carolyn				
Michelle				
Teresa				
Totals	**4**	**1**	**4**	**9**

Appendix J: Frame of Analysis 4—Instrumental Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Learn New Skills from Others	Code 2: Improve Local Economy	Code 3: Help Establish Trust Among People	Total Codes 1-3
Bill	1	2	1	4
Sally	3		1	4
Cynthia	1	1	2	4
Mary	2		3	5
Karen	1	1	3	5
Bud	2		3	5
Amy			3	3
Carolyn		1	2	3
Michelle			2	2
Teresa			8	8
Totals	**10**	**5**	**28**	**43**

Appendix K: Frame of Analysis 5—Altruistic Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Gain Satisfaction Helping Others	Code 2: Help People in Need	Code 3: Give Back to the Community	Code 4: use Your Skills to Do Something for Others	Total Codes 1-4
Bill	1	1		1	3
Sally	1	1	1	1	4
Cynthia	1	1		1	3
Mary	1	1	1	1	4
Karen	1	1		1	3
Bud	1	1	1	1	4
Amy	1	1	1	1	4
Carolyn	2	3	1	1	7
Michelle	1	1	1	1	4
Teresa	1	3	1	1	6
Totals	**11**	**14**	**7**	**10**	**42**

Appendix L: Frame of Analysis 6—Needs Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Obtain Services You Can Not Perform Yourself	Code 2: Expand Your Purchasing Power	Code 3: Obtain Needed Services of Goods You Could Not Afford	Total Codes 1-3
Bill	2	1	2	5
Sally				0
Cynthia	2		1	3
Mary	1	1	2	4
Karen	1	1	3	5
Bud	3			3
Amy	3			3
Carolyn				0
Michelle				0
Teresa				0
Totals	**12**	**3**	**8**	**23**

Appendix M: Frame of Analysis 7—Social Capital Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Frequency You Volunteer	Code 2: Involvement with Community Civic/Political Groups	Code 3: Political Activism	Code 4: Attend Non-Time Bank Events	Code 5: Entertain Friends at Home	Total Codes 1-5
Bill	2					2
Sally	1	1	1	1	1	5
Cynthia	1			1		2
Mary	1					1
Karen						0
Bud	1	1	1	2	1	6
Amy						0
Carolyn	1	1	1	1	2	6
Michelle	1	1	1	1	1	5
Teresa	1	1	2	1	1	6
Totals	**9**	**5**	**6**	**7**	**6**	**33**

Appendix N: Frame of Analysis 8—Economic Instrumental Outcomes

The data in this table informed Research Questions 1, 2, and 3. The results include data sourced using the a priori codes shown in Appendix O, along with the emergent codes developed during the NVivo analysis.

Participant Pseudonym	Code 1: Obtain Goods/Services You Normally Would Pay Cash For	Code 2: Obtain Goods/Services You Would Rather Not Pay Cash For	Total Codes 1-2
Bill	2		2
Sally		1	1
Cynthia	2		2
Mary			
Karen	4		4
Bud		1	1
Amy	1		1
Carolyn			
Michelle			
Teresa			
Totals	**9**	**2**	**11**

Appendix O: Retrospective Membership Survey (Preexisting Survey Instrument Used to Create a priori Codes for Manual Coding)

(Collom et al., 2012 p. 145)

I built upon the study by Collom et al. (2012) that focused on the relationship between older people and time bank membership. I fine-tuned their study by focusing on older people, timebanks, and aging in place. These themes formed the foundation for the creation of frames of analysis.

Table 6.2 HEP Outcome items and scales corresponding with 29 motivation items (scales and items; range=1-4)

		Mean	SD
1	Altruistic Outcomes		
	Altruistic Outcomes Scale (a = .75):	*2.81*	*.61*
	Gain satisfaction from helping others	3.22	.71
	Help people in need	2.86	.79
	Give back to the community	2.85	.79
	Use your skills to do something for others	2.30	.90
2	Economic/Instrumental Outcomes		
	Wants Outcomes Scale (a = .81)	*2.77*	*.88*
	Obtain services or goods that you would not normally pay cash for	2.80	.97
	Obtain services or goods that you would rather not pay cash for	2.74	.96
3	*Instrumental Outcomes Scale (a = .76)*	*2.71*	*.65*
	Learn new skills from others	2.89	.82
	Improve the local economy	2.87	.81
	Help establish trust among people	2.54	.93
	Use or improve skills that you do not get to use regularly	2.52	.86
4	*Needs Outcomes Scale (a = .53)*	*2.66*	*.63*
	Obtain needed services that you do not get to use regularly	2.52	.86
	Expanded your purchasing power	2.78	.82
	Obtain needed services or goods that you could not afford	2.33	.87
5	Social Outcomes		
	Social Outcomes Scale (a = .85)	*2.34*	*.60*
	Spend more time with acquaintances or friends	3.00	.91
	Have a good time doing things in a social setting	2.89	.82

	Meet new people or make friends	2.66	.93
	Helped you to feel needed or useful	2.44	1.01
	Experience new activities in group settings	2.29	.91
	Feel better about yourself	2.05	.89
	Spend more time with like-minded people	2.03	.86
	Helped you to have something worthwhile to do with your free time	1.90	.98
	Helped you to feel less lonely	1.79	.88
6	Health Outcomes		
	Health Outcomes Scale (a = .89)	*2.48*	*.76*
	Improve your standard of living	2.80	.89
	Get help from others	2.72	.90
	Learn about sources of support and advice in the region	2.53	.94
	Enabled you to feel less financially stressed	2.50	.97
	Improved your mental health	2.23	.95
	Improved your physical health	2.09	.98
7	Social Capital Outcomes		
	Social Capital Outcomes Scale (a = .86):	*1.78*	*.67*
	The frequency with which you volunteer	2.08	.93
	Your involvement with community, civic, or political groups	1.93	.90
	Your political activism	1.79	.84
	The frequency with which you attend non-Time Bank social, political, or community events	1.61	.78
	The frequency with which you entertain guests at your home	1.51	.71
8	Work Outcomes		
	Work Outcomes Scale (a = .73):	*1.56*	*.69*
	Enabled you to learn new job-related skills	1.73	.85
	Provided you with the opportunity to work	1.62	.95
	Helped you to find a job	1.32	.74

Adapted from *Equal time, equal value: Community currencies and time banking in the U.S.* (p. 145), by E. Collom, J. N. Lasker, and C. Kyriacou, 2012, Surrey, UK: Ashgate Publishing. Copyright [2012] by Ashgate Publishing Limited. Adapted with permission.

Appendix P: Summary Total for the Eight Frames of Analysis

The frames of analysis are ranked in order by the total number of references throughout all of the interviews.

Frame of Analysis	Code References[a]	Code Frequency[b]	Appendix	Alignment of Frames with Conceptual Framework
Social (includes 7 sub codes)	72	53	J	C[c], A[d], T[e]
Health (includes 5 sub codes)	58	39	I	C, A, T
Instrumental (includes 3 sub codes)	43	20	L	C, A, T
Altruistic (includes 4 sub codes)	42	37	M	C, A, T
Social Capital (includes 5 sub codes)	33	29	O	C, A, T
Needs (includes 3 sub codes)	23	13	N	C, A, T
Economic Instrumental (includes 2 sub codes)	11	6	P	C, T
Work (includes 3 sub codes)	9	4	K	C, T

Notes. [a]Code References = The number of times this specific code was mentioned by any participant. [b]Code Frequency = The number of participants who cited various codes falling under this frame. [c]C = Co-Production Theory. [d]A = Aging in Place. [e]T = Time Banking