Strengthening the Direct Service Workforce in Rural Areas

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Overview

The Direct Service Workforce (DSW) Resource Center has received feedback from many states about difficulties related to recruitment, retention, and training of direct service workers in rural areas.[1] Both urban and rural areas struggle with providing quality long-term supports and services to help older people and people living with disabilities live independently at home and in the community. However, the DSW Resource Center's work with rural states and review of reports and websites shows that rural areas face unique direct service workforce challenges that require unique solutions.

States can use the information presented here to learn about some direct service-related strategies that other states and rural agencies have implemented to overcome these common challenges. These include:

► opportunities under the new health reform law
► participant-directed service options in long-term care financing programs
► general recruitment/retention strategies
► "grow-your-own" initiatives (developing a direct service workforce of local residents)
► supports for rural family caregivers
► worker-owned cooperatives
► training/credentialing opportunities for rural workers
► worker access to transportation
► worker registries
► mobile adult day care
► collaborating with urban agencies
► telehomecare
► the Program of All-Inclusive Care for the Elderly (PACE).

The **Appendix** provides an annotated list of resources.

Opportunities Under the 2010 Health Reform Law

The new federal health reform, signed into law in the Patient Protection and Affordable Care Act (ACA) of 2010, provides new opportunities to address direct service workforce challenges. Several provisions of the law include a focus on rural and other underserved communities:[2]

► **Nursing Assistant and Home Health Aide (NAHHA) Program :** In September, 2010, the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) announced 10 NAHHA grants.[3] The three-year grants to colleges or programs to support the development of community-based training to nursing assistants and home health aides who serve elders and people with chronic illness or disability. Preference was given to applicants that benefit rural or underserved populations or that help meet public health nursing needs.[4]

► **Money Follows the Person (MFP) Rebalancing Demonstration:** The ACA extends MFP through September 2016 and extends eligibility to people who resided in an inpatient facility for 90 consecutive days or more.[5] MFP presents an opportunity for states to focus on building the housing, transportation, and workforce needed to support transitioning people from institutional care facilities back to their homes and the community. Several MFP grantees are working to strengthen HCBS systems in rural areas.

► **National Health Care Workforce Commission:** In 2010, a National Health Care Workforce Commission was appointed[6], with the purpose of developing and commissioning "evaluations of education and training activities to determine if demand is met, to identify barriers to improved coordination across governmental entities and recommend actions, and to encourage innovation to meet needs."[7] The ACA specifies that the Commission include a balance between urban, suburban, rural, and frontier representatives. A priority topic area is the workforce needs of special populations such as rural populations.

Direct Service Workforce Challenges in Rural Areas

Many rural areas struggle with providing quality home-based supports due to the following:

► geographic isolation: fewer direct service agencies available to provide services; fewer direct service workers available for agencies to hire, and great size of service regions and distances between individuals in need of services and service agencies, resulting in direct service workers spending more time traveling to and from people in need of services and less time providing services

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► transportation limitations: lack of effective public transportation systems, seasonal road and weather conditions

► need to support informal caregivers: In many rural areas, family members, neighbors and friends often fill gaps in caregiving services[8]. Migration of many adult children to larger, more urban areas often reduces the number of family members available to provide care; thus many rural elders and people with disabilities must rely on friends, their church, and neighbors for informal services

► overall challenges in recruiting and retaining direct service workers

► higher proportion of older persons in the total population in rural than urban areas.[9]

Rural areas face unique challenges in recruiting and retaining not only direct service workers but also health care workers in general. For instance, rural areas constitute the majority of Health Provider Shortage Areas in the United States (approximately 85 percent).[10] A large part of this shortage occurs due to the higher proportion of people who lack health insurance in rural areas, which results in lower financial incentives for licensed medical care providers to work in rural areas.

Rural home health agencies face particular challenges. They experience a lower number of visits and smaller and more dispersed client base compared with their urban counterparts. Rural home health agencies also tend to be smaller, are more likely to be non-profit, and generally provide fewer services.[11]

In addition, both rural and urban home care agencies struggle with recruiting and retaining workers, in a tight labor market where they compete with hospitals and nursing facilities in their area, which generally offer higher wages and benefits.[12]

General Recruitment and Retention Strategic Planning

Increasing the size of the available workforce provides the most direct solution to the shortage of rural direct care workers. The Annapolis Coalition's report for the Substance Abuse and Mental Health Services Administration *An Action Plan for Workforce Development* contains a section on workforce recruitment/retention of the behavioral health workforce in rural areas.[13] The recommendations were developed through a strategic planning process that included two conferences in 2003 and 2005 and getting input from an expert panel. Although this report focuses on a specific segment of the rural direct service workforce, many of its recommendations can be generalized to the wider group of direct service providers. The report described the following action plan goals for rural behavioral workforce development:

1) increasing elders' and people with disabilities' level of self-direction and individual responsibility for their own care;

2) educating the community on identifying long-term care infrastructure needs;

3) implementing recruitment strategies (grow-your-own approaches), including participant-directed service models;

4) increasing the supply of effective training opportunities;

5) fostering leadership development;

6) enhancing infrastructure to support and coordinate workforce development; and

7) implementing a national research and evaluation agenda on workforce development.

"Grow-Your-Own" Initiatives and Participant-Directed Service Options

► Some rural localities have used "grow-your-own" approaches to workforce development. These programs recruit and offer incentives to residents who already live in underserved areas so that they stay and become part of the direct service workforce. A critical aspect of these efforts is providing opportunities for increasing workers' professional knowledge and creating opportunities for advancement. One of the better-known grow-your-own initiatives for the rural direct service workforce is the Behavioral Health Aide (BHA) program from the Alaska Native Tribal Health Consortium. [14] This program is developing, as the Annapolis Coalition describes, a "multi-tiered career ladder for behavioral health aides." The ladder includes BHA trainee (non-certified); BHA levels I, II, and III; and BH Practitioner. [15] The program reports that Behavioral Health Aides in Alaska work in the village where the live, work for their tribal health organization, and make between $10.00 and $27.00 an hour (average $17.00). Alaska also has a large participant directed services program.

Participant-directed service options in long-term care financing programs provide individuals and their representatives the opportunity to hire, manage, and fire their direct service workers. Funds may also be used to purchase other goods and services, such as assistive technology, home modifications, personal care supplies, and transportation, within state guidelines. This contrasts to traditional Medicaid home and community based programs, in which all participants receive services from Medicaid-certified home care agencies. Typically, participants who choose participant-direction receive assistance with managing finances and payroll.

Arkansas' experience with the Cash and Counseling demonstration program illustrates how a participant direction

model can help address workforce shortages in rural areas by providing opportunity for Medicaid beneficiaries to hire relatives, neighbors, friends, or unrelated workers who live nearby to provide paid direct services. Arkansas used the Cash and Counseling option to expand access to paid care for frail elders and adults with physical disabilities living in rural and other hard-to-serve areas, where many people faced limited access to services due to worker shortages.[16] More than a third of Arkansas' Cash and Counseling enrollees lived in rural areas, and about 70 percent lived in an area that was either rural or non-rural but with high crime or poor public transportation. Fifty-six percent of caregivers in Arkansas who were the person's primary unpaid caregiver at enrollment began receiving pay. Among Arkansas participants who used the allowance to pay workers, three quarters of those age 65+ and 70 percent of those under 65 hired a worker who was their child, parent, or other relative. Compared with the control group, Cash and Counseling participants in Arkansas were significantly more likely to be receiving paid personal assistance, to have their needs met, and to be satisfied with their care. Participants also reported that the program improved their lives a great deal, and their caregivers reported much less physical, emotional, and financial stress.

The Cash and Counseling model of participant direction has been expanded to 15 states.[17] In addition, as of 2007, states have the option of developing participant direction programs in Medicaid without waivers.[18] The Administration on Aging's Community Living Program funds states to develop participant-directed programs for people at risk of nursing home entry. The Veteran's Directed Home and Community Based Services Program supports participant directed programs for veterans at risk of institutionalization. In addition, the Department of Veterans Affairs administers the Housebound benefit and the Aid and Attendance benefit, which are benefits paid in addition to monthly pension, for veterans who require assistance with daily activities or are substantially housebound due to a disability.[19]

Efforts to Support Rural Family Caregivers

Family members and other unpaid caregivers provide the majority of long-term care, and studies have found no consistent difference between rural and urban elders in likelihood of receiving care from family members.[20] Family caregiving can be stressful. A 2009 survey conducted by the National Alliance for Caregiving and AARP found that caregivers who had been providing care longer were more likely to experience health decline, emotional stress, and economic hardship. Many caregivers struggle with lack of time for friends and other family members (53%), emotional stress (31%), and impacts on work responsibilities (70%).[21] Also, 78 percent of caregivers reported a need for more help or information on topics such as keeping their family member safe, managing their

stress, easy activities to do with the care recipient, or finding time for themselves.

Caregiver stress is a strong predictor of nursing home entry.[22] Helping alleviate challenges for family caregivers can increase the chances that they will be able to continue caring for their family members at home.

Caregiver support programs in rural areas often aim to teach hands-on caregiver skills, stress management, care management skills (ability to identify and coordinate care with outside support services), and self-care skills to elders and people with disabilities. Training within these systems can be conducted using videoconferencing, conference calls, in-person meetings, or web-based training. One training system often utilized for rural areas is the "Powerful Tools for Caregivers," a six-week education program developed by Caregiver Legacy Services in Portland, Oregon.[23] The program has been taught in 30 states since 1998 and reached over 60,000 family caregivers .The six classes focus on 1) taking care of you; 2) identifying and reducing personal stress; 3) communicating feelings, needs, and concerns; 4) communicating in challenging situations; 5) learning from our emotions; and 6) mastering caregiving decisions.

Under the Administration on Aging's (AOA) Alzheimer's Disease Supportive Services Program (ADSSP), caregivers around the country have been assisted. One program that ADSSP uses to assist rural caregivers is the Savvy Caregiver Program (SCP), an intervention designed for both urban and rural caregivers of persons with dementia. In Michigan, several SCP trainings have been conducted in rural communities.[24] One study examined the effectiveness of this program among rural Colorado residents.[25] The ongoing intervention targeted rural dementia caregivers and provided them with education, training, and services. Researchers found support for the overall effectiveness of SCP amongst both rural and urban participants. However, results on measures of depression showed significant improvement in rural participant depression scores, whereas this was not seen amongst the urban group. Access to training and support services, including attending a support group, may have assisted in the improvement of the rural family caregivers' depression scores.

Caregiver support programs in rural areas also often aim to facilitate the development of caregiver support networks, which can provide support and even respite care to rural caregivers. The Rural Caregivers Website, sponsored by Purdue University and the State Office of Rural Health in Indiana, contains links to many of these support communities and collections of resources to support family caregivers in rural areas.[26] Purdue University's Breaking New Ground Resource Center in cooperation with the Minnesota AgrAbility Project has developed a caregivers' manual, workshop leaders' guide, and video for caregivers of farmers and ranchers with disabilities.[27] Barn Builders is a

nationwide peer support network of farmers, ranchers, and caregivers impacted by disability.[28] Participants agree to assist another farmer, rancher or caregiver by talking with others, corresponding, and/or making farm or hospital visits. Family Caregiver Alliance's Handbook for Long-Distance Caregivers can be helpful for caregivers who live far away from their family members.[29] Although not meant specifically for rural communities, United Hospital Fund's Next Step in Care's collection of family caregiver resources, which include guides for all caregivers, planning for hospital discharge, rehabilitation, and home care, can also be helpful for informal caregivers.[30]

Worker-Owned Cooperatives

Major causes of direct service worker attrition include low wages and lack of benefits, workers feeling a lack of respect for their knowledge and skills, and low job satisfaction due to lack of professional growth opportunities, inadequate training, and unmanageable workloads.[31] Worker-owned cooperatives, direct service agencies owned and operated by direct service workers themselves, are one method that has been utilized to help give caregivers more ownership in the process, control over their work environments, and in some cases increased earnings and benefits. Researchers have surmised that the reason for these increased earnings might be a worker co-op's ability to secure consistent hours for its workers, consolidate resources and implement consistent billing policies. [32]

Several worker-owned cooperatives have been formed in rural areas. For instance, Cooperative Care started in 2001 in rural Waushara County, Wisconsin, with a workforce of 63 independent providers.[33] The program was developed by the Waushara County Department of Health Services with the help of USDA Rural Development. It was modeled after the Cooperative Home Care Associates cooperative in the Bronx, New York, the first home care cooperative in the nation. It is able to pay its workers higher wages than when the workers were primarily employed directly by people receiving services, as well as paid time off, holiday pay, health insurance, and other benefits previously unavailable to them.[34] Cooperative Care does this primarily by consolidating the workforce in this rural area, which allowed it to negotiate with Waushara County to serve Medicaid-eligible individuals through a single contract rather than many different individual providers. This consolidation also allows the co-op to coordinate services efficiently so that direct service workers can travel in the most efficient manner possible. In addition, members report feeling less isolated as a result of training opportunities, meetings, newsletters, and other social events provided by the co-op. Annual turnover is little or none, compared to an estimated 40-60 percent at other home care agencies. Cooperative Care was a finalist in the highly competitive Innovations in Government Award from the John F. Kennedy School of Government at Harvard University and has received national attention from

other communities wishing to replicate the model.

Another organization providing assistance to home care co-ops is the Cooperative Development Foundation (CDF), which has provided technical assistance grants to Cooperative Care, as well as the Paradise Home Care Cooperative in Pahoa, Hawaii, and the Circle of Life Caregiver Cooperative in Bellingham, Washington (www.cdf.coop/recent-grants/).[35] Two of these grants were awarded to the Northwest Cooperative Development Center, which provided critical technical assistance to both the Paradise Home Care Cooperative and the Circle of Life Caregiver Cooperative. For additional information, see the DSW Resource Center issue brief on Worker-Owned Cooperatives.[36]

Training/Credentialing

Direct service workers often need additional training to advance their careers. Obstacles to direct service workers receiving the training they need include: the costs of training and traveling to classes, a lack of well-defined direct service work career paths/job titles, and the lack of state and federal investment in training for these workers. In addition to general difficulties with direct service worker training, training in rural areas is difficult to execute because of geographic dispersion, lack of nearby education institutions, and smaller class sizes (thus less profit for training providers). In addition, employers often do not reimburse direct service workers for mileage to training and do not pay employees for training time.[37] Because of these and other obstacles, employers provide most training themselves post-hire.

Internet-based technology can give rural providers and workers increased access to advanced training courses. When a locality offers higher education/training opportunities through distance learning, it allows far-off students to gain the same educational opportunities they would have near a university or training facility. Examples of online training programs for direct service workers include the College of Direct Support (CDS), Volunteers of America, and Alzheimer's Association online training programs.[38] Such programs can reduce transportation and lodging costs that one might otherwise incur to participate in on-site training. Recognized educational platforms can enhance career path opportunities for rural direct service workers. For example, South Dakota, a rural state, adopted the CDS statewide.

Training systems in rural areas are not limited to online training methods. While online training methods can be cost-effective, some rural areas have found ways to deliver training in-person by fostering collaboration with private, public and non-profit partners. For instance, the Healthcare Regional Skills Alliance of Northwest Michigan provides in-person trainings for homecare workers (although the trainings are open to all direct service workers) in 12 rural counties. [39] The program is funded by the US

Department of Labor's High Growth Jobs Training Initiative (HGJTI) specifically for establishing a Direct Care Worker Career Pathway. In this program, healthcare employers, educators, and workforce development organizations work together to provide coordinated training. The program provides a variety of training opportunities, such as a Certified Nursing Assistant Apprenticeship, Certified Nurse Aide USDOL Registered Apprenticeship Program, and a skills refresher course. Scholarships are also available for many of the programs. In addition, rural localities can consider using mixed training methods, which combine online and in-person training methods.

Whatever the training method, one especially important resource for training for rural direct service workers is colleges located in rural states. Rural colleges already have established financial and intellectual resources and often serve several rural areas at the same time. The Ithaca College (IC) Gerontology Institute is an example of an educational setting in a rural area that has taken on training programs to fill training gaps. For instance, the center produced several internet-based, free trainings that are relevant for a variety of students and professionals interested in learning about aging and gaining skills for working with older adults.[40] The center also developed a Rural Interdisciplinary Geriatrics Training Module that describes the practice of interdisciplinary geriatric assessment in rural areas.[41]

Several state governments, including those with many rural areas (e.g., Alaska, Iowa, Louisiana, Ohio), are working to develop more clearly delineated competencies and career paths so that direct service workers have a clear, logical career lattice with which to plan for the future.[42] Also, with more clearly defined roles for direct service workers, defining career paths for direct service workers can help state administrators more easily identify job types, and thus shortages and specific areas that need strengthening.

Workers Access to Transportation

Rural and urban areas also struggle with the low pay and benefits of direct service work combined with transportation costs as an obstacle to worker recruitment and retention.[43] Most urban areas have the advantage of better-developed public transportation systems that make direct service work more accessible for direct service workers. In rural areas, the complications that result from the long distances direct service workers must often travel (variable gas prices and other costs of automobile ownership, variable seasonal road and weather conditions, and serving fewer people per day due to significant travel time) make serving people living in rural/geographically isolated areas less financially viable for traditional agency-based service providers and direct service workers.

Some providers, such as Mountain Empire Older Citizens, Inc. of Southwestern Virginia, own or lease vehicles and develop their own transportation for direct service workers.[44] This option, however, may not be financially viable for agencies with fewer resources or for direct service workers who work independently and are hired directly by the people they support. Although having a well-developed transportation infrastructure or community-based agency providers that are able to purchase vehicles is ideal, most rural areas do not have these resources. Instead, several intermediate steps might make a difference in this area, such as:

► Carpooling,
► Scheduling based on geography,
► Reimbursing direct service workers for mileage expenses, and
► Arranging with rental companies to rent highly fuel-efficient cars for direct service workers to use.

Rural Programs of All-inclusive Care for the Elderly (PACE) initiative, in their resource "PACE in Rural Areas: Infrastructure Challenges and Strategies" provides several recommendations for rural areas to finance improved transportation services for direct service workers.[45] PACE, in this resource, recommends that rural areas:

► Use alternative care sites and other settings such as senior housing facilities, assisted living facilities, and churches to deliver specific services.
► To the extent state regulations allow, use community and family caregivers to minimize reliance on PACE staff.
► Increase emphasis on home care as an alternative to day center attendance. Utilize advanced telecommunications technologies.
► Build a coordinated network between multiple rural health care providers interested in sponsoring a PACE program and contractors necessary to operate a program.[46]

Web-Based Direct Service Worker Registries

Related to transportation is helping people who use personal care services to find direct service workers who live in the closest proximity possible. One possible method to match workers and people in need of services is utilizing web-based worker registries. The DSW Resource Center website contains several resources on this subject, including a list of existing state registries at the "Find a Worker" function[47] and a "Registry Resources" bibliography of resources on starting and/or maintaining a registry and selected state registry websites.[48] In addition, PHI's Matching Service Project provides information on publicly-supported matching registries across the country.[49]

Mobile Adult Day Care

The Georgia Mobile Adult Day Care Program provides adult social day care and respite services to rural Georgia by sharing staff, who travel between locations.[50] Rural Healthy People 2010, an initiative of the Federal Office of Rural Health Policy, identified the program as a "model for practice" that demonstrated innovation, measurement and assessment, and replicability across rural settings. Program staff travel up to 50 miles one way each day to deliver services, generally at a senior center in the community. Staffing varies but typically includes a registered nurse, an activity director, an aide, and community volunteers. Most sites serve up to eight clients, with a staff to client ratio of 1:4. The program provides people with Alzheimer's disease and related disorders with a range of services, including exercises, cognitive activities, movies, crafts, reminiscing, lunch, and snacks.

Caregivers have reported that the mobile adult day care program helped them keep their family member with dementia at home longer, reduced caregiver burden, and provided them with relief and peace of mind. Originally funded with an Alzheimer's Demonstration Grant, the program currently is funded using a sliding fee reimbursement system, with United Way and state general funds, and some funds from private pay clients. It has expanded from one to three sites and now serves six counties in Georgia. In addition, other counties in Georgia and over 25 states have requested information about the program. A video about the program is available on the Georgia Department of Human Services, Division of Aging Services website at: http://www.aging.dhr.georgia.gov/ (*click on Programs, Home and Community Based Services, Mobile Adult Day Care*).

Collaborating with Urban Agencies

In the study "Medicare Home Health Care in Rural America," Sheila J. Franco found that, among a sample of 43,488 rural residents served by 9,410 home health agencies across the U.S., urban agencies often provided services to rural residents (*nearly 25% of the time*).[51] While the only examples we could locate regarding collaboration between rural and urban areas involve Medicare reimbursed home health agencies (due, perhaps, to Medicare's higher reimbursements), state administrators should be familiar with the concept.

If urban home health agencies are providing a substantial portion of the homecare in rural areas and encouraging home health agencies to locate in rural areas is not always realistic, it follows that one area where states might focus is increasing urban agencies willingness to serve rural individuals. New York State, for instance, implemented a series of Medicare add-ons that allowed urban agencies to serve individuals in rural areas. The state passed a recruitment and retention add-on (which expired in 2006) for agencies that serve individuals in upstate

New York. This add-on reimbursed such expenses as gas and other auto expenses, which helped offset the costs of urban-based workers traveling to rural areas. The state also provided funding to allow agencies to lease telehealth equipment that helped urban agencies reach into areas that are more rural.[52]

If fiscally feasible, states can explore the possibility of providing similar add-ons or payments to urban direct service agencies for providing services in rural areas. Because Medicare reimbursement is higher than Medicaid, such fiscal incentives for collaboration with urban agencies might be more feasible with Medicare home health care than for Medicaid personal assistance services. Yet, even if incentive payments are not fiscally realistic, states can gauge nearby urban agencies' ability and willingness to provide home support services in rural areas. Moreover, telehealth/telehomecare can be another possible method for getting urban agencies involved in serving rural areas.

Telehomecare

Telehealth enables providers to serve more individuals per day across a broader geographic area.[53] In recent years, a number of telehealth solutions have been developed that allow providers to remotely monitor and communicate with people receiving services in their homes or assisted living facilities. These include interactive devices for remote patient monitoring, "smart homes," and remote medication management devices. The term *telehomecare* refers to the use of telecommunication technology to provide long- term services and supports in people's homes. An important point to note is that these activities do not replace in-person, hands on care. However, urban or rural areas can utilize telehomecare, using technology that monitors vital signs and specially adapted video/audio technology, to deliver some basic health monitoring services in remote or rural areas at low costs. For instance, through telehomecare, providers can monitor an individual's vital signs, observe adherence to medication regimens, detect significant differences in an individual's health status and communicate regularly with the person receiving services to assess mental status and general well-being. Although telehealth services cost less than in-person visits, start-up costs for telehealth are expensive. Several federal agencies and states provide funding to help finance telehomecare devices and services.

For veterans with conditions that might make it difficult to live independently in their homes, the Department of Veterans Affairs will provide care coordination/home telehealth, if the veteran has been assessed and determined that this is an appropriate way for them to get care.[54] The most common technologies VA uses are devices that connect a veteran to their care coordinator at a VA hospital from home using video technology and messaging devices that collect information about symptoms and vital signs. The care coordinator provides training on how to use the home telehealth device and link with

the physician to arrange whatever treatment the veteran needs.

The Health Services Resources Administration (HRSA) Office for the Advancement of Telehealth, part of HRSA's Office of Rural Health Policy, promotes the use of telehealth.[55] The office administers three telehealth grant programs: 1) the Licensure Portability Grant Program, for programs to reduce statutory and regulatory barriers to telemedicine; 2) the Telehealth Network Grant Program, for telehealth projects serving underserved populations in urban, rural, and frontier (sparsely populated and isolated rural) communities; and 3) the Telehealth Resource Center Grant Program, to establish centers to assist with implementing telehealth programs to serve rural and medically underserved areas and populations.

New York and Minnesota both initially financed the purchasing of telehealth equipment through grants at the state level.[56, 57] Minnesota's Department of Human Services grants funded the purchase of telehealth equipment to deliver skilled nursing care to support older or at-risk adults in small communities throughout Minnesota.[58] Services were paid for through Elderly or Alternative Care Waivers. In 2001, the Minnesota Legislature approved reimbursing telehomecare skilled nurse visits through Minnesota Medical Assistance at the same rate as a skilled nurse visit conducted in a patient's home.[59] The visits must use audiovisual communication technology and equipment allowing the practitioner to measure the patient's physical status. The Minnesota "elderly waiver and "alternative care" home and community-based service programs also provide reimbursement for telehomecare services.[60] Some insurers in Minnesota have begun reimbursing for such services as well.

In 2007, Pennsylvania and New Mexico became two of the first states to provide reimbursement for home telehealth through a Medicaid waiver for adults age 60 and older.[61] The reimbursement covers remote patient monitoring technologies, "Smart Home" technologies that sense and monitor the person's activities, medication dispensing/monitoring devices, and personal emergency response systems. New Mexico implemented a policy of reimbursing telehealth visits with eligible providers at the same rate as in-person visits. Several other states have also considered or implemented telehealth reimbursement policies.[62]

States also may review the practices of the insurance plans licensed in their state, as several states have enacted laws that prohibit discrimination in the reimbursement for telehealth in private indemnity plans.

PACE Model

Another source for ideas related to home services and supports in rural areas is the efforts of the Program of All-Inclusive Care for the Elderly (PACE) model. PACE is a long-term care services model (funded, primarily, by both Medicare and Medicaid) that aims to provide, under the same agency, all medical services, ancillary services, home health services, respite care and other services a person, and their family as appropriate, might need to avoid nursing home care and live in the community successfully. Through their work, PACE sites are accumulating lessons and insight on financial considerations, operational considerations, planning and development, policy, and technology. Because PACE has adapted their program to rural settings, PACE has developed a website specific to rural areas that might be helpful for states to consult.[63] While applying for site status might be an option for some states and localities, the accumulated information gathering and case studies from the PACE program might help programs across the rural home health spectrum develop strategies to better care for elders and people with disabilities in rural areas.

Conclusion

This issue brief is a short introduction to the challenges of the direct service workforce in rural areas and strategies rural stakeholders can use to provide high-quality long-term care services and supports. Please consult the attached Rural Resource Collection, which focuses on innovative strategies and case studies, for more details.

Appendix: Rural Resource Collection

Collections of Resources/Guides:

Rural Assistance Center

http://www.raconline.org/

Established by the US Department of Health and Human Services, the Rural Assistance Center is meant to be the rural health and human services "information portal". Many useful resources are available on the site, including funding opportunities, information guides, links to organizations, articles, and success stories (detailed in the "Case Studies" section of this list).

Rural Caregivers Website

http://www.ruralcare.info/

A website that provides a web support community for rural caregivers, with links to information and groups. Although the information is not rural specific, the site may be especially helpful to rural caregivers and who face challenges of geographic isolation, gaps in rural service delivery systems. There is a state-specific guide at http://cobweb.ecn.purdue.edu/~agenhtml/ABE/Extension/BNG/Caregiving/bystate.html

Rural Health Resource Center (RHRC)

http://www.ruralcenter.org/

The RHRC is a nonprofit organization that focuses on five areas to improve health care in rural communities: (1) Performance Improvement; (2) Health Information Technology; (3) Recruitment & Retention; (4) Community Health Assessments; and (5) Networking.

Center for Rural Health

http://www.ruralhealth.und.edu/

The Center for Rural Health is a resource for identifying and researching rural health issues, analyzing health policy, strengthening local capabilities, developing community-based alternatives, and advocating for rural concerns.

Literature Review:

Hutchison et al. "Access to Quality Health Services in Rural Areas: Long-Term Care"

http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.htm

Comprehensive literature review of issues related to access to long-term care (residential and non-residential) for rural areas. Includes discussion of "proposed solutions or interventions that are feasible in rural areas." Some of these focus on the direct service workforce.

Reports:

Mueller, Keith J. (June 2010). "The Patient Protection and Affordable Care Act: A Summary of Provisions Important to Rural Health Care Delivery". RUPRI Center for Rural Health Policy Analysis.

http://www.unmc.edu/ruprihealth/Pubs/PPACA%20Rural%20Provision%20Summary.06_08_10.pdf

This report reviews sections of the Patient Protection and Affordable Care Act (PPACA) as they relate directly to, or have an impact on, rural health issues.

Easter Seals. "Caregiving in Rural America"

http://www.easterseals.com/site/DocServer/Caregiving_in_Rural-saveas-compress.pdf?docID=49463

This report focuses on caregiving by family members or friends in rural areas. The report details information on the demographic, income, living arrangements, type of care and personal supports of rural caregivers. The report also includes program profiles of entities that provide statewide support services for family and friend caregivers. These services include network building, technical assistance and training.

Buckwalter, Kathleen & Linda Davis. "Elder Caregiving in Rural Communities". University of Iowa

http://www.centeronaging.uiowa.edu/archive/pubs/Elder%20Caregiving%20in%20Rural%20Communities.htm

Overview description of the rural elderly population, description of the shortage of rural caregivers, literature review on "What Supports Rural Caregivers" and a "promising practices" section. The promising practices section includes descriptions of mobile outreach programs, nurse care management, and caregiver support programs.

Whitaker, J. et al. (March 2005). Home Care Cooperatives: Worker Ownership in Focus.

http://www.uwcc.wisc.edu/info/health/homecare.pdf

Description of cooperative home care agencies, which are agencies distinguished by the fact that the workers are part co-owners. Because of the often fragmented nature of rural direct service provision, cooperative home care agencies are one strategy for achieving coordinated home care services and fostering cooperation among direct service workers in rural areas. This brief describes several forms of cooperative home care agencies and describes the rural Cooperative Care agency in rural Wautoma, Washington.

Sutton, J. "Home Health Payment Reform: Trends in the Supply of Rural Agencies and Availability of Home-Based Skilled Services." NORC Walsh Center for Rural Health Analysis Policy Brief. W Series, No. 6., 2005.

http://www.norc.org/NR/rdonlyres/51442860-0B0F-4F45-A76B-0C3B093FBCFD/0/WalshCtr2005_NORCMarchCX2.pdf

Study of the effect of reimbursement rates/policies on the supply of rural home health workers. This resource might be useful for states exploring increasing reimbursement rates as one way of recruiting/retaining rural caregivers.

Franco, S. "Medicare Home Health Care in Rural America." NORC Walsh Center for Rural Health Analysis Policy Brief. W Series, No. 1., 2004.

http://www.norc.org/NR/rdonlyres/7FD9CA92-9D98-43EA-9319-BD27CE4C6948/0/WalshCtr2004_NseriesJan04v1.pdf

This report focuses on the importance of urban agencies in providing home health care for rural residents and the prevalence of urban agencies that serve rural individuals. Collaborating with urban agencies can be one method for increasing service options for people with disabilities and/or people that are elderly in rural areas.

Mohatt, D.F. and Bradley, M.M., (2007) "Rural Issues in the Behavioral Workforce." In Hoge, M.A. Morris, J.A., Daniels, A.S., Stuart, G.W., Huey, L.Y., Adams, N. An Action Plan on Behavioral Health Workforce Development. Annapolis Coalition for the Behavioral Health Workforce. Report for Substance Abuse and Mental Health Services Administration (SAMHSA). pp. 220-235.

http://www.samhsa.gov/workforce/annapolis/workforceactionplan.pdf

This chapter discusses the behavioral health workforce needs of rural areas and provides recommended actions for strengthening the rural behavioral health workforce.

"Evaluation of the Rural PACE Provider Grant Program"
    http://www.npaonline.org/website/navdispatch.asp?id=3841

This Report to Congress evaluates the effectiveness of Rural PACE Provider programs. Fifteen rural pilot sites were awarded PACE grants. This primarily qualitative study asks research questions about experiences with start-up, enrollment, and implementation, and use of PACE funds.

Case Studies:

Program: Cooperative Care

Location: Wautoma, Wisconsin

http://www.srph.tamhsc.edu/centers/rhp2010/html/access/ltc/CoopCare.htm

A description of Cooperative Care, a rural in-home care services cooperative where long-term care providers are not only employees, but also business owners. The cooperative model helps give employees input into how the business operates and encourages coordination/centralization of long-term care services in the area.

Program: A Rural Minority Geriatric Care Management Model

Location: Charleston, South Carolina

http://www.srph.tamhsc.edu/centers/rhp2010/html/access/primarycare/ruralminority.htm

Description of a comprehensive care management program serving low-income African Americans in need of long-term care services in rural South Carolina. The program includes home health services, which operate out of local health clinics, including Federally Qualified Health Centers.

Technical Information:

Medicare Billing Information for Rural Providers, Suppliers, and Physicians. **The Centers for Medicare & Medicaid Services**

http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf

Official document from CMS on billing procedures for rural providers. This document has a specific section on home health [Page 20], which provides technical details of procedures for reimbursing rural home health providers.

Events/Calendar:

Association of Programs for Rural Independent Living (APRIL)

http://www.april-rural.org/

The APRIL website maintains an updated calendar of events related to rural independent living.

Related Academic Resources:

Beidler, S.M., and Bourbonniere, M. Aging in place: A proposal for rural community-based care for rural elders. Nurse Practitioner Forum 10(1):33-38, 1999.

This article explores existing models of long-term care for the older population and proposes a model for rural community-based care. This model emphasizes the contributions of advanced practice nurses as coordinators of a collaborative system of care for the targeted population.

Coburn AF. Rural long-term care: what do we need to know to improve policy and programs? J Rural Health. 18 Suppl: 256-69, 2002.

This article discusses specific topics and questions relevant to long-term care policy and program improvements for rural communities and people: (a) the changing role of the rural nursing home; (b) residential care alternatives in rural areas; (c) health personnel and rural long-term care; (d) the quality of rural long-term care; (e) innovations in long-term care financing and service delivery; (f) use of technology in rural long-term care; and (g) the effects of Medicaid and Medicare policy changes on the rural long-term care system.

Gerontological Social Work in Small Towns and Rural Communities. Hawthorn Press, Inc., 2003.

This book is a collection of scholarly articles on gerontological social work in rural communities. Includes chapters on long-term care and program planning. The 18 articles are published simultaneously as the Journal of Gerontological Social Work vol. 41, nos. 1/2 and 3/4 (2003).

Krout, J.A. Rural Aging Community-based Services. In: Coward, R.T. et al. (eds.) Health Services for Rural Elders. New York, NY: Springer Publishing, Inc.:84-107, 1994.

Book about research on the current state of the delivery of health services to the rural elderly. Examines in-home care, ambulatory, acute, and hospital settings, mental and social health and more.

Magilvy, J.K.; Congdon, J.G.; and Martinez, R. Circles of care: Home care and community support for rural older adults. Advanced Nursing Science 16(3):22-33, 1994.

The researchers in this study conducted an ethnography to describe rural home care for frail older adults from the perspective of those delivering and receiving services. A major theme identified was "Circles of Care." Grounded in rural culture, the circles assisted the system of formal care to work in harmony with informal care, maintaining independence for vulnerable rural elderly and their families.

Patanian, Miriam M. Modeling the Mental Health Workforce in Washington State: Using State Licensing Data to Examine Provider Supply in Rural and Urban Areas. Journal of Rural Health. 22(1):50-58, 2006.

Examines mental health shortage areas using existing licensing and survey data for Washington State.

Schoenberg, N.E., and Coward, R.T. Residential differences in attitudes about barriers to using community-based services among older adults. Journal of Rural Health 14(4):295-304, 1998.

This study conducted focus groups with urban and rural older adults to explore reasons why rural elders tend to use fewer community based services than their urban or suburban counterparts. Rural elders more frequently highlighted barriers to using community-based services, including a lack of awareness of services, inadequate transportation, and perceived rigid program eligibility standards. While the study found differences between rural and urban elders, the authors also concluded that regardless of residence, older adults face substantial barriers to services, resulting in unmet needs.

Virnig, Beth PhD National Study of Home Health Access in Rural America. Office of Rural Health Policy (ORHP) ORHP-funded Individual Grantees. 2005.

This project developed home health care service measurement areas to measure access to home health care for rural Medicare beneficiaries who die of cancer. The report also recommends options for increasing access to home health care in underserved rural areas.

Rural PACE Grantees in DSW Resource Center/Money Follows the Person States:

State	City	Awardee
Arkansas	Jonesboro	AllCare of Arkansas
Colorado	Grand Junction/Montrose	Volunteers of America
Hawaii	Kahului	Hale Makua
Iowa	Sioux City	Hospice of Siouxland
Montana	Billings	Billings Clinic PACE Foundation
New York	Olean	Community Care of Western New York

State	City	Awardee
North Carolina	Carrboro	Piedmont Health Services
North Dakota	Bismarck	Northland Healthcare Alliance
Pennsylvania	Kulpmont	Geisinger Health System Foundation
Pennsylvania	Chambersburg	Lutheran Social Services of South Central Pennsylvania
South Carolina	Orangeburg	The Methodist Oak
Virginia	Cedar Buff	Appalachian Agency for Senior Citizens
Virginia	Big Stone Gap	Mountain Empire Older Citizens
Vermont	Rutland	PACE Vermont
West Virginia	Charleston	CAMC Health Ed and Research

Relevant Tools that are Not Rural Specific:

Cornell Institute for **Translational** Research on Aging (CITRA) *Retention Specialist Resource Toolkit* **http://www.citra.org/wordpress/rsp-tookit/**

Information relevant to developing a "retention specialist" position for long-term care agencies, including mentoring, career ladders, supervisor training, recognition, communication skills and multi-component programs.

United Hospital Fund. *Next Step in Care for Family Caregivers: Guides and Checklists.* **http://www.nextstepincare.org/ left_top_menu/Caregiver_Home/**

Rural areas have a high prevalence of informal caregiving. This resource guides an informal caregiver through the different stages of the informal caregiver process, including hospital admission, discharge planning, discharge from the hospital, and process of providing home care.

National Direct Service Workforce (DSW) Resource Center. *Find a Worker.* **http://www.dswresourcecenter.org/tiki-index.php?page=Find%20a%20Worker**

Individuals in rural areas that need long-term care services often have difficulty connecting with potential direct service workers. This website contains links to various State Worker Registries, which match people who need direct support or personal assistance at home or in the community with caregivers looking for work.

National Direct Service Workforce (DSW) Resource Center. Health Reform. http://www.dswresourcecenter.org/tiki-index.php?page=Health+Reform

Several components of the new health reform legislation are aimed at improving the care of those who need long-term services and supports, and the working conditions and training for direct care workers. This page provides links to resources for more information about what the bill means for the direct service workforce.

Paraprofessional Healthcare Network. Registry Resources. http://www.dswresourcecenter.org/tiki-download_file.php?fileId=110

A registry resources toolkit, which include general resources on worker registries and also challenges and lessons learned from many states that have implemented worker registries.

National Resource Center for Participant Directed Services. www.participantdirection.org

The National Resource Center for Participant-Directed Services serves to assist all programs, regardless of funding source, to develop and improve their participant-directed options. The NRCPDS draws upon years of experience as a National Program Office for the Cash & Counseling project.

Endnotes

1 Direct service workers include certified nursing assistants, direct support professionals, personal and home care aides, home health aides, psychiatric aides, and other workers who support people with disabilities and older persons to perform everyday activities and to live more fulfilling, self-directed lives.

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