

## STRENGTHENING THE DIRECT SERVICE WORKFORCE IN RURAL AREAS

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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.<sup>1</sup> Both urban and rural areas struggle with providing quality long-term supports and services to older people and people living with disabilities, especially when it comes to providing services in consumers' own homes. Several issues and trends make these challenges even more complex for providers and consumers in rural areas.

People in need of long-term supports generally rely on a mix of informal caregiving and formal support from paid providers to live independently in the community. Many rural areas struggle with providing quality home-based supports due to geographic isolation, fewer available services, transportation limitations, demographic trends reducing the supply of informal caregivers, and less ability to recruit an adequate supply of direct service workers. While many states officials are concerned about addressing these issues, they have few written resources available to help them.

The DSW Resource Center's review of reports, studies, and websites addressing rural-specific challenges to providing direct services shows that while all areas face certain direct service workforce challenges, rural areas face unique challenges that require unique solutions. States engaged in the development of their direct service workforce can use the resources presented here to gain knowledge of common challenges in rural areas and learn about some direct service related strategies that other states and rural agencies have implemented. The Appendix also contains an annotated list of resources.

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

## GENERAL RECRUITMENT AND RETENTION INITIATIVES

Rural and urban home- and community-based services both struggle with worker retention and recruitment. Rural areas, however, struggle to recruit 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%).<sup>2</sup> 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.

Rural providers of home-based long-term care services face particular challenges. Rural direct service agencies struggle with a lower number of visits and consumers. Due to a smaller and more dispersed client base in rural areas, rural direct service agencies are usually smaller organizations than their urban counterparts, are more likely to be non-profit, and provide fewer services.<sup>3</sup> In addition, rural direct service agencies also struggle with providing wages and benefits that can compete with long-term care institutions, which can often

### GEOGRAPHIC ISOLATION

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2 Annapolis Coalition (2007) "Rural Issues in the Behavioral Workforce" in *An Action Plan on Behavioral Health Workforce Development*. pp. 220-235. [http://www.samhsa.gov/matrix2/matrix\\_workforce.aspx](http://www.samhsa.gov/matrix2/matrix_workforce.aspx)

3 Ibid.

afford to offer higher wages and benefits.<sup>4</sup> Thus, rural areas face the dual challenge of recruiting direct service workers (a task difficult in its own right) and doing so in an already tight labor market for workers in similar occupations in health care.

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 *An Action Plan for Workforce Development* contains a section on workforce recruitment/retention of the behavioral health workforce in rural areas.<sup>5</sup> 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 Annapolis Coalition’s recommendations include increasing consumers’ self-direction and individual responsibility for their own care, educating the community on identifying long-term care infrastructure needs, implementing recruitment strategies, increasing the supply of effective training opportunities, and fostering leadership development.

Also relevant, although not specific to rural populations, in the area of retention, is the Cornell Institute for Translational Research on Aging’s (CITRA) *Retention Specialist Resource Toolkit*, which includes research and resources on retaining DSWs after recruiting them.<sup>6</sup> This toolkit includes a detailed background on the Retention Specialist Program and resources in several important topics for retaining long-term care workers, including:

- ▶ Mentoring
- ▶ Career Ladders
- ▶ Supervisor Training
- ▶ Recognition
- ▶ Communication Skills
- ▶ Multi-component Programs

## “GROW-YOUR-OWN” INITIATIVES

Some rural localities have used “grow-your-own” approaches to workforce development. These

4 National Association for Homecare and Hospice (February 2005). *Preserve Access to Rural Home Health Services*. Retrieved July 10, 2009, from [http://www.nahc.org/NAHC/LegReg/05/Rural\\_HHS.pdf](http://www.nahc.org/NAHC/LegReg/05/Rural_HHS.pdf)

5 Annapolis Coalition. (2007).

6 Cornell Institute for Translational Research on Aging (CITRA) *Retention Specialist Resource Toolkit* Retrieved July 2, 2009, from [http://www.citra.org/wordpress/rsp\\_tools/#](http://www.citra.org/wordpress/rsp_tools/#)

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 promoting retention by providing opportunities for increasing workers’ professional knowledge and creating opportunities for advancement.<sup>7</sup> One of the better-known grow-your-own initiatives for the rural direct service workforce is the Behavioral Health Aide program from the Alaska Native Tribal Health Consortium. This program is developing, as the Annapolis Coalition describes, a “multi-tiered career ladder for behavioral health aides.”<sup>8</sup> The program reports that Behavioral Health Aides in Alaska work in the village where they live, are eligible for continuing education from the University of Alaska, and make between \$10.00 and \$27.00 an hour (average \$17.00).<sup>9</sup>

## EFFORTS TO SUPPORT RURAL FAMILY CAREGIVERS

Statistics from the National Center for Health Statistics suggest that family members and other unpaid caregivers provide the majority of long-term care, in both rural and urban areas.<sup>10</sup> Family caregivers face many stresses. For instance, a 2004 survey conducted by the National Alliance for Caregiving and AARP found that many caregivers struggle with finding time for themselves, managing stress, balancing work responsibilities with caregiving, and talking to doctors about the health needs of the person for which they are caring.<sup>11</sup>

More rural caregivers indicate caregiving was “very stressful” compared to their urban and suburban counterparts.

7 Ibid.

8 Alaska Native Tribal Health Consortium. Behavioral Health Aide Project. Retrieved July 2, 2009 from Accessible Online at: <http://www.anthc.org/chs/behavioral/>

9 Alaska Center for Rural Health (2009). Behavioral Health Aide. Retrieved September 29, 2009, from [http://www.healthcareersinalaska.info/images/uploads/Behavioral\\_Health\\_Aide.pdf](http://www.healthcareersinalaska.info/images/uploads/Behavioral_Health_Aide.pdf)

10 Hutchison, Linnae, Catherine Hawes, and Lisa Williams (2005). *Access to Quality Health Services in Rural Areas – Long-Term Care: A Literature Review*. Retrieved July 2, 2009 from [http://www.srph.tamhsc.edu/centers/rhp2010/Volume\\_3/Vol3Ch1LR.htm](http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.htm)

11 National Alliance for Caregiving and AARP (2004). *Caregiving in the U.S.*. Retrieved July 2, 2009, from <http://www.caregiving.org/data/04finalreport.pdf>

Caregiver stress is a strong predictor of nursing home entry.<sup>12</sup> Helping alleviate challenges for family caregivers can increase the chances of continuing care 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 consumers. Training within these systems can be conducted using videoconferencing, conference calls, in-person meetings or web-based training.<sup>13</sup> One training system often utilized for rural areas is the “Powerful Tools for Caregivers,” which was funded by the Meyer Memorial Trust in Portland, Oregon. These services include respite care, support groups, resource guides, and six classes that prepare informal caregivers in three main areas: processing difficult emotions, reducing stress and avoiding burnout, and effective communication.<sup>14</sup>

Caregiver support programs in rural areas also often aim to facilitate the development of caregiver support networks in rural areas, which can provide support and even respite care to rural caregivers. Several online communities exist where family caregivers can join virtual support groups and search for resources in their state. 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.<sup>15</sup> Although not meant specifically for rural communities, Next Step in Care’s collection of family caregiver resources, which include guides for hospital admission, planning for discharge, discharge, and next steps for caregiving, can also be helpful for informal caregivers.<sup>16</sup>

12 B.C. Spillman, S.K. Long (2007). *Does High Caregiver Stress Lead to Nursing Home Entry?* Washington, D.C.: U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. [http://www.pascenter.org/publications/publication\\_home.php?id=728](http://www.pascenter.org/publications/publication_home.php?id=728)

13 Ibid.

14 Legacy Health Systems (April 2009). *Powerful Tools for Caregivers*.

15 Purdue University’s Breaking New Ground Resource Center and the Indiana State Office of Rural Health. *Rural Caregiver’s Website*. Retrieved July 2, 2009, from <http://cobweb.ecn.purdue.edu/~bng/BNG/Caregiving/index.html>

16 United Hospital Fund. *Next Step in Care for Family Caregivers: Guides and Checklists*. Retrieved July 2, 2009, from [http://www.nextstepincare.org/left\\_top\\_menu/Caregiver\\_Home/](http://www.nextstepincare.org/left_top_menu/Caregiver_Home/)

## WORKER-OWNED COOPERATIVES

One major cause of direct service worker attrition is burnout. Direct service workers who feel overworked, underpaid, underappreciated, and unequipped to properly serve consumers will not stay in the field for long. Worker-owned cooperatives, direct service agencies owned and operated by DSWs 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. Researchers have surmised that the reason for these increased earnings might be a worker coop’s ability to secure consistent hours for its workers, consolidate resources, and implement consistent billing policies.<sup>17</sup> Rural areas, which often have a more diffuse direct service workforce that is less able to bargain for higher wages, can benefit from the workforce consolidating activities of a worker cooperative. In addition, rural direct service workers often must travel long distances to serve consumers and can benefit from the service coordination capabilities of a worker coop.

There are several examples of worker-owned cooperatives in rural areas. For instance, Cooperative Care is a rural-based cooperative in Wautoma, Wisconsin. It is able to pay its workers higher wages than when the workers were primarily “consumer employed.” Cooperative Care does this primarily by consolidating the workforce in this rural area, which allows 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 coop to coordinate services efficiently so that direct service workers can travel in the most efficient manner possible. Wisconsin also has another DSW cooperative, Circle of Care in Appleton, which was supported by a large grant by the Northcountry Cooperative Development Fund (NCDF).<sup>18</sup> Another organization providing assistance to coops, the Northwest Cooperative Development Center, has provided technical assistance for the foundation of the Paradise Home Care Cooperative in Pahoia, Hawaii and the Circle

17 Whitaker, J. et al. (March 2005). *Home Care Cooperatives: Worker Ownership in Focus*. Retrieved July 6, 2009, from <http://www.uwcc.wisc.edu/info/health/homecare.pdf>

18 USDA: Rural Development - Business and Cooperative Programs (January 2007). *Co-op Development Action: Nurturing Caregiver Co-ops*. Retrieved July 10, 2009, from <http://www.rurdev.usda.gov/rbs/pub/jan07/coop.htm>.

of Care coop in Bellingham, Washington.<sup>19</sup> The University of Wisconsin Center for Cooperatives has produced a detailed description of worker-owned social and public services (including healthcare) cooperatives, which can be located on the Center’s website at <http://reic.uwcc.wisc.edu/services>.

## TRAINING/CREDENTIALING

Direct service workers often need additional training to advance their careers. Obstacles to DSWs receiving training include the costs of training and traveling to classes, a lack of well-defined career paths/job titles for DSWs, and the lack of state and federal investment in training for DSWs. In addition to general difficulties with DSW 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 DSWs for mileage to training and do not pay employees for training time.<sup>20</sup> 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. 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 support workers. For example, South Dakota, a heavily 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 DSWs) in 12 rural counties. 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 U.S. Department Of Labor Registered Apprenticeship Program and a skills refresher course. Scholarships are also available for many of the programs.<sup>21</sup>

Rural localities can also consider using mixed training methods, which combine online and in-person training methods. One example of this is the Lighthouse International model, which combines online training lessons that a teacher/mentor monitors, phone meetings with the mentor, and in-person meetings at a training center. Local colleges, hospitals, and various community services agencies in Northwest Michigan provide the trainings.<sup>22</sup>

Whatever the training method, one especially important set of entities for delivering training for rural DSWs are rural colleges. 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. The IC Gerontology Institute, through The Finger Lakes Geriatric Education Center of Upstate New York, identifies training gaps for the upstate New York rural area and then implements training programs to fill those gaps. For instance, the center produced several internet-based, free trainings that are relevant for a

19 Northwest Cooperative Development Center. Retrieved July 10, 2009, from <http://www.nwcdc.coop/>

20 Direct Service Workforce Resource Center (November 2008). “A synthesis of direct service workforce demographics and challenges across intellectual/ developmental disabilities, aging, physical disabilities, and behavioral health” Retrieved July 2, 2009, from [http://www.dswresourcecenter.org/tiki-download\\_file.php?fileId=12](http://www.dswresourcecenter.org/tiki-download_file.php?fileId=12)

21 Healthcare Regional Skills Alliance of Northwest Michigan. Retrieved June 29, 2009, from <http://www.nwm.org/healthcarersa.asp>

22 Lighthouse International. Distance Learning for Paraprofessionals Accessible Retrieved June 29, 2009, from <http://www.lighthouse.org/education-services/professional-education/distance-learning-for-professionals/>

variety of direct service professionals.<sup>23</sup> The center also developed a “train-the-trainer” program that addresses shortages of mentors for direct support professionals in rural areas.<sup>24</sup>

Several state governments, including those with many rural areas (e.g., Alaska, Iowa, Louisiana, Ohio, and New Jersey), are working to develop more clearly delineated competencies and career paths so that direct support professionals have a clear, logical career lattice with which to plan for the future. Also, with more clearly defined roles for direct support professionals, defining career paths for DSWs can help state administrators more easily identify job types, and thus shortages and specific areas that need strengthening. The DSW Resource Center white paper *A synthesis of direct service workforce demographics and challenges across intellectual/ developmental disabilities, aging, physical disabilities, and behavioral health* contains a description of different career path programs, including the Department of Labor’s Apprenticeship Programs for direct service workers.<sup>25</sup> The DSW Resource Center Website contains a description of New Jersey’s career path.<sup>26</sup>

## IMPROVING WORKERS’ ACCESS TO TRANSPORTATION

Rural and urban areas also struggle with the low pay of direct service work combined with transportation costs as an obstacle to worker recruitment and retention.<sup>27</sup> 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 DSWs must often travel (variable gas prices, registration, repairs and maintenance, oil changes, insurance, and a driver’s license) make serving consumers in widespread areas less financially viable.

Inadequate public transportation options also limit 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 support professionals.<sup>28</sup> This option, however, may not be financially viable for agencies with fewer resources or for individual providers. While having a well-developed transportation infrastructure or community providers organized enough to purchase vehicles is ideal, most rural areas will not have these resources. Instead, several intermediate steps might make a difference in this area, such as:

- ▶ Carpooling
- ▶ Scheduling based on geography,
- ▶ Reimbursing workers for mileage expenses, and
- ▶ Arranging with rental companies to rent highly fuel-efficient cars to DSWs.<sup>29</sup>

The Rural Programs of All-inclusive Care for the Elderly (PACE) initiative, in their resource “PACE in Rural Areas: Infrastructure Challenges and Strategies” has a section with several recommendations for rural areas to finance improved transportation services for DSWs.<sup>30</sup> 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.

23 Ithaca College Gerontology Institute. Welcome to your online training. Retrieved June 29, 2009, from <http://www.ithaca.edu/aging/training/>

24 Ithaca College Gerontology Institute. Retrieved June 27, 2009 at <http://www.ithaca.edu/aging/>

25 Direct Service Workforce Resource Center (November 2008).

26 Direct Service Workforce Resource Center. “New Jersey” Retrieved July 2, 2009, from <http://www.dswresourcecenter.org/tiki-index.php?page=New+Jersey>

27 National Direct Service Workforce Resource Center (September 2008). “Gas Prices and Other Transportation Challenges,” Webinar. Retrieved July 2, 2009, from <http://www.dswresourcecenter.org/tiki-index.php?page=Webinars/Calls>

28 PACE. Setting the PACE for Rural Healthcare. Retrieved July 2, 2009, from <http://pace.techriver.net/website/download.asp?id=586>.

29 National Direct Service Workforce Resource Center (September 2008).

30 Rural PACE. PACE in Rural Areas: Infrastructure Challenges and Strategies. Retrieved June 29, 2009, from <http://pace.techriver.net/website/download.asp?id=589>

## WEB-BASED WORKER REGISTRIES

Related to transportation is helping consumers obtain direct services from workers that live in the closest proximity possible. One possible method to match workers and consumers 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<sup>31</sup> and a “Registry Resources” bibliography of resources on starting and/or maintaining a registry and selected state registry websites.<sup>32</sup>

## 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 US, urban agencies often provided services to rural consumers (nearly 25 percent of the time).<sup>33</sup> 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 consumers. New York State, for instance, implemented a series of Medicare add-ons that allowed urban agencies to serve consumers in rural areas. The state passed a recruitment and retention add-on (which expired in 2006) for agencies that serve consumers 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.<sup>34</sup>

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. As mentioned before, one difficulty for other home and community based agencies is that Medicaid reimbursements are lower than those for Medicare and, thus, such collaboration with urban agencies might be limited to home health. Yet, even if incentive payments are not fiscally realistic for some states struggling with home health support shortages in rural areas, states can gauge nearby urban agencies’ ability and willingness to provide home support services in rural areas. Moreover, while not limited to urban agencies, another possible method for getting urban agencies involved in rural areas is telehealth/telehomecare.

## TELEHEALTH

Telehealth usually refers to methods that allow physicians to utilize telecommunication technology to diagnose and treat patients in rural areas. The term telehomecare refers to the use of telecommunication technology to provide long term care supports. It is important to note 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 a consumer’s vital signs, observe adherence to medication regimens, detect significant differences in a consumer’s health status and communicate regularly with consumers to assess mental status and general well-being.<sup>35</sup>

Yet, even though agencies can provide telehealth services at a lower cost than in-person visits, start-up costs are expensive. Because of these start-up costs and the generally low profit margin of home and community based services agencies, some states have utilized Medicare add-ons, state funds, or

31 National Direct Service Workforce (DSW) Resource Center. Find a Worker. Retrieved June 29, 2009, from Available Online at: <http://www.dswresourcecenter.org/tiki-index.php?page=Find%20a%20Worker>

32 Paraprofessional Healthcare Network. (October 2006) Registry Resources. Accessible Online at: [http://www.dswresourcecenter.org/tiki-download\\_file.php?fileId=110](http://www.dswresourcecenter.org/tiki-download_file.php?fileId=110)

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

34 Information on New York’s Urban/Rural collaborations from Carol Rodat at PHI (personal communication, July 2, 2009).

35 Landers, D. (2000) Home Care Overview. Retrieved July 2, 2009, from: <http://iml.jou.ufl.edu/projects/Fall2000/Landers/default.htm>

grant funding to finance telehomecare services. For instance, New York and Minnesota both initially financed the purchase of telehealth equipment through grants at the state level.<sup>36 37</sup> Once initial purchasing costs are covered, a state may refine its Medicaid reimbursement rate to account for capital costs as well as different types of monitoring (e.g., store and save, interactive). States may also 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. Several states have telemedicine reimbursement policies built into their Medicaid rate.<sup>38</sup> The Office for the Advancement of Telehealth has produced a “Grantee Profile” document profiling several states efforts to advance telehealth programs, including by utilizing Medicaid funding.<sup>39</sup>

## 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 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 consumer and their family 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.<sup>40</sup> 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 consumers 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.

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40 National PACE Association. Rural Pace Resources. Accessible Online at: <http://www.npaonline.org/website/article.asp?id=774>

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36 Information on New York’s Telehealth Efforts from Carol Rodat at PHI (personal communication, July 2, 2009).

37 The Center for Rural Mental Health Studies: University of Minnesota Medical School Duluth (March 2005). An Evaluation of Technical and Implementation Selected Telehomecare Projects Funded by the Department of Human Services. Retrieved on June 29, 2009, from [http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs\\_id\\_054529.pdf](http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_054529.pdf)

38 An example of New Mexico’s Medicaid Rate, for instance can be found in: New Mexico Human Services Department (September 2007). Telehealth Services Now Available for Medicaid Recipients. Retrieved July 2, 2009, from [http://www.bhc.state.nm.us/pdf/Medicaid\\_Telehealth\\_NR.pdf](http://www.bhc.state.nm.us/pdf/Medicaid_Telehealth_NR.pdf)

39 Office for the Advancement of Telehealth. Grantee Profiles: 2007-2008. Retrieved July 2, 2009, from [http://www.hrsa.gov/telehealth/granteedirectory/grantee\\_profiles\\_0708.pdf](http://www.hrsa.gov/telehealth/granteedirectory/grantee_profiles_0708.pdf)

## APPENDIX: RURAL RESOURCE COLLECTION

### *Collections of Resources/Guides:*

**Rural Assistance Center: Home Health**  
[http://www.raconline.org/info\\_guides/homehealth/](http://www.raconline.org/info_guides/homehealth/)  
 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.” Some of the most useful resources are links to relevant organizations, relevant articles and links to 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 who face challenges of geographic isolation and gaps in rural service delivery systems. A state-specific guide is available at

<http://cobweb.ecn.purdue.edu/~agenhtml/ABE/Extension/BNG/Caregiving/bystate.html>

### *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](http://www.srph.tamhsc.edu/centers/rhp2010/Volume_3/Vol3Ch1LR.htm)

Comprehensive literature review of issues related to access to long-term care for rural areas. The non-residential providers section begins on page 7. Includes discussion of “proposed solutions or interventions that are feasible in rural areas.” Some of these focus on the direct service workforce.

### *Reports:*

**Easter Seals. “Caregiving in Rural America”**  
[http://www.easterseals.com/site/DocServer/Caregiving\\_in\\_Rural-saveas-compress.pdf?docID=49463](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, and 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 older adults in rural areas, 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/ronlyres/51442860-0B0F-4F45-A76B-0C3B093FBCFD/0/WalshCtr2005\\_NORCMarchCX2.pdf](http://www.norc.org/NR/ronlyres/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/ronlyres/7FD9CA92-9D98-43EA-9319-BD27CE4C6948/0/WalshCtr2004\\_NseriesJan04v1.pdf](http://www.norc.org/NR/ronlyres/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 consumers. 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.

**Annapolis Coalition. “Rural Issues in the Behavioral Workforce” in Action Plan for Behavioral Health Workforce Development.** pp. 220-235, 2007.  
<http://208.106.217.45/pages/images/WorkforceActionPlan.pdf>  
 While not solely focused on direct service workers, this report is the culmination of work by the Annapolis Coalition, including the U.S. Substance Abuse Mental Health Services Administration (SAMHSA) sponsored conferences, on rural behavioral workforce development. The report includes relevant goals and recommendations for growing and sustaining the behavioral workforce in rural areas. Also, it includes sections on recruitment/retention, training (including the use of special technologies to do this), and coordinating state officials, providers, community members, and consumers to garner support for workforce initiatives.

**“PACE in Rural Areas: Staffing Challenges and Strategies”**

<http://pace.techriver.net/website/download.asp?id=588>

This issue brief came out of a workgroup discussion of rural Program of All-inclusive Care for the Elderly (PACE) grantees and rural health experts. Some of the challenges discussed include recruitment and retention, coordinating different team members in different locations, and obtaining access to training.

**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\\_tools/#](http://www.citra.org/wordpress/rsp_tools/#)

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/](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>

Consumers 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.

**Paraprofessional Healthcare Institute. Registry Resources.**

[http://www.dswresourcecenter.org/tiki-download\\_file.php?fileId=110](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.

**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.

**Setting the PACE for Rural Elder Care: Three Rural PACE Case Studies**

<http://pace.techriver.net/website/download.asp?id=586>

These three case studies focus on the implementation of Program of All-inclusive Care for the Elderly (PACE) models, which include home health services, in rural areas. These case studies might be useful for other organization aiming to conduct needs assessments, coordinate resources, garner stakeholder support, etc.

**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/index.html>

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-RC/MFP States:

State	City	Awardee
Hawaii	Kahului	Hale Makua
Iowa	Sioux City	Hospice of Siouxland
New York	Olean	Community Care of Western New York
North Carolina	Carrboro	Piedmont Health Services
North Dakota	Bismarck	Northland Healthcare Alliance
Pennsylvania	Danville	Geisinger Health System Foundation
Pennsylvania	Chambersburg	Lutheran Social Services of South Central Pennsylvania
South Carolina	Orangeburg	The Methodist Oak