Strengthening the Direct Service Workforce in Rural Areas

Overview

Most Americans would like to remain in, and receive care in, their own homes and communities as long as possible. Adults living in rural areas are even more likely to indicate this preference.[1] However, Medicaid long-term services and supports (LTSS) users in rural areas are less likely to receive home and community-based services (HCBS) than their counterparts in urban areas. This is due, in part, to shortages in the direct service workforce (DSW), lack of service provider coordination, limited funding, provider shortages, and challenges in HCBS infrastructure.[2] Nationally, the demand for direct service workers is expected to increase by 48 percent between 2015 and 2030.[3] The population of adults aged 18 to 64, which comprise the majority of the workforce, is expected to remain relatively constant, creating a gap between demand and potential workforce.[4] This disparity is more pronounced in rural areas, which have a higher proportion of older adults than urban areas, suggesting greater demand for the DSW.[5] The COVID-19 pandemic has further exacerbated the shortage of direct service workers in rural areas, with rural providers facing worse staffing outcomes than their urban counterparts.[6] The Centers for Medicare & Medicaid Services (CMS) supports states in their efforts to equitably expand and enhance HCBS, including specific initiatives promoting access to and quality of HCBS in rural communities.[7]

Considerations

States face a set of well known, yet persistent, challenges in maintaining an adequate DSW. These challenges include high turnover rates, a shrinking pool of workers, low wages, and undervaluing of the profession.[9] These challenges can uniquely affect states and agencies serving rural areas. Often, direct service workers in rural areas experience a lower number of visits, a smaller and more dispersed client base, and longer commute time to and from client visits compared with their urban counterparts. Home care agencies located in rural areas also tend to be smaller, are more likely to be non-profit, and generally provide fewer services.[10] The following considerations may affect the rural DSW.

What is a Rural Area?

The United States Census Bureau defines rural as any population, housing, or territory not in an urban area, where "urban area" comprises "urbanized areas," incorporated places with a population of 50,000 people or more, and "urbanized clusters," incorporated places with a population between 2,500 and 50,000 people.[8] The term "nonmetro" is not synonymous with "rural" in this definition.

- **Proportion of older persons residing in rural areas.** Over 46 million older people (those aged 65 years and older) live in the United States. Of those older Americans, more than one in five live in rural areas, with many concentrated in states where more than half of the older populations live in rural areas. In addition, American Community Survey 2012-2016 data reported 17.5 percent of the rural population was 65 years and older compared to 13.8 percent in urban areas.[11,12]
- **Geography.** There are fewer direct service agencies operating in rural areas to provide services and fewer direct service workers available for agencies to hire. Also, rural service regions can be vast and the distances between individuals in need of services and service

agencies can be wide. These factors result in direct service workers spending more time traveling to and from people in need of services and less time providing services.

- **Transportation.** There is a lack of effective public transportation systems in rural areas and road conditions and seasonal variations in weather conditions can make travel a challenge.
- **Role of informal caregivers.** In many rural areas, family members, neighbors, and friends often fill gaps by providing informal HCBS.[9] Migration of younger family members to larger, more urban areas often reduces the number of family members available to provide care. As a result, many older adults and people with disabilities living in rural areas may choose to follow informal caregivers to urban areas.[12]
- **Technology.** A third of Americans living in rural areas lack adequate access to broadband, where "adequate access" is defined by the Federal Communications Commission as internet at speeds of at least 25 megabits per second download.[13,14] This lack of access can present challenges in accessing online resources, including worker matching registries and telehealth.

States can use the information presented here to learn about strategies other states and rural agencies have implemented to overcome these common DSW challenges.

Strategies for States to Increase the Rural Direct Service Workforce

Paying Family Caregivers

Hiring neighbors, friends, and family as paid caregivers addresses the shortage of direct service workers by increasing the pool of direct service workers available in rural areas and may have positive effects for individuals receiving HCBS and their caregivers. For example, caregivers may have to reduce their work hours or stop working to care for their relative. This can result in lost income and put a strain on relationships between individuals receiving care and caregivers. In one study, state developmental disabilities administrators reported that individuals with intellectual and developmental disabilities (I/DD) were more satisfied when family members or friends were being paid for providing support and were more likely to ask for help when they needed it if a family caregiver was paid than if the family caregiver was not paid.[15] In addition, older adults often hire family and friends who they know and trust with their care.[16] Paid family caregivers can also be an important component of an individual's backup plan and in designating backup direct service staff when a primary direct service worker cannot report for work for any reason.

Most Medicaid and other publicly funded programs, such as the Veterans Health Affairs' Veteran Directed Care Program, permit relatives of individuals receiving services to be paid direct service workers. Medicaid formerly did not allow "legally responsible" relatives (e.g., spouses, parents, legal guardians of minor children) to be paid direct service workers, but this is now permitted under section 1915(c) HCBS waiver programs under extraordinary circumstances, through section 1115 demonstrations, and under section 1915(i), (j), and (k) state plan options if states choose to provide this option. However, language at section 1905(a)(24) prohibits the hiring of legally responsible relatives under the Medicaid State Plan Personal Care Services option.

Rural Workforce Development

The Annapolis Coalition prepared a report, *An Action Plan for Workforce Development,* for the Substance Abuse and Mental Health Services Administration (SAMHSA), providing ways to strengthen the behavioral health workforce. The following recommendations on recruitment and retention of the behavioral health workforce in rural areas can be generalized to the broader DSW:

- increasing older adults' and people with disabilities' capacity to self-direct and individuals' responsibility for their own care;
- educating the community on identifying long-term care infrastructure needs;
- implementing recruitment strategies ("grow-your-own" approaches), including participant-directed service models;
- increasing the supply of effective training opportunities;
- fostering leadership development; and
- enhancing infrastructure to support and coordinate workforce development and implementing a national research and evaluation agenda on workforce development.[17]

"Grow-Your-Own" Initiatives

Some rural localities have used "grow-your-own" approaches to DSW development. These approaches recruit and offer incentives to residents who already live in underserved areas so that they stay and become part of the workforce. A critical aspect of these efforts is providing opportunities for increasing workers' professional knowledge and creating opportunities for advancement.

Alaska Behavioral Health Aide Program

One of the better-known "grow-your-own" initiatives for the rural DSW is the Behavioral Health Aide (BHA) Program founded by the Alaska Native Tribal Health Consortium in 2009.[18] This program was modeled after the Community Health Aide Program, which was established to assess and provide emergent, acute, and chronic medical care to residents in rural communities.[18] This program has developed a four-level, multi-tiered career ladder for BHAs.[19]

BHAs in Alaska work in the village where they live and are employed by their tribal health organization. In addition, the State of Alaska Department of Health (DOH) now recognizes BHAs certified at various levels of BHA as billable Medicaid providers. The BHA scope of work and billable Medicaid services are dependent on BHAs' certification level.

The State of Alaska DOH also offers eligible Alaskans two Medicaid-funded personal care services programs in which recipients can select their direct service workers to provide those personal care services: the Community First Choice program and the Consumer-Directed Personal Care Services program. Both self-directed options are available to most communities in Alaska.[20] In both, the direct service workers are employed by a personal care services agency and need to pass a background check and have proof of receiving mandatory trainings.

Self-directed Options

Self-directed options for HCBS delivery provide individuals and their representatives, as appropriate, choice and control over the HCBS they receive and the direct service workers who provide services. This includes the ability to select, hire, manage, and discharge their workers. Self-directed options increase the pool of direct service workers available in rural areas by allowing neighbors, friends, and family members who are involved in participants' lives to be paid caregivers.[21] CMS calls this self-directed option "employer authority."

Participants may also have decision-making authority over how Medicaid funds in an individual-directed budget are spent. CMS refers to this as "budget authority." An individual's budget may contain funds for the purchase of direct service labor and individual-directed goods and services that reduce participants' reliance on human assistance and increase their independence and community inclusion. Individual-directed goods and services often include items that typically would not be covered under traditional Medicaid HCBS.

States may offer self-directed options as a choice for receiving Medicaid-funded HCBS, although it may not be the only option available for Medicaid beneficiaries. States may implement self-directed options with Medicaid 1905(a) state plan personal care services, section 1915(c) HCBS waiver programs, and sections 1915(i), (j), and (k) state plan options. Currently, every state, the District of Columbia, and Puerto Rico have implemented at least one publicly funded self-directed option, with the majority of states offering this option on a statewide basis.

Worker-owned Cooperatives

Major causes of direct service worker attrition include low wages, lack of benefits, workers reporting 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.[22] Worker-owned cooperatives are direct service agencies owned and operated by direct service workers. These cooperatives are one method to provide direct service workers more ownership and control over their work environments and, in some cases, increased earnings and benefits. Researchers surmise that the reason for these increased earnings might be that worker-owned cooperatives provide worker-owners a portion of the profit and prioritize reducing internal inequality over other compensation goals.[23] Worker-owned cooperatives have been developed in a number of states, with several formed in rural areas.[24]

Worker Access to Transportation

Low pay and benefits for direct service work in rural and urban areas combined with transportation costs are obstacles to direct service worker recruitment and retention.[25,26] Most urban areas have the advantage of better-developed public transportation systems that make transportation more accessible for direct service workers. In rural areas, the complications that result from the long distances direct service workers often must travel (e.g., variable gas prices and other costs of automobile ownership, variable seasonal road and weather conditions, serving fewer people per day due to significant travel time) make serving people living in rural and geographically isolated areas less financially viable for traditional agency-based service providers and direct service workers.

Transportation Strategies

Ideally, community-based agency providers supply vehicles for direct service workers. However, many rural providers do not have these resources. Instead, several intermediate steps may make a difference in this area, such as:

- carpooling;
- scheduling based on geography;
- reimbursing for mileage expenses; and
- arranging with rental companies to rent highly fuel-efficient cars for direct service workers to use.

Web-based Direct Service Worker Matching Registries

Web-based Direct Service Worker Matching Registries Across States

Several web-based direct service worker matching registries are connected to public authorities, including statewide registries in Oregon and Washington State.

- The Oregon Home Care Commission is in the process of replacing the current statewide registry with a more modern option. Emerging from partnerships with SEIU Local 503, Carewell SEIU 503/Rise Partnership and Carina, this new registry will better assist individuals and families looking for care to quickly and easily match with a homecare worker, personal care attendant, or personal support worker who best meets their needs. Statewide rollout is projected to be completed by the end of 2022.
- Washington State has developed a statewide web-based Referral Registry maintained by Carina, a non-profit registry funded through the collective bargaining agreement between Washington and the home care union SEIU 775.

A key component of effective HCBS delivery is the ability to connect people requiring HCBS with direct service workers and to determine if these workers have the credentials and training necessary to provide quality services. Some states are implementing web-based direct service worker matching registries and job boards to address this need. Matching registries are online platforms that enable individuals or their designated representatives, as appropriate, to identify and recruit direct service workers with the right mix of skills, experience, and availability to meet the individual's care needs. They also enable direct service workers to find employment and build sustainable work schedules. These voluntary registries serve a critical need for individuals enrolled in HCBS that offer a self-directed option and are growing in number and popularity.[27]

Strategies for States to Develop Infrastructure to Support the Rural DSW

To achieve the desired level of quality in the DSW, now and in the future, federal, state, and local policymakers and planners must anticipate labor market changes as well as the future needs of older adults and individuals with disabilities. The following are practices that could strengthen the DSW for states.

Training and Credentialing of Direct Service Workers

Direct service workers often need additional training to improve their skills and advance their careers. Obstacles for direct service workers to receive the training they need include: the costs of training and traveling to classes, a lack of well-defined direct service work career paths or job titles, and the lack of consistent state and federal guidelines in training for these workers. In addition to general difficulties with DSW training, training in rural areas is difficult to execute because of geographic dispersion, lack of nearby educational 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.[28] Because of these and other obstacles, most DSW training is provided by employers post-hire.

Use of Internet-based Technology in Providing Training to the Rural DSW

Internet-based technology can give rural providers and workers increased access to advanced training courses. When a locality offers higher education or training opportunities through distance learning, it allows students in remote locations 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 DirectCourse curricula developed by the University of Minnesota in collaboration with Elsevier, and trainings from the Education Center developed by the Alzheimer's Association.[29,30] Such programs can reduce transportation and lodging costs that a worker might otherwise incur to participate in on-site training. States may wish to consider internet availability when exploring online training options, as some individuals living in rural areas lack adequate access to broadband.[13]

Other Training Methods for the Rural DSW

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 collaborating with private, public, and non-profit partners. Scholarships are also available for many of the programs. In addition, rural localities can consider using a blended learning model, which combines online and in-person training methods.

Several state governments, including those with many rural areas have worked on developing more clearly delineated competencies and career paths that have a clear, logical career lattice with which to plan for the future.[31] Also, with more clearly defined roles for direct service workers, defining career paths for these workers can help state administrators more easily identify job types, and thus shortages and specific areas that need strengthening.

Program of All-inclusive Care for the Elderly Model in Rural Areas

In many instances, the challenges all rural health providers face (e.g., large service area distances, low population density, limited access to services, a scarcity of providers) may benefit from approaches that are less hierarchical and more collaborative across disciplines. The Program of All-inclusive Care for the Elderly (PACE) model is an innovative approach for addressing health and LTSS needs. PACE is an LTSS model (funded, primarily, by both Medicare and Medicaid) that "provides comprehensive medical and social services to certain frail, community-dwelling older adults, most of whom are dually eligible for Medicare and Medicaid benefits."[32] As of June 1, 2022, 146 PACE programs operated 273 PACE Centers in 31 states, serving more than 60,000 participants.[33] PACE 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. Rural areas tend to have older and lower income residents and health care infrastructure with greater financial difficulties. To address these challenges, Congress authorized the rural PACE provider grant program through section 5302 of the Deficit Reduction Act of 2005 (P.L. 109-171).[34] Additional information on rural PACE programs is described below.

Rural PACE Programs

The Rural PACE Pilot Program awarded 15 providers with start-up grant funds to develop PACE programs in rural areas.[35] A number of successes were reported by evaluators; in many cases, PACE directors, staff, and participants suggested that rural PACE programs preserve, enhance and, in many cases, restored the independence, health, and well-being of participants. PACE was found to reduce burden among family care, and evaluators found that overall participants, communities, and the rural PACE sites had favorable experiences as of the early phases of implementation.[34] One example of a PACE program in a rural community is the Senior CommUnity Care of Colorado PACE Program, which serves older adult participants in rural Montrose and Delta counties in Colorado. The program addresses all older adult participants' medical and social needs including transportation services, meals, nursing, and dental and mental health care. Members are served at their PACE Day Centers, in their own homes, or in other locations.[36]

Telehealth

Telehealth is a modality for offering services to improve an individual's health through interactive communication between the individual and provider. Telehealth services can, for example, be used for assessment, diagnosis, intervention, consultation, and supervision across distances.[37] In addition to two-way audio/visual communication, or video chats, telehealth also includes remote monitoring and audio-only communications.[37] Telehealth may enable providers to serve more individuals per day across a broader geographic area. For example, nurses who previously conducted three to five physical home visits during a given day can conduct virtual visits with many more individuals during that same day, with additional savings in travel time and costs. While such virtual visits cannot and should not completely replace in-person visits, they provide a valuable supplement that has a proven benefit for individuals.[38]

The federal government, and in particular the Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, part of HRSA's Office of Rural Health Policy, and the Federal Communications Commission, promote the use of telehealth. The HRSA Office for the Advancement of Telehealth 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.[39]

The Rural Health Care Program, administered by the Federal Communications Commission, provides funding to eligible health care providers for telecommunications and broadband services necessary for the provision of health care. The program currently consists of two programs: The Healthcare Connect Fund Program and the Telecommunications Program. In addition to leveraging funds from the Rural Health Care Program to address barriers in implementing telehealth programs, rural telehealth programs can offer services via cellular networks or text messaging.[40] Some rural programs have also adopted long-term plans and formed partnerships to build telecommunications infrastructure.[41]

The COVID-19 pandemic has pushed telehealth forward, and flexibilities allowed by CMS have expanded the use of telehealth services. CMS issued a State Medicaid & CHIP Telehealth Toolkit

to help states accelerate adoption of broader telehealth policies during the COVID-19 public health emergency (PHE).[i] CMS also published a Supplement to this Toolkit to provide additional support to states in their adoption and implementation of telehealth as they begin to plan beyond the COVID-19 PHE.[ii] Medicare began to allow individuals in their homes to access telehealth services for diagnosis, evaluation, and treatment of mental health disorders.[42] In some rural environments, specialized care delivered via telecommunications have been implemented and show early signs of success.[43]

Telehomecare is a subfield of telehealth provided in an individual's home. It is a communication and clinical information system that enables interaction of voice, video, and health-related data using ordinary telephone lines.[44] Telehomecare is often interchanged with remote monitoring; however, it is not strictly monitoring because it incorporates a range of health care delivery through education, emotional and social support, information dissemination, and self-care help and suggestions. The implementation of telehomecare can increase access to health care services, particularly to the aging population in rural areas, improve the management of chronic conditions, and reduce the cost of health care.[45]

Bay Rivers Telehealth Alliance

Bay Rivers Telehealth Alliance (BRTA) collaborates with two rural hospitals in the Tidewater Virginia area. Individuals enroll at the time of emergency room or hospital discharge, and telemonitoring equipment is drop-shipped to the individual's home. Soon after, a health coach visits the individual and uses an evidence-based assessment to further assess and build the individual's understanding of both their behavioral health and chronic disease challenges.[46] Remote monitoring is intended for a recommended 90-day period. Health information is transmitted to the partner health system's coordination center where incoming data are assessed by nurses. Any values outside an expected range are evaluated by phone, home, or office visit. Due to encouraging early results showing improved readmission rates and decreased emergency room evaluations, BRTA, project partners, and third-party payers are meeting to explore reimbursement models.[46]

[i] See: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.
[ii] See: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.

Support for Rural Family Caregivers

As highlighted in the National Strategy to Support Family Caregivers released by the Administration for Community Living, each year, around 53 million people provide a broad range of assistance to support the health, quality of life, and independence of a person close to them who needs assistance as they age or due to a disability or chronic health condition. Family members and other informal caregivers provide the majority of long-term care, and studies have found no consistent difference between rural and urban older adults in the likelihood of receiving care from family members.[10] A 2020 AARP report found that more than one in five Americans (21.3 percent) are caregivers who have provided care to an adult or child with special needs at some time in the past 12 months. In 2017 alone, family members caring for older adults contributed an estimated $470 billion of unpaid care.[49] In addition, a greater portion of caregiving adults were providing care to multiple people in 2020 compared to 2015, with 24 percent caring for two or more individuals, an 18 percent increase since 2015.[50]

The Savvy Caregiver Program

The Savvy Caregiver Program is an intervention designed for both urban and rural caregivers of persons with dementia. The program was initially field tested in California, Maine, and Michigan.[47] As part of this testing, group workshops were provided to family caregivers at weekly two-hour sessions over six weeks and focused on training family caregivers in the basic knowledge, skills, and attitudes needed to handle the challenges of caring for a family member with dementia. Evidence demonstrated the Savvy Caregiver Program's effectiveness in increasing caregiver skill, knowledge, and confidence as well as reducing caregiver distress. In Maine, a translational study of the program examined 770 caregivers, 60 percent of whom resided in rural areas.[48] Researchers found support for the overall effectiveness of the Savvy Caregiver Program amongst both rural and urban participants.

AARP reported that more than half (51 percent) of caregivers feel their role has given them a sense of purpose or meaning. These positive emotions often coexist with feelings of stress or strain. Caregivers reported physical, emotional, and financial strain with two in ten reporting they feel alone. When compared with caregiver self-reporting in 2015, fewer caregivers in 2020 reported their health status as excellent or very good (41 percent, down from 48 percent in 2015) and a greater proportion reported being in fair or poor health (21 percent, up from 17 percent in 2015). In addition, one in four caregivers reported difficulty in taking care of their own health (23 percent) and a similar proportion reported caregiving had made their own health worse (23 percent). This decline in caregiver self-reported health further emphasizes the importance of supporting caregivers.[50] Caregiver stress is also a strong predictor of nursing home entry.[51] 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, as in all 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 older adults and people with disabilities. Training can be conducted using videoconferencing, conference calls, in-person meetings, or web-based training. The National Strategy to Support Family Caregivers developed a list of actions for both federal and non-federal stakeholders to take in order to advance the support of family caregivers, including an Actions for States, Communities, and Others document with more than 150 suggested actions to leverage in supporting family caregivers.

Opportunities under the Money Follows the Person Demonstration

The Money Follows the Person (MFP) demonstration initially was authorized under section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and Congress authorized a series of extensions, with the last three authorized in 2019, 2020, and 2021.[52] The demonstration supports states' efforts to rebalance their LTSS systems so that individuals have a choice of where they live and receive services. From the start of the program in 2008 through 2020, states transitioned 107,128 people from nursing facilities to community living under MFP.[53] The MFP demonstration also has supported the infrastructure (e.g., workforce, services) needed to support people to live where they want to live. MFP has advanced planning and development across rural areas, including tribal lands in five states (MFP Tribal Initiative).[54] The Consolidated Appropriations Act of 2021 authorized additional awards to states and territories not currently participating in MFP[55] for planning and workforce capacity building activities including:

- assessing HCBS system capacity and determining where additional providers or services are needed;
- recruitment, education, training, and technical assistance for providers and direct service workers, including training for individuals with disabilities to become direct service workers;
- caregiver and transition coach training and education; and
- assessing and implementing changes to reimbursement rates and payment methodologies aimed at building HCBS provider capacity or improving HCBS quality.[56]

Current MFP grantees also have workforce capacity building funds that they could use for the same purposes, and states could also potentially use administrative funding for capacity building activities.

Opportunities under Section 9817 of the American Rescue Plan Act

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) into law. Under ARP section 9817, all 50 states and the District of Columbia received a temporary 10 percentage point increase to their federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS from April 1, 2021, through March 31, 2022. As a result of this percentage point increase to their FMAP, 48 states are planning to expend nearly $10 billion on strengthening the DSW through rate increases or adjustments, one-time bonuses and retention payments, and hourly wage increases and benefits packages.[57] States receiving increased FMAP under ARP section 9817 are not required to address challenges in the rural DSW specifically, but have an opportunity to use these funds to increase the rural DSW and build infrastructure to strengthen the DSW in rural areas. Multiple states have incorporated strategies into their spending plans to strengthen the DSW and its infrastructure statewide, including through many of the strategies described above.[58]

- **Allowing family caregivers to be paid:** Some states are allowing previously ineligible family caregivers to become paid caregivers,[59] thus increasing the pool of available workers without the need for family caregivers to sacrifice income.
- **Expanding self-directed program options:** Within their ARP section 9817 spending plans some states are expanding self-directed services under section 1915(c) HCBS waiver programs or raising reimbursement rates for self-directed workers.

- **Providing increased worker access to transportation:** Some states are aiming to address transportation as a barrier to direct service worker retention. Proposed plans include establishing a fund to provide transportation to direct service workers and allowing use of rideshare services.
- **Creating matching service registries:** A few states are leveraging ARP section 9817 funds to create new or expand existing matching service registries. These registries aim to help recruit and retain direct service workers and allow employers to easily find individuals that meet requirements for training, credentials, and availability.
- **Instituting training and credentialing measures to increase worker professionalization:** Some states are leveraging ARP section 9817 funds to create standardized curricula through progressive certifications, enhancing the professionalization of the DSW and creating additional career development opportunities. Many states are developing new or enhancing existing training curricula by partnering with universities and community colleges.

Preparation of this document was funded by the Centers for Medicare & Medicaid Services, Contract # HHSM-500-2014-00033I to The Lewin Group.

References

[1] AARP. (2019). *2018 Home and Community Preferences Survey: A National Survey of Adults Age 18-Plus a Look at Rural Communities*. Retrieved from https://www.aarp.org/content/dam/aarp/research/surveys_statistics/liv-com/2019/home-community-preferences-rural-communities.doi.10.26419-2Fres.00231.010.pdf.

[2] Coburn, A. F., Griffin, E., Thayer, D., Croll, Z., & Ziller, E. C. (2016). *Are Rural Older Adults Benefitting from Increased State Spending on Medicaid Home and Community-Based Services?* Maine Rural Health Research Center. Retrieved from http://muskie.usm.maine.edu/Publications/rural/Medicaid-Home-Community-Based-Services-Rural.pdf.

[3] National Center for Health Workforce Analysis. (2018). *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*. U.S. Department of Health and Human Services. Retrieved from https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/hrsa-ltts-direct-care-worker-report.pdf.

[4] PHI. (2020). *Direct Care Workers in the United States: Key Facts*. Retrieved from https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts/.

[5] Centers for Medicare & Medicaid Services. (2020). *Long-Term Services and Supports Rebalancing Toolkit*. U.S. Department of Health and Human Services. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.

[6] Oster, N. V., Patterson, D. G., Skillman, S. M., & Frogner, B. K. (2022). *COVID-19 and the Rural Health Workforce: The Impact of Federal Pandemic Funding to Address Workforce Needs*. University of Washington Center for Health Workforce Studies. Retrieved from https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2022/03/Covid-19-and-the-Rural-Health-Workforce-PB-2022.pdf.

[7] Centers for Medicare & Medicaid Services. (2022). *Improving Health in Rural Communities: FY 2021 Year in Review*. U.S. Department of Health and Human Services. Retrieved from https://www.cms.gov/files/document/fy-21-improving-health-rural-communities508compliant.pdf.

[8] U.S. Census Bureau. (2016). How Does the U.S. Census Bureau Define "Rural"? Retrieved from https://mtgis-portal.geo.census.gov/arcgis/apps/MapSeries/index.html?appid=49cd4bc9c8eb444ab51218c1d5001ef6#:~:text=The%20Census%20Bureau%20defines%20rural,NOT%20in%20an%20urban%20area.

[9] Campbell, S., Del Rio Drake, A., Espinoza, R., & Scales, K. (2021). *Caring for the Future: The Power and Potential of America's Direct Care Workforce*. PHI. Retrieved from http://www.phinational.org/resource/caring-for-the-future-the-power-and-potential-of-americas-direct-care-workforce/.

[10] Hutchison, L., Hawes, C., & Williams, L. (2010). *Access to Quality Health Services in Rural Areas – Long-Term Care: A Literature Review*. ResearchGate. Retrieved from https://www.researchgate.net/publication/251282191_Access_to_Quality_Health_Services_in_Rural_Areas-Long-Term_Care_A_Literature_Review.

[11] Symens Smith, A., & Trevelyan, E. (2019). *In Some States, More Than Half of Older Residents Live In Rural Areas*. United States Census Bureau. Retrieved from https://www.census.gov/library/stories/2019/10/older-population-in-rural-america.html#:~:text=More%20than%201%20in%205,to%2013.8%25%20in%20urban%20areas.

[12] Symens Smith, A., & Trevelyan, E. (2019). *The Older Population in Rural America: 2012-2016*. United States Census Bureau. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2019/acs/acs-41.pdf.

[13] Federal Communications Commission. (2017). Mapping Broadband Health in America 2017. Retrieved from https://www.fcc.gov/reports-research/maps/connect2health/#ll=29.840644,-102.568359&z=3&t=insights&inb=in_bb_rural_access&inh=in_pcp_access&dmf=none&inc=none&slb=90,100&slh=0,0.0008&zlt=county.

[14] Federal Communications Commission. (2017). Mapping Broadband Health in America in 2017: Data. Retrieved from https://www.fcc.gov/reports-research/maps/connect2health/data.html.

[15] DeCarlo, M. P., Bogenschutz, M. D., Hall-Lande, J. A., & Hewitt, A. S. (2018). Implementation of Self-Directed Supports for People with Intellectual and Developmental Disabilities in the United States. *Journal of Disability Policy Studies, 30*(1), pp. 11-21. Retrieved from https://journals.sagepub.com/doi/full/10.1177/1044207318790061.

[16] Matthias, R. E., & Benjamin, A. E. (2008). Paying Friends, Family Members, or Strangers to be Home-Based Personal Assistants: How Satisfied are Consumers? *Journal of Disability Policy Studies, 18*(205). Retrieved from https://doi.org/10.1177/1044207307311526.

[17] Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion*. The Annapolis Coalition on the Behavioral

Health Workforce for the Substance Abuse and Mental Health Services Administration. Retrieved from https://annapoliscoalition.org/wp-content/uploads/2021/01/action-plan-full-report.pdf .

[18] Alaska Community Health Aide Program. (2022). About the BHA Program. Retrieved from https://akchap.org/behavioral-health-aide/about/. ANTHC is a consortium of 18 Tribal Health Organizations (THOs) within the state of Alaska. THOs created and tasked the Tribal Behavioral Health Directors Committee (TBHDC) with identifying community health priorities. Through the guidance and leadership of the TBHDC, the BHA Program aims to improve behavioral health outcomes by addressing the various training needs of the BHA workforce.

[19] Alaska Native Tribal Health Consortium. (2022). Behavioral Health Aide Program. Retrieved from https://www.anthc.org/behavioral-health-aide-program/.

[20] Alaska Department of Health and Social Services. (2022). Community First Choice (CFC). Retrieved from https://dhss.alaska.gov/dsds/Pages/cfc/default.aspx.

[21] Legally responsible relatives such as a spouse or parent of a minor child may not be a paid caregiver under Medicaid state plan services.

[22] Institute of Medicine. (2008). *Retooling for an Aging America: Building the Health Care Workforce*. Washington, D.C.: The National Academies Press.

[23] Democracy at Work Institute. (2019). *2019 Worker Cooperatives in the United States*. Retrieved from https://cameonetwork.org/wp-content/uploads/2020/02/2019-Worker-Cooperative-Economic-Census-EN-FINAL_020220.pdf.

[24] Wright, B. (2011). *Cooperatives: A Growing Strategy for Strengthening the Home and Community Based Services Direct Service Workforce*. Centers for Medicare & Medicaid Services. Retrieved from https://www.paproviders.org/archives/secure/Toolkits/Workforce/3.12.pdf.

[25] PHI. (2018). *The Direct Services Workforce in Long-Term Services and Supports in Maryland and the District of Columbia*. Retrieved from https://www.phinational.org/wp-content/uploads/2018/09/DSWorkers-Maryland-2018-PHI.pdf.

[26] Rural Health Research Center. (2016). *Access to Rural Home Health Services: Views from the Field*. Retrieved from https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/02/RHRC_FR152_Skillman.pdf.

[27] PHI. (2020). Matching Service Registries. Retrieved from https://www.phinational.org/advocacy/matching-service-registries/.

[28] Hewitt, A., Larson, S., Edelstein, S., Seavey, D., Hoge, M. A., & Morris, J. (2008). *A synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health*. National Direct Service Workforce Resource Center. Retrieved from https://nadsp.org/wp-content/uploads/2016/08/Cross-DisabilitySynthesisWhitePaperFinal.pdf.

[29] DirectCourse. (2022). Curriculum: College of Direct Support. Retrieved from https://directcourseonline.com/direct-support/.

[30] Alzheimer's Association. (2022). Education Center. Retrieved from https://training.alz.org/.

[31] O'Reilly, L. (2009). *Direct Service Workforce Core Competencies: Annotated Bibliography*. Centers for Medicare & Medicaid Services. Retrieved from http://www.advancingstates.org/sites/nasuad/files/hcbs/files/174/8658/Core_Competencies.pdf.

[32] Centers for Medicare & Medicaid Services. (2021). Program of All-Inclusive Care for the Elderly (PACE). Retrieved from https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/PACE/PACE.

[33] National PACE Association. (2022). PACEFinder: Find a PACE Program in Your Neighborhood. Retrieved from https://www.npaonline.org/pace-you/pacefinder-find-pace-program-your-neighborhood.

[34] Anderson, K. K. (2011). *Evaluation of the Rural PACE Provider Grant Program*. Centers for Medicare & Medicaid Services. Retrieved from https://www.npaonline.org/sites/default/files/PDFs/Rural%20PACE%20Report%20to%20Congress.pdf.

[35] The 15 PACE Pilot Programs included AllCare of Arkansas, Jonesboro, Arkansas; Volunteers of America, Grand Junction and Montrose, Colorado; Hale Makua, Kahului, Hawaii; Hospice of Siouxland, Sioux City, Iowa; Billings Clinic Foundation, Billings, Montana; Community Care of Western New York, Olean, New York; Piedmont Health Services, Carrboro, North Carolina; Northland Healthcare Alliance, Bismarck, North Dakota; and Geisinger Health System Foundation, Danville, Pennsylvania.

[36] Rural Health Information Hub. (2022). Program for All-Inclusive Care for the Elderly (PACE). Retrieved from https://www.ruralhealthinfo.org/toolkits/services-integration/2/care-coordination/pace.

[37] Centers for Medicare & Medicaid Services. (n.d.). *State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth COVID-19 Version*. U.S. Department of Health and Human Services. Retrieved from https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.

[38] Engquist, G., Johnson, C., & Johnson, W. C. (2010). *Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation*. Center for Health Care Strategies, Inc. Retrieved from https://www.chcs.org/media/LTSS_Innovations.pdf.

[39] Health Resources & Services Administration. (2021). Office for the Advancement of Telehealth. Retrieved from https://www.hrsa.gov/rural-health/telehealth.

[40] Rural Health Information Hub. (2022). Connectivity Considerations for Telehealth Programs. Retrieved from https://www.ruralhealthinfo.org/toolkits/telehealth/4/connectivity,

[41] Rural Health Information Hub. (2022). Funding by Topic: Broadband. Retrieved from https://www.ruralhealthinfo.org/funding/topics/broadband.

[42] Centers for Medicare & Medicaid Services. (2021). *CMS Physician Payment Rule Promotes Greater Access to Telehealth Services, Diabetes Prevention Programs.* U.S. Department of Health and Human Services. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-promotes-greater-access-telehealth-services-diabetes-prevention-programs.

[43] Impact of COVID-19 on Telehealth. (2020). *American Health & Drug Benefits*, *13*(3), pp. 125-126. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7370821/.

[44] Bowles, K. H., & Baugh, A. C. (2007). Applying Research Evidence to Optimize Telehomecare. *Journal of Cardiovascular Nursing, 22*(1), pp. 5-15. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2874189/.

[45] Laupacis, A., & Silversides, A. (2012). Does evidence support expanding telehomecare in Ontario? *Healthy Debate*. Retrieved from https://healthydebate.ca/2012/06/topic/cost-of-care/telehomecare/.

[46] Rural Health Information Hub. (2019). Bridges to Care Transitions – Remote Home Monitoring and Chronic Disease Self-Management. Retrieved from https://www.ruralhealthinfo.org/project-examples/1016.

[47] Hepburn, K. W., Lewis, M., Sherman, C. W., & Tornatore, J. (2003). The Savvy Caregiver Program: Developing and Testing a Transportable Dementia Family Caregiver Training Program. *The Gerontologist, 43*(6), pp. 908-915. Retrieved from https://doi.org/10.1093/geront/43.6.908.

[48] Samia, L. W., Aboueissa, A., Halloran, J., & Hepburn, K. (2013). The Maine Savvy Caregiver Project: Translating an Evidence-Based Dementia Family Caregiver Program Within the RE-AIM Framework. *Journal of Gerontological Social Work, 57*(6-7), pp. 640-661. Retrieved from https://doi.org/10.1080/01634372.2013.859201.

[49] The RAISE Act Family Caregiving Advisory Council, & Advisory Council to Support Grandparents Raising Grandchildren. (2022). *2022 National Strategy to Support Family Caregivers*. The Administration for Community Living. Retrieved from https://acl.gov/CaregiverStrategy.

[50] AARP Public Policy Institute. (2020). *Caregiving in the U.S.* Retrieved from https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf.

[51] Spillman, B. C., & Long, S. K. (2007). *Does High Caregiver Stress Lead to Nursing Home Entry?* Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. Retrieved from https://aspe.hhs.gov/sites/default/files/private/pdf/74886/NHentry.pdf.

[52] To date, the MFP demonstration has been amended by Section 2403 of the Patient Protection and Affordable Care Act (P.L. 111-148), the Medicaid Extenders Act of 2019 (P.L. 116), the Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39), Section 205: Further Consolidation Appropriations Act, 2020 (P.L. 116.94), Section 3811: Coronavirus Aid, Relief and Economic Security Act of 2020 (P.L. 116-136), and Section 204 of the Consolidated Appropriations Act of 2021 (P.L. 116-260) through 2023.

[53] Peebles, V., & Dolle, J. (2022). *Money Follows the Person: Updated State Transitions as of December 31, 2020*. Chicago, IL: Mathematica. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-2020-transitions-brief.pdf.

[54] Centers for Medicare & Medicaid Services. (2021). *Money Follows the Person – Tribal Initiative Grant*. U.S. Department of Health and Human Services. Retrieved from https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/mfp.

[55] Centers for Medicare & Medicaid Services. (n.d.). *Money Follows the Person*. U.S. Department of Health and Human Services. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.
[56] Centers for Medicare & Medicaid Services, Department of Health and Human Services. Money Follows the Person Demonstration Program Notice of Funding Opportunity; CMS-1LI-22-001. Retrieved from https://www.grants.gov/web/grants/view-opportunity.html?oppId=334196.
[57] Centers for Medicare & Medicaid Services. (n.d.). *American Rescue Plan Act of 2021 (ARP) Section 9817: Overview of State Spending Plans*. U.S. Department of Health and Human Services. Retrieved from https://www.medicaid.gov/medicaid/home-community-based-services/downloads/arp-sec9817-overview-infographic.pdf.
[58] Centers for Medicare & Medicaid Services. (n.d). *Strengthening and Investing in Home and Community Based Services for Medicaid Beneficiaries: American Rescue Plan Act of 2021 Section 9817*. Department of Health and Human Services. Retrieved from https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html.
[59] Caregivers considered ineligible under Medicaid state plan services include legally responsible relatives such as a spouse or parent of a minor child.