Closing the Care Gap: Strengthening Long-Term Services and Supports in Rural California

CALIFORNIA POLICY BRIEF • NOVEMBER 2025

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Nearly 1 in 11 Californians ages 65+ lives in a rural community.[1] Rural California has higher proportions of older adults, adults with disabilities, and chronic illness, yet faces severe shortages of services and providers. Long-Term Services and Supports (LTSS), including home- and community-based services (HCBS) and institutional care, are essential for dignity, independence, and cost-effective care. While institutional care remains necessary for some, HCBS allows more people to remain safely at home and reduces state spending on costly nursing home and hospital care.

Budget and Policy Landscape: Why Action Matters Now

Federal budget cuts through H.R.1 (2025-2026) and a tight fiscal environment create real constraints on new investments. Yet failing to act on rural LTSS will lead to higher long-term costs through preventable hospitalizations, premature institutionalization, workforce gaps and turnover. Our policy recommendations prioritize scalable, cost-effective strategies that strengthen care now while reducing expenditures over time.

Rising Demands of Rural Aging

- **Higher share of aging residents:** In rural counties, 1 in 4 residents is ages 65+, compared to 1 in 6 statewide.[2]
- **More disability:** On average across rural counties, over 40% of rural older adults live with a disability vs. 34% in non-rural counties.[3]
- **Higher rates of serious illness:** Rural older adults face greater prevalence of conditions like heart disease (23% vs. 19%), stroke (8.3% vs. 6.2%), and lung disease (13% vs 6%).[4]
- **Economic insecurity:** 10.8% of rural adults ages 65+ live below the federal poverty line.[5]
- **Explosive growth in population ages 85+:** By 2040, the population ages 85+ in rural California will grow 158%—nearly 50 times faster than the traditional working-age population (ages 18-64).[6]

Rural Caregivers Fill Critical Gaps but Lack Support

- **Rural adults are more likely to be caregivers:** 32% of rural adults (ages 18+) care for a family member or friend with illness or disability, compared to 26% in non-rural areas.[7]
- **But they are less often paid for their care:** Family caregivers make up only 60% of In-Home Supportive Services (IHSS) providers in rural areas, compared to 70% in non-rural areas.[8]
- **Caregiving is more intense in rural areas:** Among those who have accessed California's Caregiver Resource Centers, rural caregivers are older (60% are ages 65+), more likely to provide 40+ hours of care per week (76%), and less likely to receive support (64% report no paid help; 50% report no unpaid help) compared to non-rural caregivers.[9]

> "Lately our world is getting smaller and smaller. I used to take my wife to church but she would act up but we've gotten to the point where we didn't want to do that anymore…our world starts to shrink and then pretty soon you're not seeing anybody."
>
> *Family caregiver, Inland Empire*

Limited Access to Home- and Community-Based Services (HCBS)

- **Service Gaps:** Many HCBS are unavailable in rural areas (e.g., Multipurpose Senior Services Program (MSSP), Adult Day Programs, Adult Day Health Care, Assisted Living Waiver programs, and Aging and Disability Resource Centers (ADRCs)).[10,11] Even where these exist, capacity is limited and access is often difficult for those who are eligible.
- **Workforce Shortages:** Rural HCBS face significant staffing shortages, increasing reliance on unpaid caregivers and contributing to preventable institutionalization.
- **Limited Local Providers:** Delayed care, caregiver burnout, and unmet needs are common. Financial and logistical barriers prevent some older adults from relocating for better access.
- **In-Home Supportive Services (IHSS) Gaps:** California's IHSS program, which pays family members and others to provide care, is a critical lifeline but approved hours often fall short of needs and Direct Care Worker (DCW) shortages make finding alternative providers difficult. Rural counties have ~5% fewer IHSS providers per recipient than non-rural counties.[12]

> "We would try to find them assisted living… If they can afford it. Most likely they can't afford it. So… [you have] someone [who] might be able to live independently with support, but that's not a thing. So that's our biggest struggle."
>
> *Provider, North State*

Shrinking Institutional Care Options

- **Facility closures and displacement of older adults:** 147 rural skilled nursing facilities (SNFs) closed in 2013 and another 102 closed in 2023.[13] Closures often force older adults to relocate to other counties, separating them from their support networks.

Compounding Barriers

- **Navigation and Awareness:** Complex eligibility rules, stigma, and language/literacy gaps block access. Many family caregivers do not self-identify as caregivers and miss available support.
- **Digital Divide:** Limited broadband and low digital literacy reduce access to information and services.
- **Affordability and Eligibility:** Many fall just above the qualifying line for assistance but cannot afford private care. Multigenerational households may be disqualified from income-based programs despite care needs.
- **Isolation and Disasters:** Outmigration and climate disasters erode informal care networks, increasing reliance on scarce formal services and exacerbating health risks, especially for those aging alone.

> "Being so overwhelmed with what is going on [caregiving] and then trying to get resources, even if they are there, they are hard to navigate."
>
> *Resident, Inland Empire*

Challenges for the Direct Care Workforce

- **Low Wages and High Turnover:** Many DCWs earn below a living wage, fueling turnover and compromising care quality.
- **Fragmented Work and No Benefits:** Part-time work across settings (e.g., home care, skilled nursing, hospitals) limits benefits eligibility and retention. DCWs often juggle multiple part-time roles to equal full time pay or hold a second part-time job when providing IHSS caregiving for a family member. In rural areas, clients are widely dispersed, requiring significant travel to cover caseloads.
- **Transportation Barriers**: Limited public transit, long distances, and hazardous road conditions (such as snow and ice) make it difficult for DCWs, especially those without reliable transportation, to reach clients consistently.
- **Transportation Costs**: Some travel between clients is reimbursed, but coverage is limited and excludes home-to-client travel. For example, IHSS providers can only claim up to 7 hours per week of travel time between clients and receive no mileage or gas reimbursement. Uncompensated travel costs strain finances, reduce take-home pay, and compound workforce shortages.[15,16] Additionally, many private-pay home care companies avoid serving rural areas due to the high transportation costs.

- **Limited Training and Career Mobility:** Few opportunities for advancement discourage long-term careers.
- **Emotional and Physical Demands:** Workers face compassion fatigue, burnout, grief, workplace injuries, and verbal and physical abuse. In rural areas, care recipients often have multiple and complex needs, adding an additional layer of strain on caregivers.
- **Structural Barriers:** Inflexible schedules and insufficient hours leave DCWs struggling to meet care needs. Outdated systems prioritize efficiency over personalized care, forcing unpaid labor or inadequate care. Care recipients often lack approval for sufficient hours, contributing to moral distress.

Who are Direct Care Workers?[5]

- Personal Care Aides (PCAs; also referred to as personal care attendants, personal assistants, or home care aides)
- Home Health Aides (HHAs)
- Certified Nursing Assistants (CNAs)
- Direct Support Professionals (DSPs)
- In-Home Supportive Services (IHSS)
- Independent providers
- Workers privately hired outside of regulated programs

POLICY RECOMMENDATIONS

1. Create a Statewide Direct Care Workforce Registry

- **Expand California's existing IHSS back-up provider registry** to include all DCWs (personal care aides, CNAs, HHAs, IHSS providers) who pass background checks.
- **Document training, certifications, and experience** to help consumers find qualified workers.
- **Improve continuity of care and reduce workforce fragmentation** by enabling workers to secure job opportunities across settings (e.g., hospitals, skilled nursing facilities, home care, IHSS).
- **Phased approach:** Pilot in rural counties first, then expand statewide.
- **Sample Models:**
    - Washington State's Consumer Direct Care Network Registry
    - Wisconsin's WisCaregiver Connections workforce platform.

2. Support Family Caregivers

- **Tailor outreach and education:** Provide consistent, long-term, culturally and linguistically tailored engagement with rural, tribal, and underserved communities. Partner with trusted CBOs to help families recognize themselves as caregivers and connect with resources such as California Caregiver Resource Centers (CCRCs), Area Agencies on Aging (AAAs), and Independent Living Centers.

- **Expand respite and support:** Increase funding for CCRCs; expand Community-Based Adult Services (CBAS), Program of All Inclusive Care for the Elderly (PACE), and adult day centers.
- **Expand rural enrollment in IHSS:** Simplify enrollment for family caregivers, provide targeted outreach through trusted rural partners (AAAs, ADRCs, CCRCs, Tribal organizations), and offer rural-specific supports (e.g., application assistance, training stipends, tech support for electronic timesheets) to help informal caregivers transition into paid IHSS roles.

3. Address Financial and Structural Barriers for Rural Aging

- **Support enrollment in public programs** (e.g., Medi-Cal, IHSS, MSSP) and offer education about respite care, stress management, and financial planning.
- **Offer relocation supports**, such as tax incentives for downsizing, home clean-out programs, moving services, and caregiver counseling.
- **Identify new revenue sources to fund a statewide long-term care benefit** so all Californians have access to services when they need them, building upon the report from the Long Term Care Insurance Taskforce.[17]

4. Raise Wages and Benefits for Direct Care Workers

- **Establish competitive, tiered wages** that reflect the complexity of care provided and ensure parity with comparable frontline health roles.
- **Reduce costly turnover** by compensating workers fairly for specialized skills, strengthening continuity of care, and preventing unnecessary institutionalization.
- **Expand benefits** by leveraging existing workforce programs and federal funds where possible to make rural caregiving sustainable: hiring/retention bonuses, health care, paid leave, retirement, housing stipends, tuition assistance, and loan forgiveness.
- **Expand reimbursement of transportation costs**, including mileage and travel time from providers' to recipients' homes, to reduce the burden of long distances in rural areas.

5. Expand Training and Certification Pathways

- **Develop standardized, modular training** for PCAs, HHAs, and CNAs, delivered through rural community colleges and trusted local organizations.
- **Ensure access to:**
    - Linguistically and culturally tailored content
    - Flexible formats (online, hybrid, evening/ weekend, asynchronous)
    - WiFi/device subsidies
    - Financial support (stipends, grants, scholarships)
- **Create pipelines** including high school-to-career pathways, Workforce Development Board partnerships, and local community college partnerships and programs.

- **Build on successful models:**
  - United Domestic Workers (UDW) – California Community Colleges Chancellor's Office (CCCCO) partnership training for homecare workers
  - IHSS Career Pathways & Cal Grows (ended 2024)

6. Promote Career Growth and Leadership

- **Support advancement** through career counseling, experience credits, and paid internships (e.g., expanded College Corps).
- **Compensate experienced DCWs** for peer mentoring and training roles.
- **Establish a Rural Caregiver Advisory Council** (including paid and unpaid caregivers) to inform statewide policy.

Footnotes

1. Authors' analysis of 2023 American Community Survey (ACS) 5-year estimates. Share of Californians ages 65+ residing in rural census tracts calculated using the 2025 Health Resources Services Administration (HRSA) definition of rural.
2. Authors' analysis of 2023 ACS 5-year estimates. Share of residents ages 65+ calculated for rural (non-metro) vs. non-rural (metro) counties using the 2023 National Center for Health Statistics (NCHS) county classification. Results are a county average (unweighted).
3. Authors' analysis of 2023 ACS 5-year estimates. Percent of older adults (65+) reporting any disability, averaged across counties (unweighted). Rural vs. non-rural defined by the 2023 NCHS county classification.
4. UCLA Center for Health Policy Research. AskCHIS (2023 for heart disease and stroke; 2005 for lung disease). Rural defined by the 2023 NCHS county classification. Results are population-weighted. "Lung disease" includes COPD, emphysema, and chronic bronchitis, excludes asthma.
5. Authors' analysis of 2023 ACS 5-year estimates. Poverty defined as income below the federal poverty threshold. Rate calculated for adults ages 65+, averaged across counties (unweighted). Rural vs. non-rural defined by 2023 NCHS county classification.
6. Authors' analysis of California Department of Finance, Demographic Research Unit. Population Projections (2025 Series). County-level projections for age groups aggregated to rural vs. non-rural counties using the 2023 NCHS county classification. Results are population-weighted.
7. UCLA Center for Health Policy Research. AskCHIS, Provide care to family member/friend with illness/disability (yes/no) (2023). Rural defined by the 2023 NCHS county classification. Results are a county average (unweighted).
8. Authors' analysis of California Department of Social Services (CDSS), In-Home Supportive Services (IHSS) Program Data, May 2025. Ratio of authorized IHSS recipients and relative providers calculated for rural vs. non-rural counties using the 2023 NCHS county classification. Results are a county average (unweighted). Available at: https://www.cdss.ca.gov/inforesources/ihss/program-data

9. Authors' analysis of CareNav™ data from California Caregiver Resource Centers (caregivers ages 18+, 2021–2024). Data source: CareNav™ (HIPAA-compliant case-management database) caregiver records, 2021–2024. Results are population-weighted.
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12. Authors' analysis of CDSS IHSS Program Data, May 2025. Ratio of authorized IHSS recipients to providers calculated for rural vs. non-rural counties using the 2023 NCHS county classification. Results are a county average (unweighted). Available at: https://www.cdss.ca.gov/inforesources/ihss/program-data
13. California Department of Aging, unpublished communication with the authors, 2025 (data originally from the California Department of Health Care Access and Information [HCAI]).
14. Hunt, L., Yeh, J., & Fix, M. (2023). California's Direct Care Workforce: Who They Are, the Work They Do, and Why It Matters. University of California, San Francisco, prepared for the California Health Care Foundation. Available at: https://www.chcf.org/resource/californias-direct-care-workforce-who-they-are/
15. Centers for Medicare & Medicaid Services. (2023). Strengthening the Direct Service Workforce in Rural Areas. Available at: https://www.medicaid.gov/sites/default/files/2023-01/hcbs-strengthening-dsw-rural-areas.pdf
16. Dill, J., Henning-Smith, C., & Rydberg, K. (2023). The Direct Care Workforce in Rural Areas. Rural Health Research Gateway. Available at: https://www.ruralhealthresearch.org/projects/969
17. California Department of Insurance. Long-Term Care Insurance Task Force Reports. Available at: https://www.insurance.ca.gov/0500-about-us/03-appointments/ltcitf.cfm#Reports

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About The SCAN Foundation

The SCAN Foundation (TSF) envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. Our grants and impact investments prioritize communities that have been historically marginalized with an emphasis on: older people of color, older adults with lower incomes, and older residents in rural communities. Learn more at **https://www.thescanfoundation.org/**

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