National Rural Health Association Policy Brief

Caregiving in rural America: Strengthening supports for informal caregivers and direct care workers

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Introduction

Recent federal data show that the United States is aging rapidly, with older adults comprising a growing share of the national population and for the first time exceeding one-fifth of all residents in rural communities.[i] In 2020, the older adult population reached 55.8 million or 16.8 percent, with more than 20 percent of individuals 65 and older residing in a nonmetro area.[ii] For over a decade, 77 percent of adults 50 and older have preferred to "age in place," or remain in their homes as they age.[iii]

In order for rural older adults to remain healthy and independent, they must frequently depend on direct care workers or informal caregivers.[iv] Formal or direct care workers are trained professionals who provide paid care and are usually contracted through institutions or organizations. In contrast, informal caregivers are typically family members, neighbors, or friends who provide unpaid care.[v] For older adults in rural communities where institutional long-term care facilities are scarce, aging in place largely depends on the capacity and resilience of family caregivers who lack formal training are called upon to perform complex tasks. Currently, one in five Americans serves as an indirect caregiver by providing unpaid care to someone with health or functional needs.[vi]

Despite the crucial role these 63 million individuals play, both unpaid family members and paid direct care professionals in rural areas face disproportionate challenges and assume higher intensity responsibilities compared to urban caregivers.[vii] As the shrinking health care workforce provides few respite care options and geographic isolation creates distance from service sites, rural caregivers are left with insufficient support systems. These problems are exacerbated by limited access to training and greater financial instability, requiring rural caregivers to spend more time providing care than urban counterparts.[viii] Without formal support systems, unpaid caregivers often must take on a wide range of personal and medical-related tasks, including:[ix]

- Personal care and daily living support, such as assisting with hygiene, offering mobility assistance, preparing meals, supervising eating, and managing the household.
- Health and medical support, including administering medications, tracking health records, monitoring vital signs, managing medical equipment, and assisting with physical therapy.
- Emotional and social support, such as supporting behavioral or cognitive conditions, encouraging physical activity, and providing companionship.
- Administrative tasks, such as filling out insurance claims and paperwork, monitoring symptoms, and coordinating health treatments with medical providers.

Caregivers are a crucial pillar of rural long-term care support systems and play a pivotal role in supporting the well-being and independence of older adults.[x] As the number of older adults increases disproportionately in rural areas, the lack of younger individuals able to provide informal support decreases, exacerbating the caregiving crisis.[xi] Urgent action is necessary to address these shortages as

[*] This Policy Paper was developed by members of the National Rural Age-Friendly Initiative Interest Group, a consortium of subject matter experts brought together through the National Rural Age-Friendly Initiative, a partnership between NRHA and The John A. Hartford Foundation.

the disparity worsens. In order to support the aging population and sustain the current mixed model of professional and familial care, it is imperative to analyze the unique challenges rural communities face and reinforce the caregiving model through targeted, community-focused policy solutions.

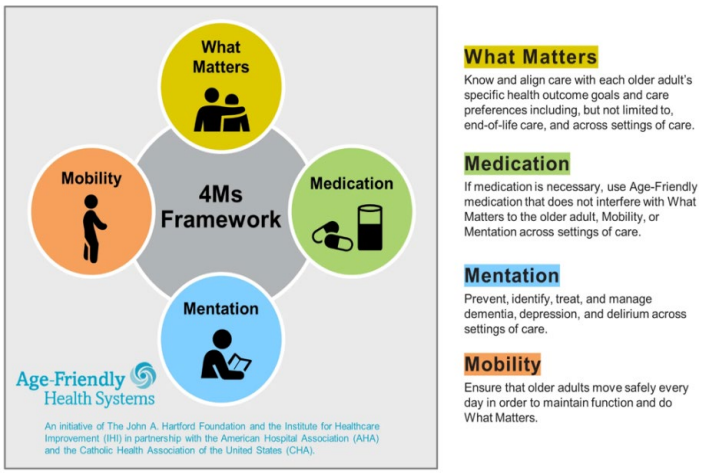
Analysis

Rural-specific strengths

The 4Ms of age-friendly care

It is imperative that informal and direct caregivers are equipped to deliver evidence-based, high-quality care.[xii] Informal caregivers in rural areas are uniquely positioned to assist in the delivery of the 4 Ms of age-friendly care (Figure 1). Because rural communities are often tight knit,[xiii] informal caregivers may know what matters to a patient because they have a personal connection to them.

Figure 1. The 4Ms of age-friendly care



Rural caregiving assets

While rural caregivers face unique challenges, they are also able to utilize certain strengths. Rural Americans report the highest satisfaction with where they live, which may help counter the negative mental health effects of caregiving.[xiv] Rural communities have strong personal connections and social networks that provide additional emotional support and a sense of safety.[xv] Rural areas are more conducive to establishing community groups for caregivers, which have been shown to offer empowerment and support while reducing situational isolation and stigma.[xvi]

The National Rural Age-Friendly Initative

Developed through a partnership between the National Rural Health Association and The John A. Hartford Foundation, the National Rural Age-Friendly Initiative (NRAFI) prioritizes the training and development of rural community health workers (CHWs).[†] As trusted advocates in rural communities, CHWs strengthen support systems and ensure older adults can safely and confidently age in place. Through NRAFI's collaboration with the University of Texas at Arlington and the Institute for Healthcare Improvement, as of 2025 182 CHWs have been trained both virtually and in person to deliver the 4Ms across rural and border Texas. By applying the 4Ms framework, NRAFI strengthens rural health systems, supports the rural health workforce, and enhances the delivery of coordinated, age-friendly services for older adults and their caregivers.

Rural challenges

Health challenges faced by caregivers

The physical, mental, and emotional strain of providing around-the-clock care increases adverse health outcomes for the caregiver.[xvii] The responsibility of informal caregiving falls predominantly on families who may not have the training or resources to support paid time off, such as caregiver's leave or social security protection.[xviii] This lack of support – compounded with the fact that rural employees receive fewer employee benefits than urban workers – increases mental and logistical strain.[xix] Furthermore,

[†] For more information on the use of CHWs in rural aging populations, see NRHA's policy paper Community health workers and rural age-friendly care.

women are far more likely to provide informal care support. An estimated 66 percent of caregivers are women, and female caregivers may spend as much as 50 percent more time providing care than male caregivers.[xx] Most of these caregivers work outside the home and provide 20 hours per week of unpaid labor.[xxi]

Caregivers report poorer general health and increased risk for chronic conditions compared to non-caregivers.[xxii] The CDC reports that of 19 measured health indicators, 13 are worse for caregivers compared to non-caregivers in the same setting, including asthma and obesity.[xxiii] Providing around-the-clock care may lead to social isolation, disrupted sleep patterns, and reliance on convenience food.[xxiv] Informal caregivers also report higher rates of depression and anxiety than non-caregivers.[xxv] These effects are especially burdensome for rural caregivers, who already face greater difficulties accessing mental and behavioral health care.[xxvi]

Workforce shortages in rural communities

The workforce shortage in rural direct care services – including personal care aides, home health aides, and certified nursing assistants – is acute and growing.[xxvii] Rural areas face markedly lower concentrations of direct care workers, including nearly 35 percent fewer home health aides, with only 32.8 home health aides per 1,000 older adults in rural regions compared to 50.4 in urban settings.[xxviii] Many direct care workers earn low wages, receive limited benefits, have minimal career advancement opportunities, and receive inadequate training.[xxix] Rural direct care workers also have limited access to behavioral health care, meaning family members frequently fill the gap and provide unpaid care at the expense of their own income and health.[xxx]

Financial and economic caregiving constraints

Rural caregiving carries significant economic burdens. Informal caregivers often absorb out-of-pocket costs, with a majority spending more than $7,200 per year on caregiving expenses, including medical supplies, home modifications, and transportation.[xxxi] Informal caregivers incur both direct and indirect costs, reflecting a bigger financial risk among rural caregivers.[xxxii] Direct costs can include medical equipment, groceries, and household necessities such as electricity, water, and home supplies.[xxxiii] Caregivers incur indirect costs via implicit losses around employment and pension contributions.[xxxiv] State models that offer caregiver tax credits or more accessible long-term care insurance demonstrate how targeted financial supports can meaningfully reduce this burden, especially for families navigating high out-of-pocket costs and limited local services.

Nearly a quarter of family caregivers report monthly missed work days and a 33 percent reduction in productivity, which correlates to an annual loss of $5,600.[xxxv] While the Federal and Family Leave Act requires employers to provide 12 weeks of leave every year for caregiving, this leave is unpaid and has stringent requirents, such as 12 months of continuous employment and more than 1,250 hours in the last employment period.[xxxvi] This means a part-time employee would have to work for the same employer for 63 weeks with no leave to qualify. As a result, rural caregivers are often left out of workplace policy design, underscoring the need for state and municipal employment protections that recognize caregiving as a core labor issue and provide flexible leave, job security, and supportive scheduling.

Geographic isolation and fewer respite options

Transportation costs and limited provider networks impose a larger burden on caregivers in rural areas, where few respite care options exist.[xxxvii] Additionally, rural residents are more likely to suffer from Alzheimer's/dementia (and experience a delayed diagnosis), making them more likely to require around-the-clock care or monitoring.[xxxviii] Watching a loved one decline cognitively increases emotional and mental strain and is more likely to negatively affect caregivers and their spouses by decreasing time for

self-care, increasing financial responsibilities, and heightening the likliehood of burnout.[xxxix] Compounded by geographic isolation, this larger burden leads to increased loneliness and social isolation.[xl] These factors increase the workload on family caregivers, reduce opportunities for breaks, and increase stress.[xli]

Policy recommendations

Action must be taken to address the complex and interrelated physical, social support, and mental health needs of informal and formal caregivers in rural areas.

- **Adjust direct care reimbursements for rural older adults:** Implement targeted reimbursement adjustments for formal caregivers to account for higher costs and lower patient volume at rural senior care sites, including Medicaid home and community-based services, long-term services and supports, and the direct care workforce. Reimbursements must account for service area size and travel time.
- **Expand community health worker travel reimbursements:** Hired by hospitals or organizations to help manage care, CHWs serve as important providers in rural areas. Policies that support CHW reimbursement for travel, such as mileage adjustment rates, may allow caregivers to travel long distances to reach rural patients.
- **Utilize paramedicine and treat-in-place structures:** Community paramedicine models allow paramedics to utilize their skills to treat patients in their homes in non-emergency settings. Research indicates the use of community paramedicine in palliative care may alleviate the burden on both direct and informal caregivers.[xlii] Mobile integrated health measures have also been shown to decrease emergency call volume and reduce overall health costs while impvoing patient experience.[xliii]
- **Expand caregivers as partners in care teams training billing guides**: Enhance and standardize these training billing guides to provide health care teams with clear pathways for reimbursing caregiver training and education, and allow teams to better support and address the comprehensive needs of caregivers across rural settings.[xliv] Strengthen health care payor recognition and support of informal caregivers.
- **Invest in telehealth services**: Telehealth and telemonitoring have proven instrumental for access to care in rural areas, especially for behavioral health. Investing in these services enables remote patient monitoring, decreasing the burden on caregivers to transport older adults to appointments. Investing in telehealth and broadband will also increase health service access for caregivers who may have a hard time leaving those in their care alone.
- **Engage family caregivers in health decisions:** Support programs that include family caregivers in health care decisions and discussions, such as HRSA's Geriatric Workforce Enhancement Program. Rural caregiving definitions often fail to capture the practical differences between living with a care recipient versus providing care from nearby, creating gaps in eligibility, support programs, and data that call for clearer, more inclusive definitional standards. Support and expand decision-sharing frameworks and ensure family engagement in federal aging programs.
- **Enhance resources for informal rural caregivers:** Through existing community-based networks such as area agencies on aging, increase support for existing infrastructure to offer caregiver training, peer support groups, and respite care programs in addition to navigational services such as senior transportation and meals programs. Ensure outreach to tribal and frontier areas are culturally appropriate. Enage and promote other resources, such as:

- Medicare's **Guiding an Improved Dementia Experience model** offers around-the-clock access to support lines, educational services, and respite care for those caring for a family member with Alzheimer's or dementia. This pilot program requires a provider partner, of which there are currently only 320 nationwide.[xlv]
- The Administration for Community Living's **National Family Caregiver Support Program** provides grants to states/territories for informal caregivers. Grants are distributed to states based on the percentage of their population over 70 years. Services include social and supplemental services, individual counseling, and limited respite care.[xlvi]
- The National Institute on Aging's **Services for Older Adults Living at Home guide** what provides comprehensive resources for older adults who want to age in place. [xlvii] The guides outline support services like personal care, household chores, meal prep, transportation, and health care.

- **Increase health care provider interactions with informal caregivers**: Ensure rural health care professionals are appropriately addressing the physical and mental health of their patients' informal caregivers. Integrate mental health screening, caregiver-centered models, and wellness assessments during check-ins or other appointments.

Recommended actions

- **Supporting Our Direct Care Workforce and Family Caregivers Act** (S. 4889) would create a national technical assistance center and grant program to support the direct care workforce and family caregivers through HHS funding.
- **Reauthorization of the Older Americans Act** (S. 2120) would appropriate the Older Americans Act for fiscal years 2026-2030, strengthening this backbone legislation and solidifying caregiver support while enhancing community-based care.
- **The Social Engagement and Network Initiatives for Older Relief (SENIOR) Act** (S. 473) would expand the Administration on Aging's grants to include services mitigating social isolation. The bill also mandates a federal report evaluating programs for reducing loneliness and fostering intergenerational connections, which can aid in strengthening support networks for older adults and their caregivers.

Conclusion

Rural caregivers are the backbone of aging in place. Because the population of older adults is increasing more rapidly in rural America, the formal and informal caregiver system must be supported to ensure the sustainability of these communities. Rural communities have specific strengths, such as support networks and safety, which should be utilized to enhance solutions. Targeted actions such as expanding reimbursement options for CHWs and rural care facilities, making telehealth services permanent, and supporting legislation that stabilizes caregivers is vital to ensuring the 4Ms of aging care are upheld in rural areas. Supporting rural caregivers is vital to ensuring older adults can age safely and with dignity in the communities they call home.

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