Using Community Health Workers in Primary Care settings to improve care for older adults in rural areas

- **Designed in rural Oregon, by rural clinicians,** to improve care for older adult patients who need additional support to maintain independence and wellbeing
- **Uses Community Health Workers (CHWs) to deliver patient-centered Age Friendly Care.** CHWs conduct home visits and implement protocols based on the 4Ms – What Matters, Medication, Mentation, and Mobility.
- **CHWs are embedded in the primary care team.** They chart directly in the EMR, and route important information or action needed back to the patient's clinician.
- **CHWs provide information and education** to patients and families, **system navigation and patient advocacy**, and connect patients with **community resources**.
- **Short term support** - Patients move off the program when relevant protocols are complete and priority needs are met (usually within 90-days).
- **Designed to meet Quadruple Aim Goals** - patient experience, outcomes, cost, and clinician well-being

Institute for Healthcare Improvement

Age-Friendly Health Systems

The Connected Care Protocols are based on the 4Ms of the IHI's Age-Friendly Health Systems Framework. Each protocol includes tools, scripts, and resources that help CHWs discover important information about a patient's well being, wishes, and priorities.

What Matters

- What Matters Conversation
- Support to complete the Advance Directive

Mentation

- Info on normal brain aging
- Pre-screening for dementia, anxiety, depression, and social isolation

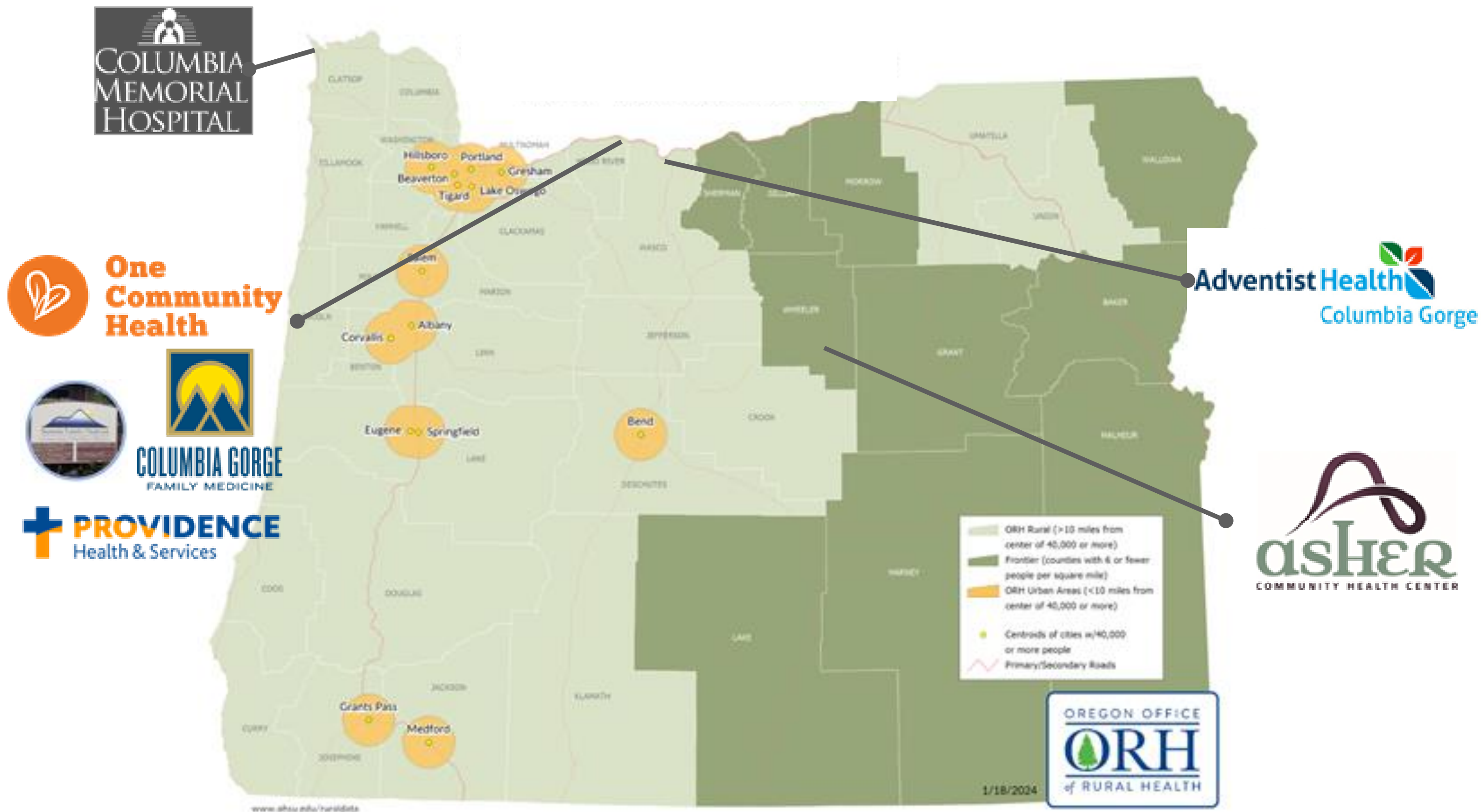
Medication

- Conduct in-home medication review and compare to current med list
- Flag any issues for clinician review

Mobility

- STEADI fall risk assessment
- Footwear review
- In-home fall risk assessment
- Exercise plan

Connected Care Pilot Clinics



Early Program Findings

- Over 500 patients referred by 86 clinicians at 7 rural clinics
- 95% of patients are covered by a public payer
- On average, patients receive 4-5 home visits and 10 care coordination calls
- Advance Directive completion increased from 34% - 68%
- Early data suggests meaningful decreases in hospital/ED utilization
- >95% of patients and clinicians were “very satisfied” with the program

What we hear from clinicians...

"I absolutely want to see this program thrive and grow in order to help increase access to services for some of our most vulnerable patients. I love it!"

"Having bilingual, bicultural staff has been wonderful, especially in discussions of Advanced Directives."

"Home visits reach people in a way we are unable to do from the clinic."

"Helped identify and troubleshoot barriers to care. Got Advanced Directives for EVERY patient referred."

What we hear from patients...

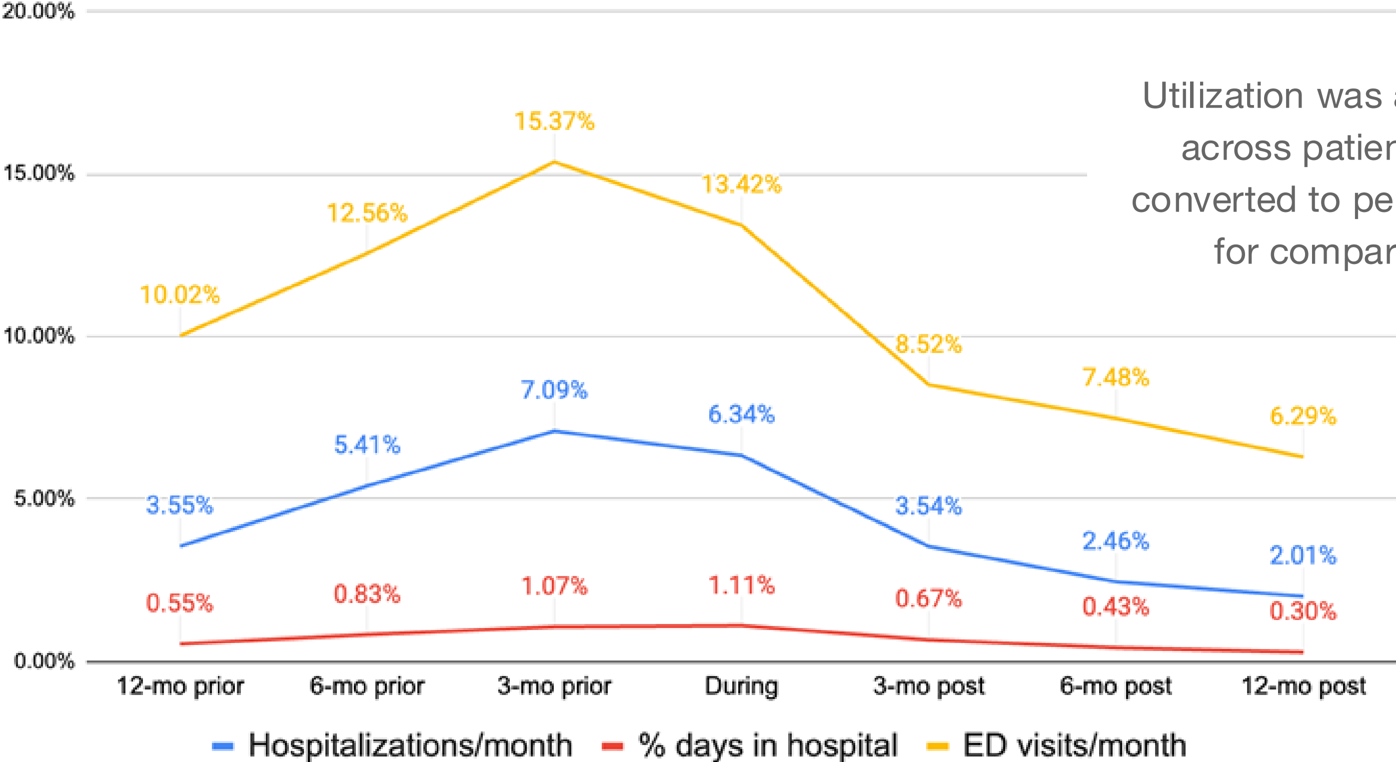
"I felt like I had more to look forward to. The CHW helped me set goals and meet them."

"I was able to stay in my home without fear of eviction. The landlord updated many things in the home that were worse for wear. My CHW gave me my peace of mind. "

"Being able to have someone come to your home and see your home setup is very helpful."

"Meeting with Connected Care helped me to make decisions and changes that will improve my daily life."

Reductions in High Cost Utilization (n=296)



Utilization was averaged across patients and converted to percentages for comparison.

Patient Story - “Denise”

Photo by Bianca Jordan

"Denise” is an older patient who had repeated lapses in her medical care. She has refractory depression that prevented her engagement in care. She was unhoused for a period of time. After months of not being in touch with her clinic, she would return with a long list of unaddressed issues or issues that were addressed previously that did not get timely follow through. Thus, processes had to be started all over again and little progress was made to improve her health and wellbeing.

Patient Story, cont...

Our Connected Care CHW was able to:

- Connect Denise with housing resources and find her placement;
- Help get her taped, broken glasses repaired;
- Schedule for much overdue dental care;
- Help her complete intake packets;
- Get a sleep study to diagnose severe sleep apnea;
- Establish regular care with our county’s mental health provider for supported treatment of her depression that has so long hindered her care.

Patient Story, cont...

Photo by Ike Ellyana

“She is now coming to appointments, and we are able to work through the steps to promote her health and wellbeing. I would not have been able to do this myself without the help of the Connected Care for Older Adults program."

What are we learning?

- Connected Care is a promising model
- For less than $2,000 per patient, it improves Advance Directive completion and care utilization
- Patients, caregivers, and clinicians value the program
- It successfully integrates the 4Ms into primary care clinics
- It utilizes the unique skill sets of Community Health Workers
- Incorporating Community Health Workers into Primary Care Teams may improve care for other high-risk populations

Opportunities for Rural Clinics

- Connected Care is expanding to additional rural clinics across Oregon beginning this summer
- Funding secured through Oregon's Rural Health Transformation Program to support program costs at up to 18 clinics in 2026/2027
- Potential fit for rural clinics that want to improve care for older adult patients, are open to incorporating CHWs into primary care teams, and are willing to innovate and problem solve collaboratively
- Visit connectedcareforolderadults.org to register interest

Call to Action - CCM Improvement Act

- Chronic Care Management (CCM) services are covered by Medicare and provide support to older adults in line with Connected Care.
- Government studies show that Medicare spent $95 less per month per patient receiving CCM services, but just 4% of fragile older adults are being served because of patient cost-sharing requirements.
- The bipartisan **Chronic Care Management Improvement Act of 2026 (HR 8261)** would eliminate Medicare cost-sharing requirements, allowing more patients to access this type of care.
- This bill is currently in the subcommittee on health, where Cliff Bentz is a member. **If you reside in District 2, please ask Representative Bentz to support or cosponsor this bill.**

Call to Action - CCM Improvement Act

Dear Representative Bentz (or fill in your Rep here),

I am writing to ask you to support The Chronic Care Management Improvement Act of 2026 (HR 8261).

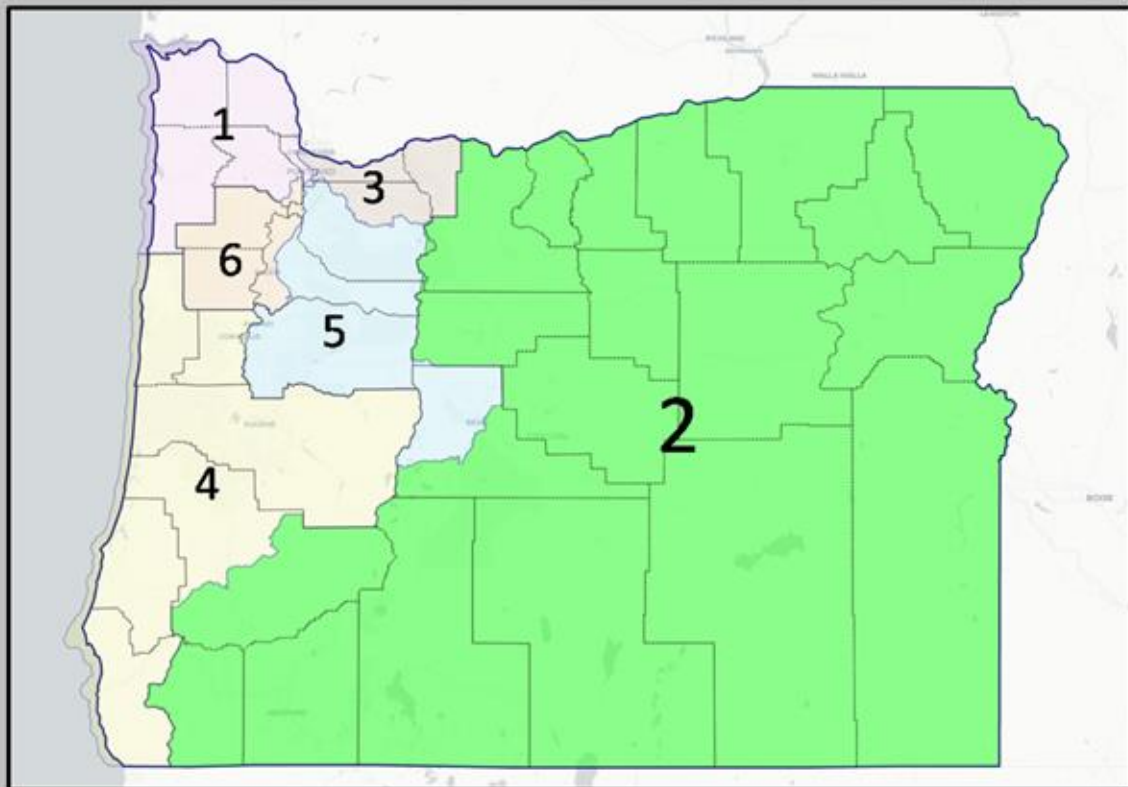
Government studies show that Medicare spent $95 less per month per patient receiving CCM services, but just 4% of fragile older adults are being served because of patient cost-sharing requirements.

This bill would eliminate the cost-sharing requirement for complex older patients, allowing more patients to access the care they need.

This bipartisan bill is currently in the Subcommittee on Health in the Committee on Commerce and Industry. Please demonstrate your commitment to older adults by supporting or co-sponsoring this bill.

Oregon's 2nd congressional district

(since 2023)



Sources:

Shape files (districts): ***https://redistrict2020.org*** **via** ***https://davesredistricting.org/***

Shape files (state & counties): ***https://www.census.gov/***

Map skin: ***https://umap.openstreetmap.fr/***

Thanks to our partners and supporters!

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For more information

www.connectedcarefPLACEHOLDER

Benefits to clinics

- Financial support to implement (subject to Federal funding), and support to transition to sustainable billing strategies.
- Implementation support for hiring and training the CHW, clinic workflow integration, quality improvement, and ongoing CHW learning and peer support.
- Expanded primary care team and enhanced service offering for older adult patients, families, caregivers.
- Provides clinicians with support to improve care for the older adult patients that they are most worried about.
- Opportunity to help prove and improve a promising new model for serving frail older adults in rural communities.

Expectations of clinics

- Engage as a partner in program’s ongoing improvement efforts.
- Identify a team to support program implementation.
- Integrate new workflows into existing EHR and clinic processes.
- Recruit, hire and train the Connected Care CHW.
- Provided desk space, technology, clinical supervision, and support.
- Provide access to required evaluation forms and data.
- Ask clinicians to complete short surveys every 6 months.
- Make all reasonable efforts to meet enrollment targets.
- Provide quarterly financial reports (req’d by Federal funders)