CONNECTED CARE



COMMUNITY HEALTH WORKERS

IMPROVING CARE FOR

OLDER ADULTS IN RURAL OREGON

The Realities of Aging in Rural Oregon



Access to Care

Fewer primary care clinicians per capita means patients must travel twice as far on average for medical care



Access to Services

There is a lack of long-term care and other services in rural and remote areas, including Home Health, Hospice, etc.



Social Connection

1 in 4 Oregonians age 65+ live alone, 1 in 3 in rural areas. Many older adults lack opportunities for social connection



Transportation

For older adults who don’t drive, getting to and from medical appointments and basic services is even more challenging

Connected Care for Older Adults

- Innovative model
- Designed by rural clinicians
- Reaches fragile, rural, older patients who are often isolated
- Provides short term support, 90d intervention
- Eligible patients are age 55+, living at home, and not enrolled in home health or hospice.



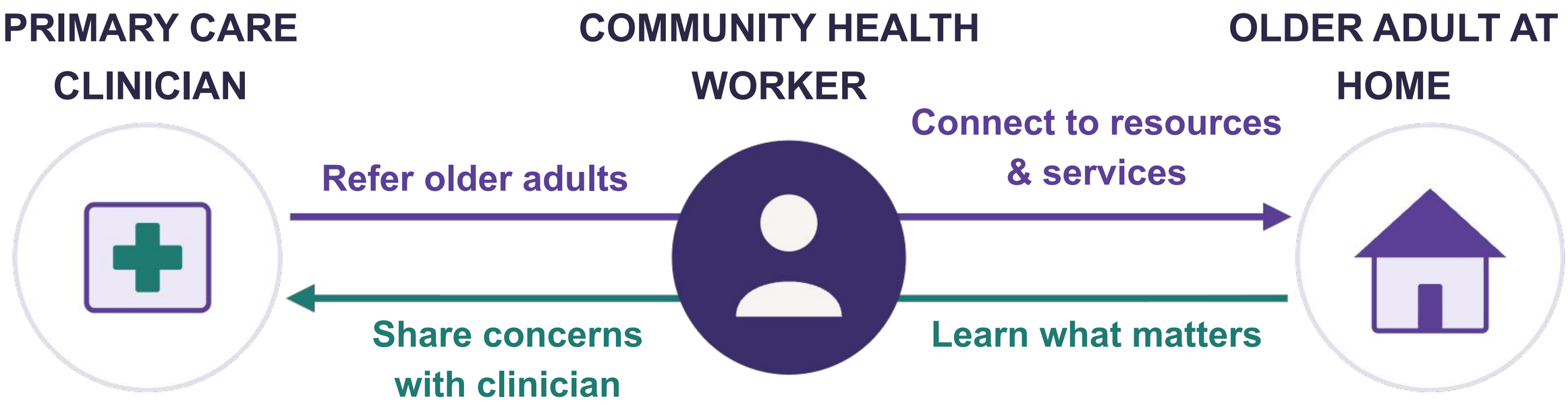
Community Health Workers are the Link

- CHWs are embedded in Primary Care clinics
- Primary Care Clinicians identify older adult patients that they are most worried about to work with the CHW.
- CHWs conduct home visits, complete evidence-based protocols and make connections to community resources.
- CHWs bring important information directly back to the Primary Clinician for action.



CONNECTED CARE

Better Care for Older Adults in Rural Areas



Evidence-based Clinic Workflows for CHWs

The Connected Care Protocols are based on the 4Ms of the Age-Friendly Health Systems, which aim to:

- Follow an essential set of evidence-based practices
- Cause no harm
- Align with What Matters to the older adult and their family caregivers

Age-Friendly Health Systems

An initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI) in partnership with the American Hospital Association (AHA) and the Catholic Health Association of the United States (CHA).

Institute *for* Healthcare Improvement

Age-Friendly Protocols for Community Health Workers



What Matters

Identify patient's goals for health and healthcare; complete Advance Directive



Medication

Provide information on medication safety; conduct in-home medication review to be compared with clinic record



Mobility

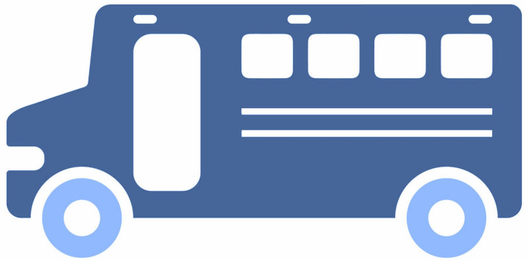
Complete fall risk assessment; remove fall hazards in the home; plan for strength and balance activities



Mentation

Provide information on brain health and aging; screen for memory loss, depression, anxiety, and social isolation

CHWs Address Social Needs That Impact Patient Health



Transportation



Food Access



Housing



Caregiver Support

Patient Story “Denise”

"Denise" struggled with refractory depression that prevented her from engaging 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 but did not get timely follow-through. Processes had to be started all over again, and little progress was being made.





Rosa, the CHW

- connected Denise with housing resources and found her permanent housing.
- helped get her taped broken glasses repaired and scheduled her for overdue dental care.
- assisted with intake packets and eligibility forms
- supported her to complete a sleep study that diagnosed severe sleep apnea.
- helped her establish regular care with the county’s mental health clinician for supported treatment of her depression that had hindered her care fo so long.

Her clinician reports: “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."

Patient Stories

A Connected Care patient was at risk for losing his housing. His CHW, together with his doctor, submitted a request stating his medical need, and were able to get him on a priority list for low-income apartments.





Another patient was able to get hearing aids after nearly two years of trying, which was life changing for her. She was able to connect better with the people around her, which helped sharpen her memory and improve her mood.

Patient Stories



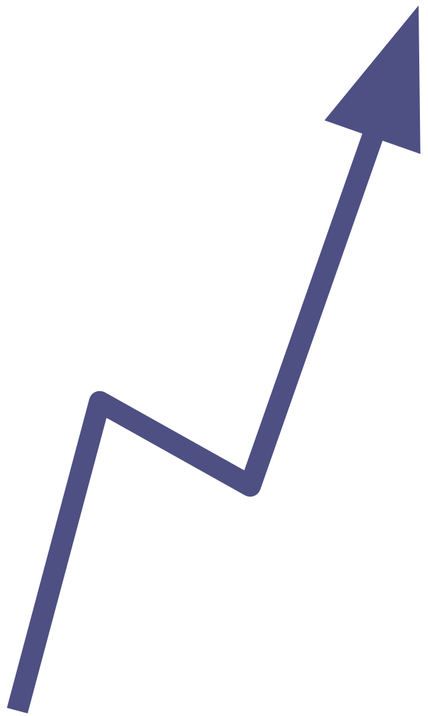
A Connected Care patient couldn’t get his walker in and out of his house, resulting in increased social isolation and depression. The CHW was able to get a ramp installed with donated materials and labor. This patient shared that the Connected Care program has been a “Godsend” to him, helping connect him to resources and get around more easily.

Pilot Results 2023 - 2025

100%
increase in Advance Directives

-44%
Emergency Department visits

-50%
Hospital visits



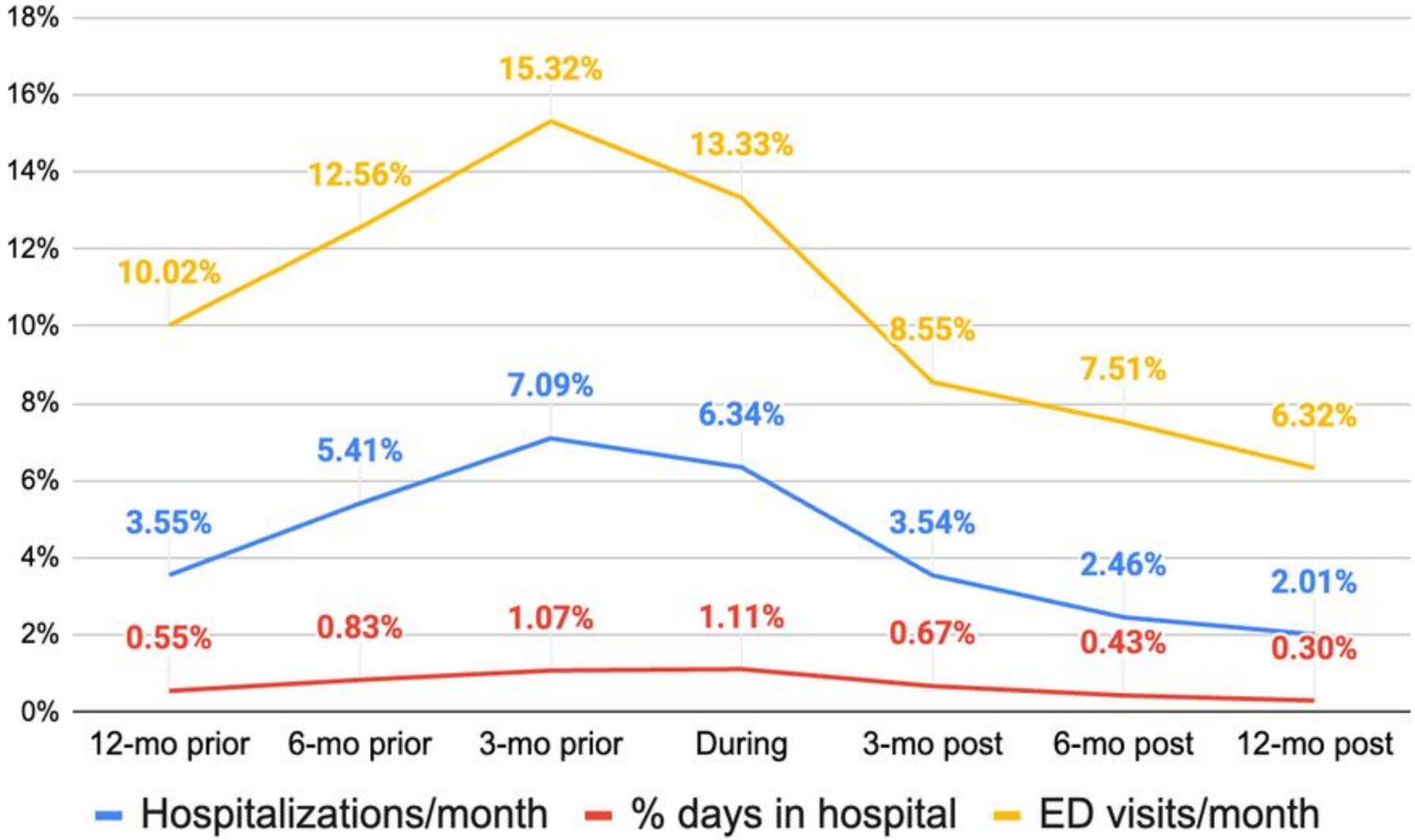
95%
of patients say it helped

100%
Clinicians very satisfied

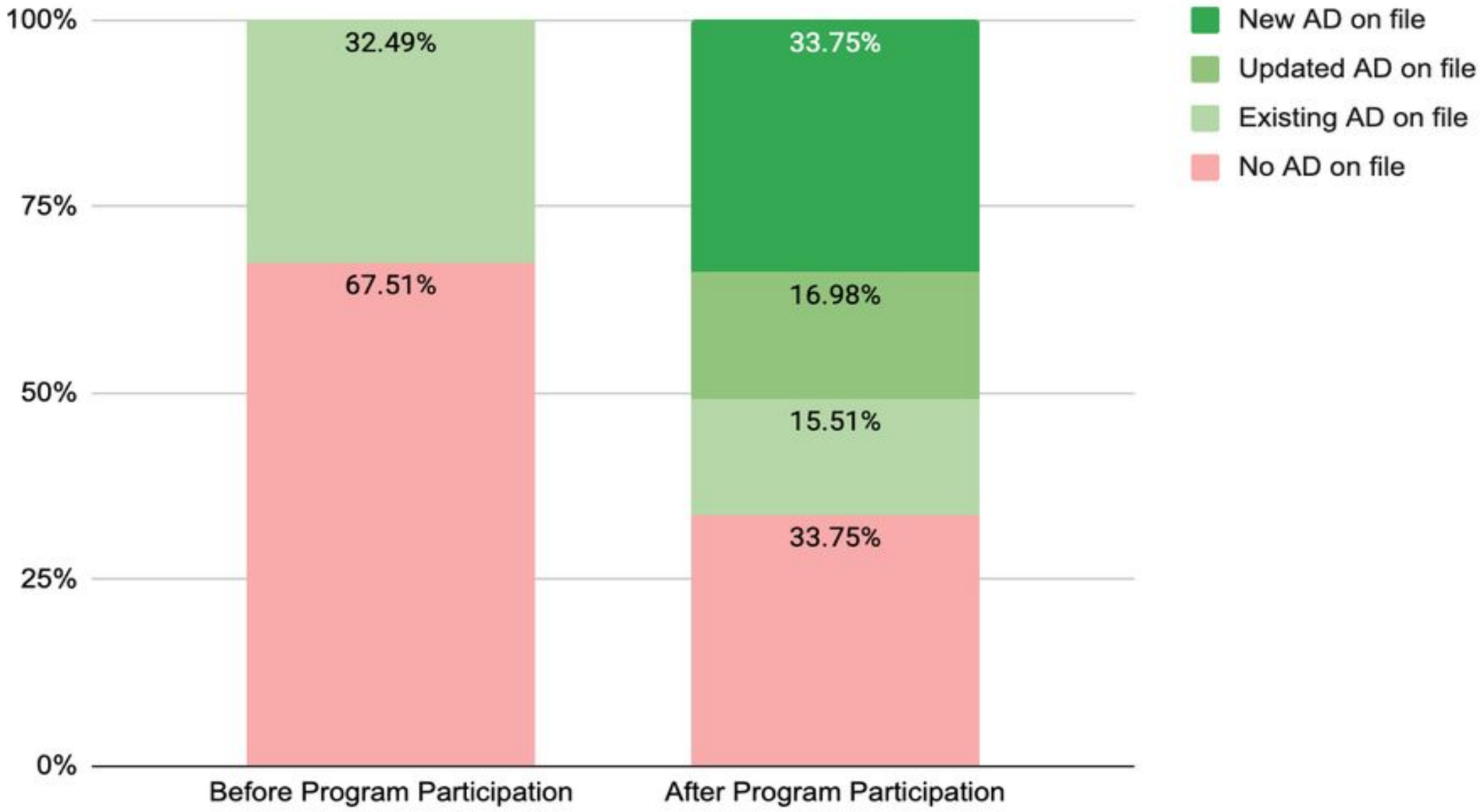
>95%
Patients covered by public insurance

Early Pilot Results: 515 patients enrolled across 7 rural Oregon clinics. ER/hospital data: Collected for 296 patients at 5 clinics, 3 months prior vs. 3 months post.

High Cost Utilization Pre/Post Program (n=296)



Advance Directive Completion (n=477)



Pilot Results 2023 - 2025

- 500+ patients referred by 86 clinicians at 7 rural clinics
- Patients averaged 94 days in the program and received 4-5 home visits and 10 care coordination calls
- Efficient CHW documentation pathways emerged for clinic notes and quality evaluation:
  - Clinicians receive focused action requests, otherwise can review progress notes and data collection PRN.
  - Clinics can access the quality metrics but don’t have to manage the data.



Pilot Results 2023 - 2025

- Clinicians have been overwhelmingly pleased with the program reaching patients that they were concerned about.
- Prioritizing what matters to a patient, seeing what is actually going on in their home, and identifying and addressing **barriers** can markedly improve clinical care.
- One clinician states: “I absolutely want to see this program thrive and grow in order to increase access to services for some of our most vulnerable patients. I love it!

Evidence Shows CHWs Reduce Costs and Improve Care

- Every $1 invested in CHW programs yields $2.28–$3.80 in healthcare savings — one of the highest-ROI workforce investments in modern healthcare (RWJF, 2023)
- CHW programs reduce hospital readmissions by up to 25% for patients with complex conditions — preventing costly repeat hospitalizations (NEJM, 2020)
- CHW-led interventions reduce HbA1c by 0.7–1.2% in diabetic patients — clinically meaningful glycemic control at community scale (AJPH, 2021)
- Doula & perinatal CHW programs associated with 41% reduction in low birth weight outcomes — transforming maternal and infant health equity (Lancet, 2022)

From “Integrating Traditional Health Workers into Healthcare Systems.” Marin Arreola, Interface Network Inc. (shared with permission)

Our data and CMS data agree: Care Coordination saves money but is not widely available

A study commissioned by the Centers for Medicare & Medicaid Services that analyzed the cost of Chronic Care Management CCM patients compared to non-CCM patients to the Medicare program found that over an 18-month period, Medicare spent $95 less per patient per month for CCM patients (1).

The latest data reveals that only 4% of Medicare beneficiaries potentially eligible for CCM received these services, approximately 882,000 of a potential pool of 22.5 million eligible CCM beneficiaries (2).

(1) Schurrer, J., O'Malley, A., Wilson, C., McCall, N., & Jain, N. (2017, November 2). Evaluation of the diffusion and impact of the Chronic Care Management (CCM) services: Final report (Final report). Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/files/reports/chronic-care-mngmt-finalevalrpt.pdf

(2) McDowell, A., Colligan, E., Clark Stearns, S., Sen, N., Hu, W., Waldo, D., Moiduddin, A., & Russell, M. (2022, March 1). Analysis of 2019 Medicare fee-for-service claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) services (ASPE Descriptive Analysis) [PDF]. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf

Challenges We've Encountered

- Rural clinics and Critical Access Hospitals are under stress - even a successful model will not endure if it is onerous.
- The rural clinical workforce continues to decline
- Viable sustainable payment mechanisms are still needed.
- Medicare Copays for Chronic Care Management present significant barriers to care for older adults.
- Chronic Care Management (which can now be done by CHWs) is limited to one hour / patient / month (not sufficient to support this model).
- Travel time / mileage for rural home visits is not currently covered by CMS billing codes.

Keys to Long Term Sustainability

The expansion of Connected Care for Older Adults is funded by the Rural Health Transformation Program for an expected 5 year term. During this time there are three things that must be achieved to attain sustainability after the grant period.

1. Remove patient co-pays for Chronic Care Management (CCM). The bipartisan **Chronic Care Management Improvement Act of 2026 (HR 8261)** would eliminate the onerous cost-sharing requirement, allowing more patients to access the care they need.
2. Modify CMS policies to support access to CCM for patients in rural areas. We met with CMS this week to discuss needed changes in rules: increasing billable hours and covering travel costs for home visits.
3. Align and simplify state payment policies for CCM: work to promote non-discounted payments by Oregon Medicaid to cover the actual cost of care.

Partnering to Transform Rural Health

- Rural solutions exist to meet the needs of our patients, but current payment mechanisms don’t support long-term viability.
- We cannot continue to pretend that stressed rural primary care clinics can “blend “ funding sources or “fundraise” for their clinical CHW positions.
- We need to institute reliable and adequate reimbursement for these important, cost effective health improvement strategies.



Keys to Success

- Center the needs of rural clinics and patients - designed by clinicians
- Streamline processes and administrative burdens on clinics
- Build educational and peer support structure for clinic-based CHW workforce
- Allow for and fund the time it takes to establish a new program and get it firmly established
- Invest in evaluation from the beginning and share results with stakeholders
- Invite feedback from all stakeholders along the way
- Keep at it!

Opportunities for Clinics

- Connected Care is expanding to 18 clinics in 2026-27.
- We are pursuing funding for an additional 10 clinics 2027-2028.
- Funding has been secured through Oregon’s Rural Health Transformation Program
- This is a potential fit for rural clinics wanting to improve care for frail older adult patients, who are open to integrating a CHW into their primary care teams, and are willing to innovate and problem solve collaboratively.
- If this is of interest to you, please contact us.

Benefits to Participating Clinics

- Provide clinicians with support to improve care for the patients they are most worried about
- Expand primary care team and enhance service offering to older adult patients, families and caregivers
- Multiyear financial support to get firmly established (subject to federal funding)
- Support for hiring and training the CHW, clinic workflow integration, ongoing CHW learning and peer support, and quality improvement data reported
- Opportunity to help prove and improve a promising new model for serving frail older adults

Connected Care in the News



MICHAEL HANSON FOR THE NEW YORK TIMES

The Help That Many Older Americans Need Most

By Paula Span April 18, 2026

With shortages of medical professionals and an aging population, thousands of community health care workers prevent older adults from falling through the cracks.

The New York Times

https://www.nytimes.com/2026/04/18/health/community-health-care-workers.html?unlocked_article_code=1.b1A.7tnO.XAAfPFAE7pKj&smid=nytcore-ios-share

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY

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Connected Care for Older Adults: A Pilot Intervention Engaging Community Health Workers to Advance Age-Friendly Care in Rural Oregon

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Contact Us

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www.connectedcareforolderadults.org

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Questions