CONNECTED CARE

Using Community Health Workers in Primary Care Settings to Improve Care for Older Adults in Rural Areas

Connected Care

- Designed in rural Oregon, by rural clinicians
- Uses Community Health Workers (CHWs) to deliver patient-centered Age Friendly Care
- CHWs are embedded in the primary care team
- CHWs provide information and education, system navigation patient advocacy, and connect patients with community resources
- Short term support
- Designed to meet Quadruple Aim Goals

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.

Institute for Healthcare Improvement

Age-Friendly Health Systems

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

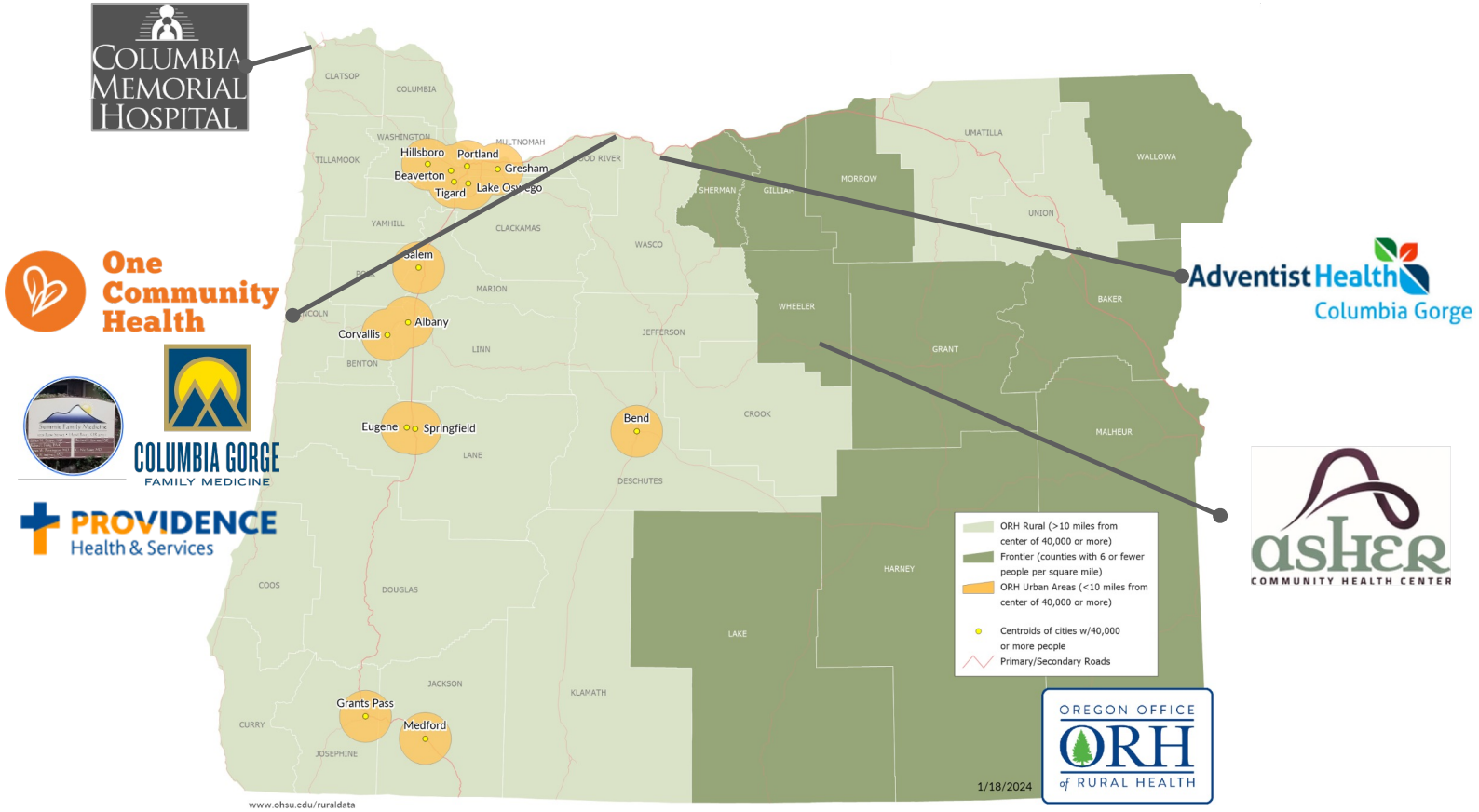
Medication

- Conduct in-home medication review
- Flag issues for clinician review

Mobility

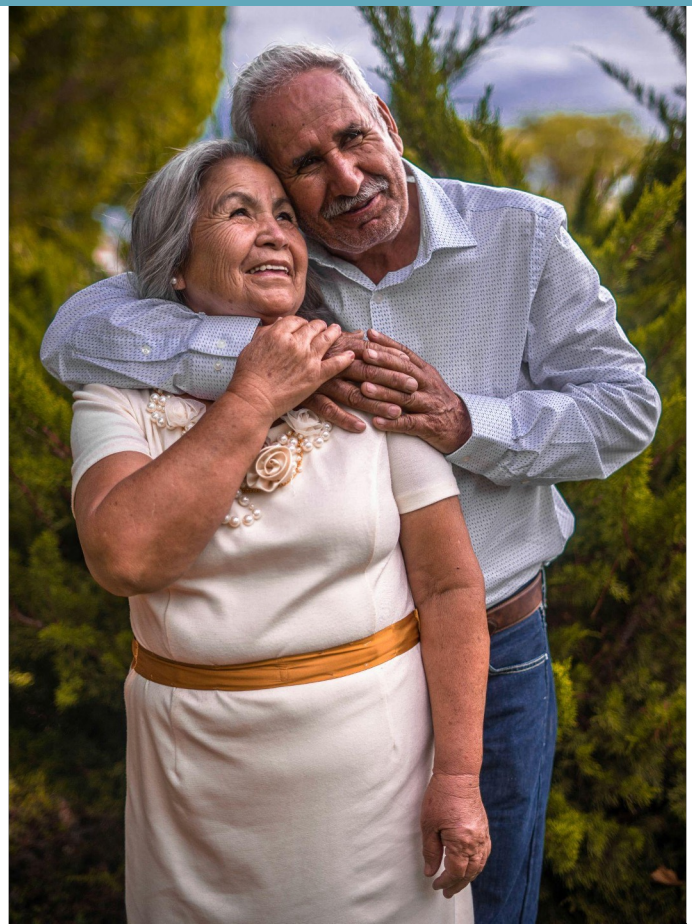
- STEADI fall risk assessment
- Footwear review
- In-home fall risk assessment
- Exercise plan

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."

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

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

What we hear from patients...

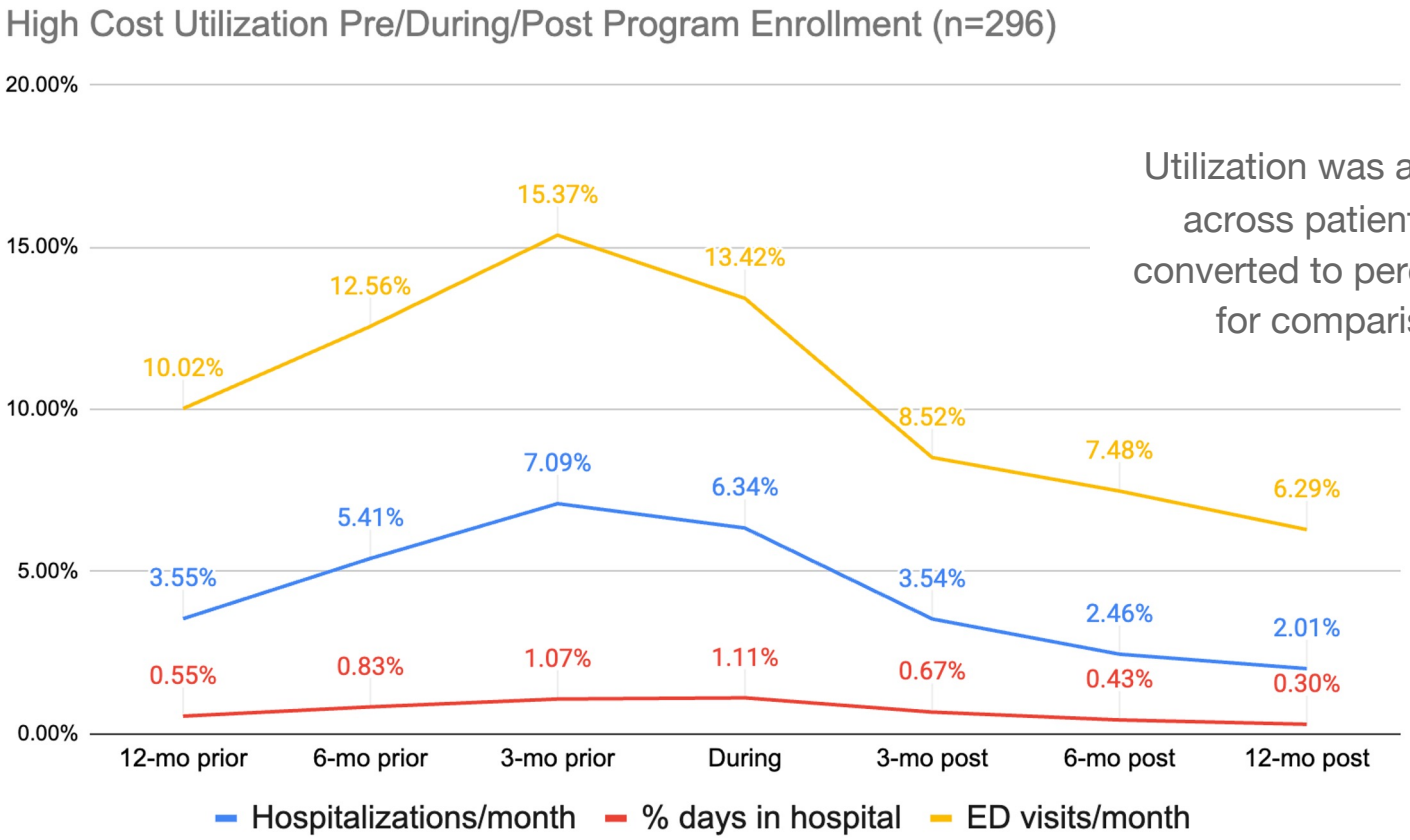
"I felt like I had more to look forward to. The CHW helped me set goals and meet them."

"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

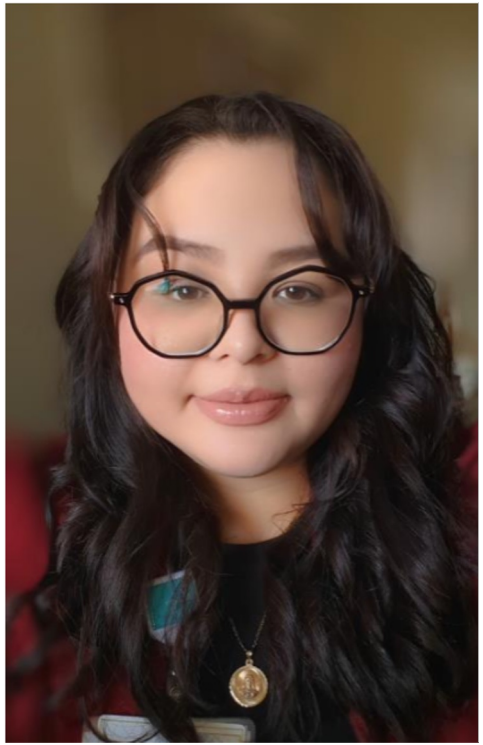


Photo by Ike Ellyana

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

Challenges

- Rural clinics and Critical Access Hospitals are under stress - even a successful model will not endure if it is onerous
- Sustainable payment mechanisms are still needed
- Payment mechanisms are burdensome and/or inaccessible
- Travel time/mileage not currently covered by CMS billing codes
- CHW recruitment, retention, and clinical integration

Keys to Success

- Center the needs of rural clinics, clinicians, and patients
- Streamline processes and administrative requirements on clinics
- Allow for (and fund) the time it takes to launch new programs and get them firmly established
- Invest in evaluation from the beginning
- Invite feedback from all stakeholders along the way
- Build diverse and lasting partnerships
- Share your work and what you are learning
- Keep at it!

Opportunities for Rural Clinics

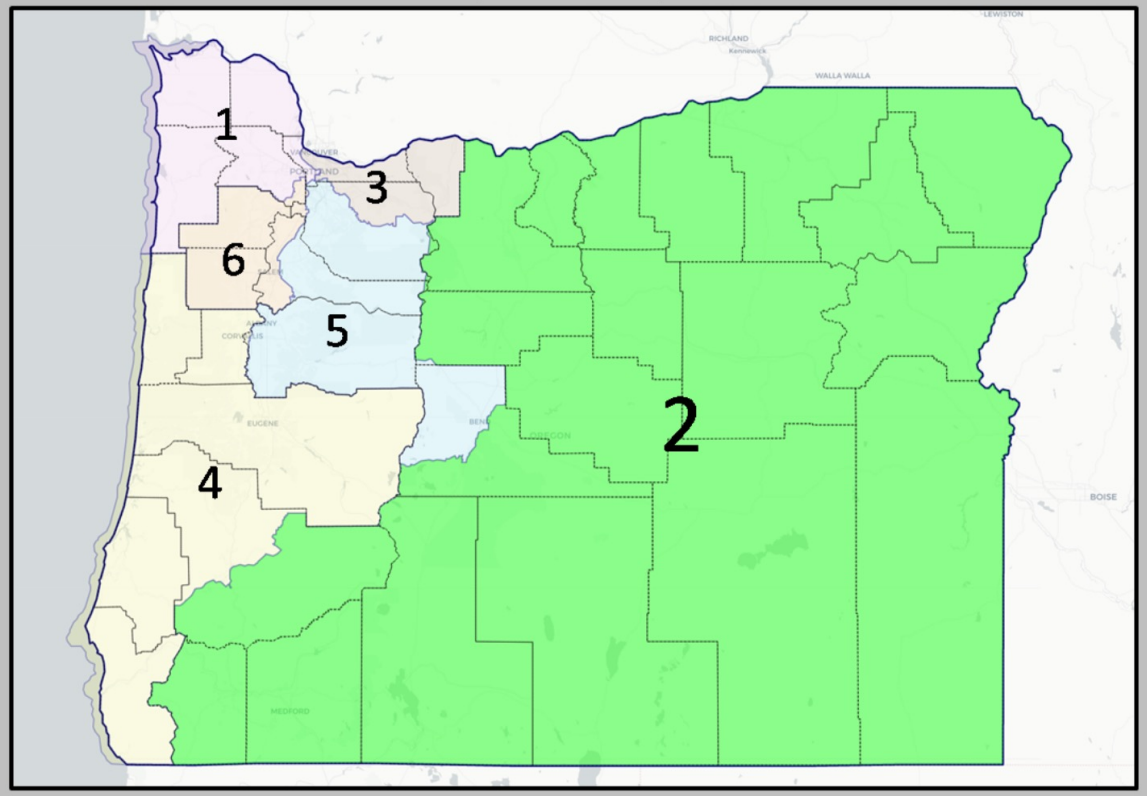
- Connected Care is expanding to new rural clinics across Oregon beginning this summer.
- Funding secured through Oregon's Rural Health Transformation Program to support program costs at up to 18 clinics in 2026/2027.
- Potential fit for rural clinics that want to improve care for older adult patients,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

New Federal Legislation Introduced April 14
Sustainable Payment step 1

- 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.
- Currently only 4% of fragile older adults are being served.
- Government data studies shows that Medicare spent $95 **less** per month per patient receiving CCM services.
- This bill is currently in the subcommittee on health, where Cliff Bentz is a member
- If you are in Representative Bentz' district, you could affect this payment system for the whole country just by asking him to support or cosponsor this bill. **100 Letter Campaign**
- Goal: Get support from the entire Oregon Congressional Delegation
- **Discharge petition –> cosponsors ½ of the house – 218**

Oregon's 2nd congressional district

(since 2023)



Sources:

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

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

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

Thanks to our partners and supporters!

For more information

CONNECTED CARE

www.connectedcareforolderadults.org

JOURNAL OF THE AMERICAN GERIATRICS SOCIETY

Clinical Investigation | Open Access

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

Bryanna De Lima, Lindsay Miller, Elizabeth Foster, Jodi Ready, Elizabeth Eckstrom

First published: 10 January 2026 | https://doi.org/10.1111/jgs.70279 | VIEW METRICS

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ABSTRACT

Background

Aging in a rural setting presents unique challenges including limited access to in-home care, lack of social support, language and cultural barriers, and the lack of transportation. We conducted a pilot study embedding community health workers (CHWs) into rural primary care teams to assist with implementation of the 4Ms of the Age-Friendly Health System: What Matters, Mentation, Medication, and Mobility.

https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.70279

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)