Community Health Workers – Expanding Capacity to Serve Rural Older Adults

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Thank you to our partners:

GOBHI
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Workforce Development

Workforce development in public health aims to improve health outcomes by enhancing the training, skills, and performance of public health workers...

Workforce development is the foundation of a healthy community.

- Public Health Foundation

https://www.phf.org/focusareas/workforcedevelopment/pages/default.aspx

What are Traditional Health Workers?

- Five THW types in Oregon
- Trusted individuals
  - From local community
  - Share lived life experiences with health plan members
- Provide person- and community-centered care
  - Connect people with health systems
  - Increase appropriate use of care
  - Advocate for patients
  - Support adherence to care and treatment
  - Empowering individuals to be agents in improving their own health

Image from https://www.cdc.gov/minorityhealth/promotores/index.html

Five Traditional Health Worker Types in Oregon

Community Health Worker

*

Community member who links health and social services; facilitates access, culturally appropriate care

Peer Support Specialist

*

Four sub-types; person with lived experience with substance use or mental health; provides supportive services

Peer Wellness Specialist

*

Lived experience with psychiatric condition and extensive training, integrates behavioral health and primary care

Personal Health Navigator

*

Provides information, assistance, tools, support to enable a patient to make the best decisions

Birth Doula

*

Birth companion: personal, nonmedical support to a birthing person during pregnancy, childbirth, postpartum

What is a CHW?

"A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."

American Public Health Association's Community Health Worker Section
https://www.apha.org/apha-communities/member-sections/community-health-workers

Rationale for the OSU CHW Training Program

- Idea for a Community Health Worker training program came about to fill identified gaps in the number of CHWs in rural Eastern Oregon
- Shared program goals
  - Increase the availability of high-quality training for CHWs
  - Improve the behavioral health system
  - Increase value and pay for performance
  - Focus on the social determinants of health and health equity
  - Maintain sustainable cost growth

CHW Course Learning Objectives

- Knowledge of the CHW profession
- Determinants of health and health promotion
- Assessment
- Interpersonal skills
- Capacity building skills
- Adult learning principles
- Service coordination skills and techniques
- Integration and application of organization, communication, and cultural sensitivity knowledge and skills relevant to CHWs

Geriatric-related services and system navigation needs

- Number of older adults in US is growing
  - Despite the need, there is a gap in capacity of a knowledgeable and skilled workforce to provide effective and appropriate care
- Older adults have a unique set of biopsychosocial challenges
  - Diminished levels of personal mobility
    - Loss in independence and access to resources
    - Challenging to complete daily household tasks
  - Diminished levels of community mobility
    - Isolation
    - Challenges accessing facilities (pharmacies, grocery stores, medical centers, etc)

Citation: Hodges, M.; Butler, D.; Spaulding, A.; Litzelman, D.K. The Role of Community Health Workers in the Health and Well-Being of Vulnerable Older Adults during the COVID Pandemic. Int. J. Environ. Res. Public Health **2023**, 20, 2766. https://doi.org/10.3390/ijerph20042766

Integration of CHW Model Into Patient Care Teams

- CHWs can be effective in improving outcomes and reduce health disparities
- CHW responsibilities vary widely
  - Provide patient education, connection to resources, navigation of healthcare system, and providing emotional support
- CHW-based geriatric trainings
  - Education
    - Common syndromes (depression, falls, risky medication management)
    - The 4Ms of the age-friendly framework (Mentation, Mobility, Medications, and What Matters Most)
  - Community Resources
  - Patient and caregiver educational information
  - Patient-centered communication/Motivational Interviewing Methods

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Connected Care for Older Adults

A community health worker model to improve care in rural areas

Connected Care for Older Adults Pilot Program

Community Health Workers support older adult patients with protocols based on Age Friendly Health Systems*

CHWs communicate key information to primary care providers and support patient-centered care planning

CHWs connect patients and families to existing community resources and services

*THE 4MS OF AGE-FRIENDLY HEALTH SERVICES WERE DEVELOPED BY THE INSTITUTE FOR HEALTHCARE IMPROVEMENT (IHI)

Who is Connected Care for?

- **Frail older adults ages 55 and older**, regardless of immigration and insurance, **living independently** (without access to in-home medical support)
- Priority patients age 85+ and transitioning from a hospital or skilled nursing facility stay
- Frailty can include a combination of factors:


Mental status


Medication use


Social support


Balance and mobility


Assistance with daily activities


Mood and mental health


Nutrition


Continence


Burden of medical illness

The Connected Care Protocols

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 Advance Directives

Mentation

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

Medication

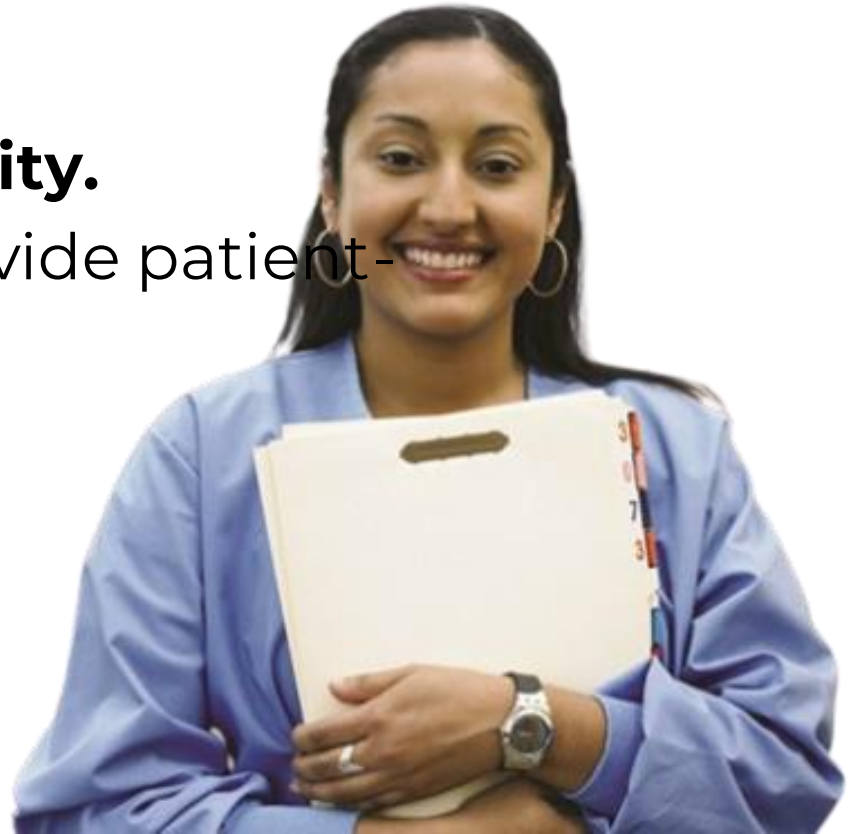
- In-home med review and current med list
- Flag issues with med list on file for RN/PCP review

Mobility

- STEADI Assessment
- Footwear review
- In-home fall risk assessment
- Mobility plan

Why Community Health Workers?

- **CHWs are system navigators, health educators, and patient advocates.** They connect patients with community resources and services. They help patients and family members understand and advocate for their own healthcare needs.
- **CHWs are trusted members of the community.** Often bilingual and bicultural, CHWs help provide patient-centered care for racially and culturally diverse older adults and their families.
- **CHWs have been improving care** related to diabetes, migrant outreach, and perinatal care at One Community Health since 1988.



What are the goals of Connected Care?

1. Improve patient, caregiver & provider experience
2. Integrate What Matters in patient care
3. Increase focus on advance care planning
4. Decrease hospitalizations and ED visits
5. Advance health equity

Primary Goals of
Connected Care

How are we measuring impact?

Patient demographics	• Patient demographics (age, gender, race/ethnicity, preferred language, insurance) • Patient enrollment, duration, reason for non-enrollment
Implementation measures	Barriers and facilitators of pilot implementation; Protocols completed; Resources and community connections made; Program experience and satisfaction of patients, caregivers, providers, and CHWs
Clinical measures	• What Matters discussed and documented • Advance Directive documented in EHR • Social Determinants of Health addressed • Screening for dementia, depression, anxiety, and social isolation complete • Medication reconciliation complete in last 12 months • STEADI Assessment and footwear review complete • Patient, caregiver, and provider satisfaction
Cost savings measures	• ED visits • Hospitalizations

Pilots currently in progress in rural communities

One Community Health

- Launched in Sept 2022
- 1.0 FTE Connected Care CHW
- 3 clinician champions
- 18 patients referred to date
- 3 program graduates

ASHER COMMUNITY HEALTH CENTER

- Launched in March 2023
- 1.0 FTE Connected Care CHW
- 2 referring clinicians
- 6 patients referred to date

Patient stories...

What we're hearing from participating providers...

"Our Connected Care CHW has helped navigate support systems for a caregiver, in order for the caregiver to continue to care for the patient! That was a really profound improvement and impact on the patient's health and I believe is preventing readmission to the hospital."

"This has been life changing for several patients!"

"The CHW's ability to meet patients in their home, identify community resources that I'm not aware of, and help patients complete the advanced directive paperwork have been so helpful!"

"The program has exceeded my expectations!"

Partners and Funders

This pilot is made possible through these partnerships

Thank you to our protocol development team!

- Gisela Ayala Echeverria, CHW (One Community Health)
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- Lorena Sprager, CHW (The Next Door, Inc)
- Katy Williams, LPN (Bridges to Health)
- Britta Wilson, MA (Older Adult Behavioral Specialist, GOBHI)

For more information about Connected Care

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OREGON OFFICE of RURAL HEALTH

2023 Forum on Aging in Rural Oregon

OPPORTUNITY Just knock.

Thank you!

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