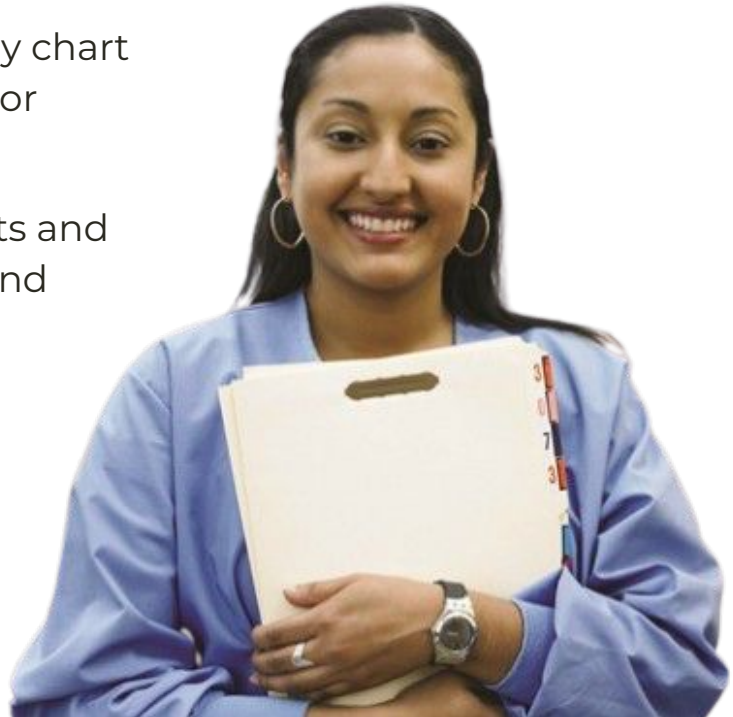
CONNECTED CARE

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



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 and compare to current med list
- Flag any issues for clinician review

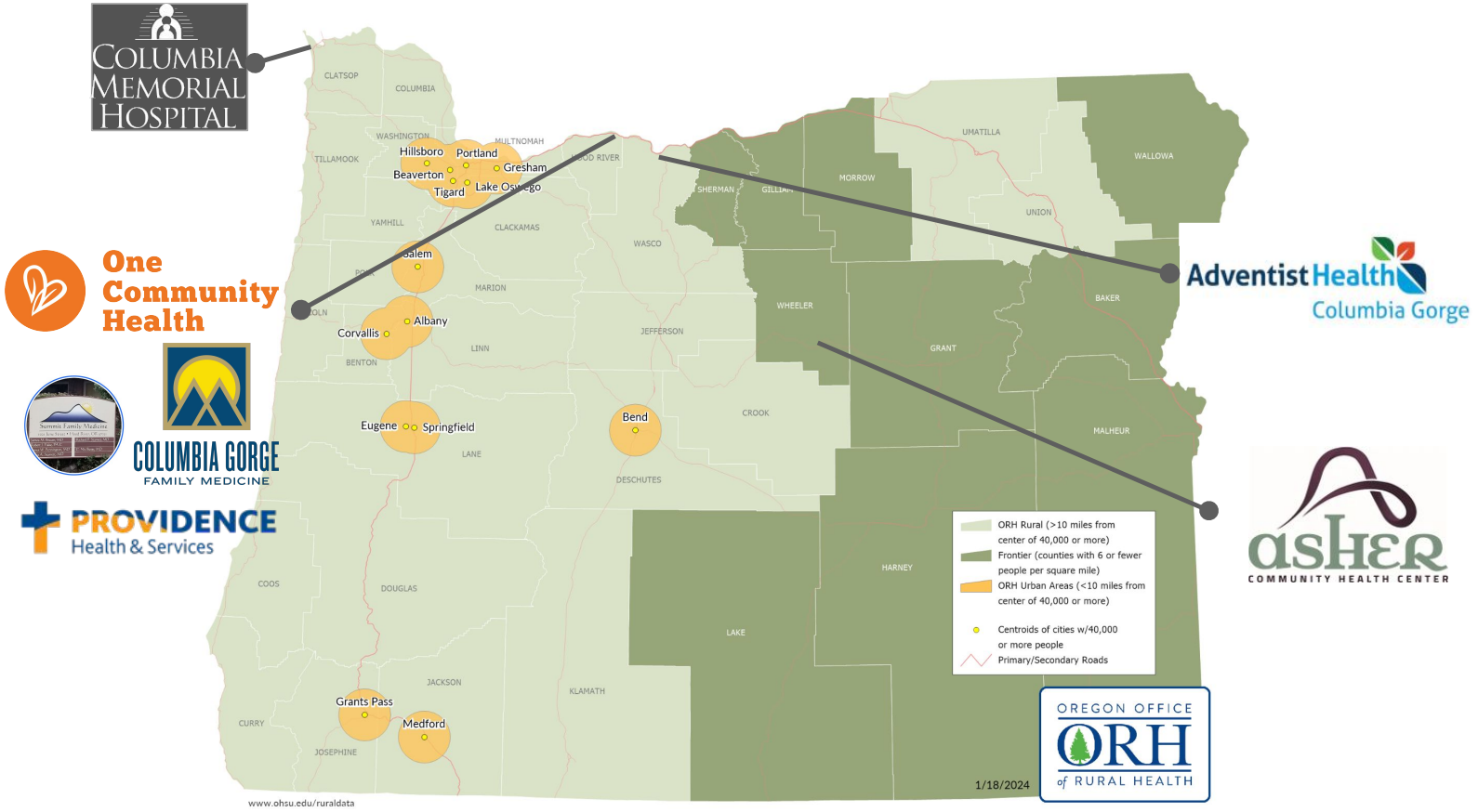
Mobility

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

CHWs also identify and support social needs

Connected Care CHWs work with patients and families to identify social needs such as housing, food access, transportation, assistance with activities of daily living, financial security, and more. They connect patients and caregivers with community resources to address their needs.

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!"

"Very strong advocacy for patients who really need it."

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

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

"Helps patients connect to local services and do more long term care planning."

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

What we hear from patients...

"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 peace of mind. "

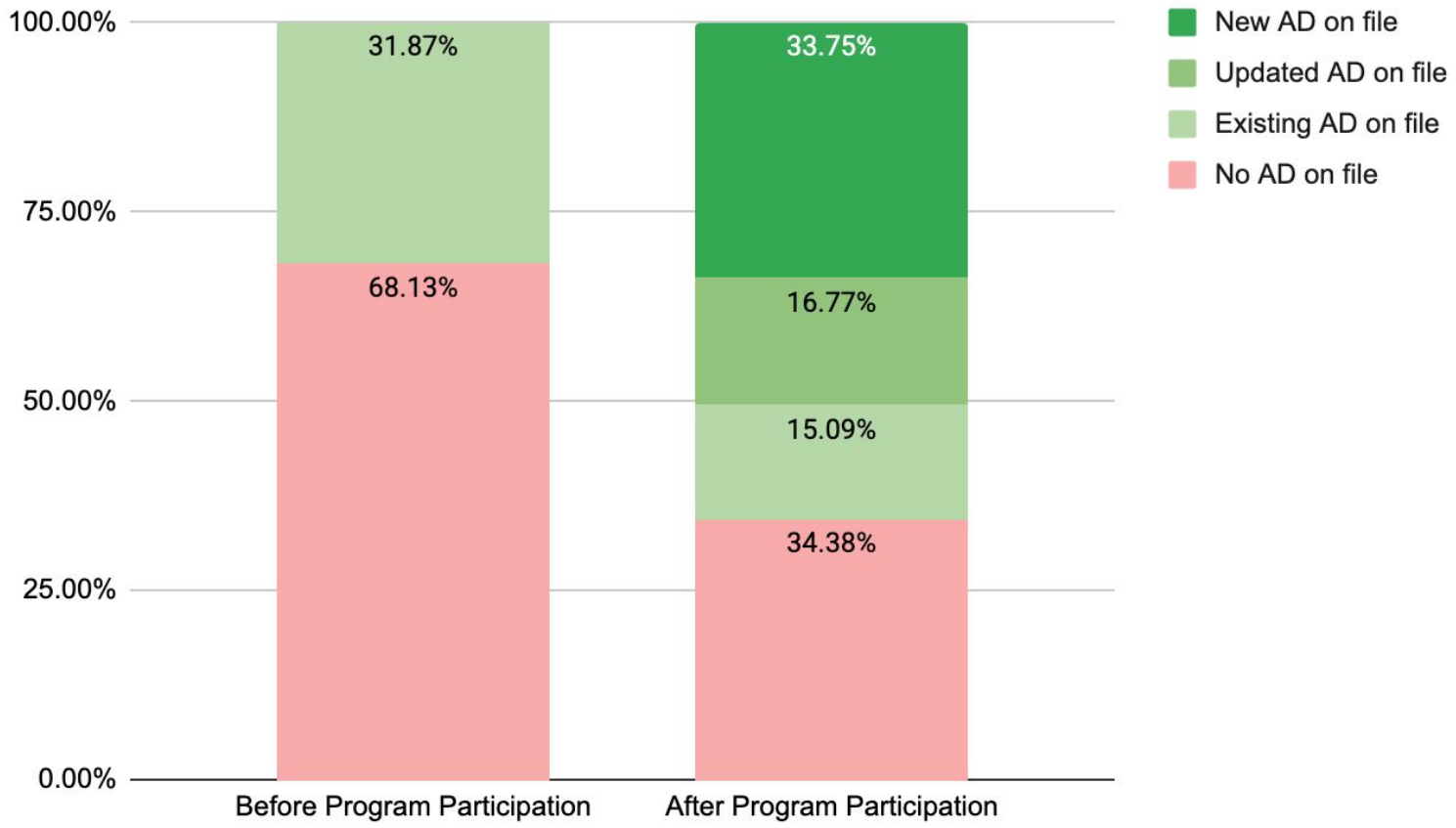
"I felt like I had more to look forward to. The CHW helped me set goals and meet them."

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

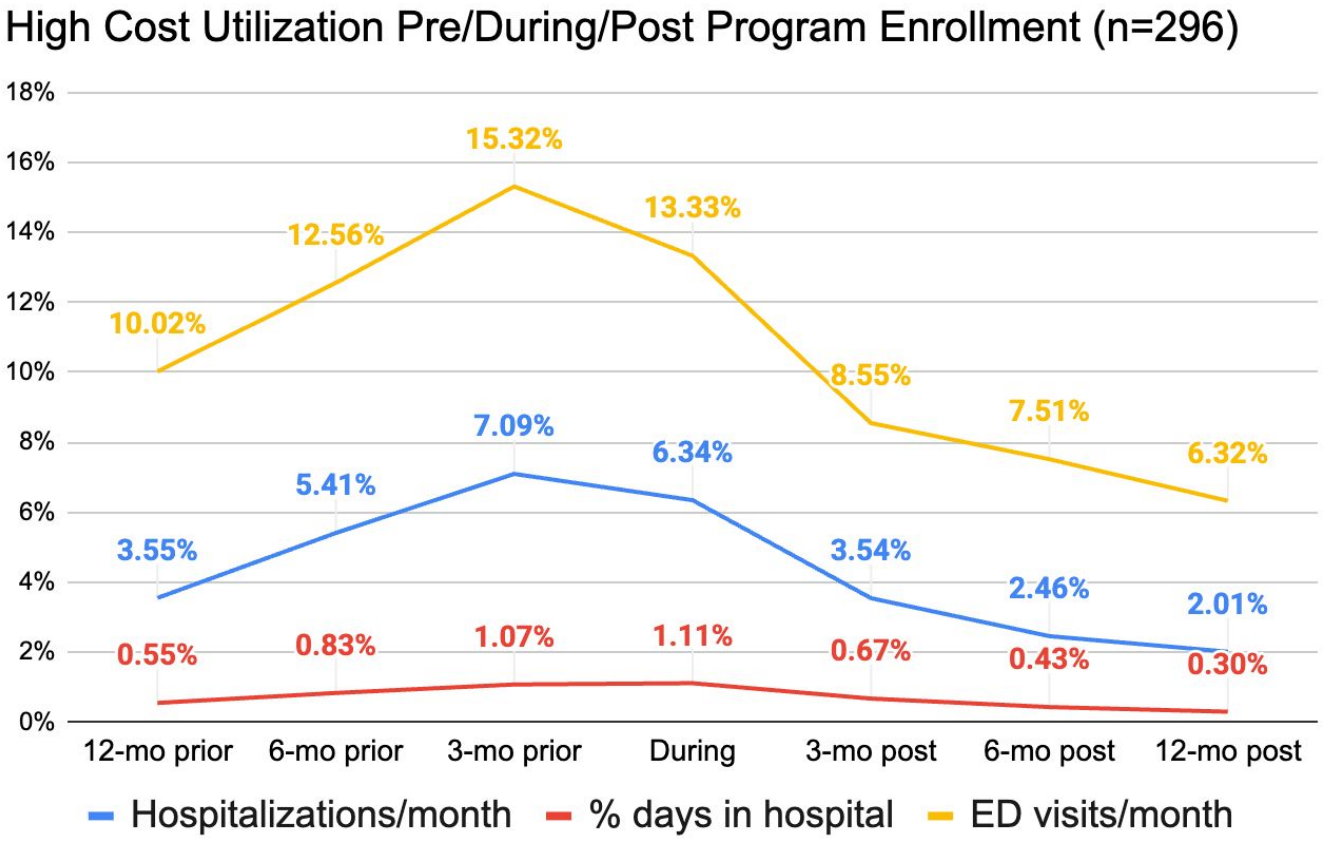
"Meeting with Connected Care helped me to make decisions and changes that will improve my daily life."

"The visits were helpful and it was great to feel that I could talk to someone that was concerned for me."

Advance Directive Completion (n=477)



Reductions in High Cost Utilization (n=296)



Patient Stories

What are we learning?

- Connected Care is a promising model for enhancing primary care services for older adult patients in rural settings.
- For less than $2,000 per patient, it makes a meaningful positive impact on Advance Directive completion, ED and hospital utilization.
- Patients, caregivers, and clinicians value the program.
- It successfully integrates the 4Ms into primary care clinics and utilizes the unique skill sets of Community Health Workers.
- Connected Care is most successful when clinics share a commitment to providing enhanced care for older adult patients, an openness to incorporating CHWs into primary care teams, and a willingness to innovate and problem solve collaboratively.

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)

Thanks to our partners and supporters!

For more information

CONNECTED CARE

www.connectedcareforolderadults.org

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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

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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.

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