Community health workers and rural age-friendly care

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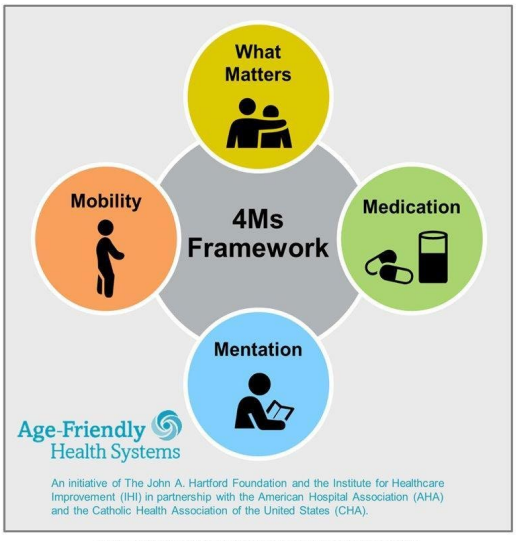
Introduction

Home to more than 20 percent of the older adult population, rural America[2] faces distinct challenges in supporting the health care needs of those over 65.[i,ii,iii] As rural communities experience an increase in the older adult population, there is an urgent need for effective policies and programs to address the challenges of aging. Rural communities face unique health care challenges particularly for aging populations, including a higher prevalence of complex health conditions, limited long-term care services, poverty, social isolation, limited transportation options, and food insecurity. In addition, the lack of in-home support services, visiting home health teams, and hospice care has impacted patients in rural areas. Age-friendly initiatives are designed to overcome these challenges but are not yet fully implemented in rural communities.

Age-friendly care

According to The John A. Hartford Foundation, age-friendly care is tailored to older adults' unique needs and preferences, helping them achieve a better quality of life.[iv] This approach prioritizes safety and is guided by evidence-based practices that focus on the "4Ms": what *matters* to the individual, appropriate *medication use*, maintaining *mentation* (mental health and cognition), and supporting *mobility*. The 4Ms framework was developed by the Institute of Healthcare Improvement in collaboration with The John A. Hartford Foundation, the American Hospital Association, and the Catholic Health Association of the United States as core elements of high-quality care for older adults. A growing number of hospitals, practices, clinics, and nursing homes are adopting this model through the Age-Friendly Health Systems initiative.



[1] This Policy Paper was developed by members of the National Rural Age-Friendly Initiative Interest Group, a group of subject matter experts brought together through the National Rural Age-Friendly Initiative, a partnership between NRHA and The John A. Hartford Foundation.

[2] In 2021, people 65 years and older made up over 20 percent of the nonmetro population for the first time in history, compared with 16 percent of the metro population.

The concept of "aging in place" is an important component of age-friendly care, as the majority (77 percent) of adults 50 and older say they would prefer to remain in their homes as they age.[v] Aging in place refers to the ability of older adults to live in their own homes or communities safely, independently, and comfortably regardless of age, income, or ability.[vi5] It involves adapting the home environment while accessing support services and resources to maintain a high quality of life.[5] For many older adults in rural areas, the ability to age in place is impacted by barriers like lack of transportation, social isolation, and food insecurity.[vii] Nearly 30 percent of rural (29.6 percent) and urban (28.5 percent) older adults report experiencing at least one of the selected risk factors contributing to poor health among U.S. older adults in rural and urban areas: injury, food insecurity, or lack of social and emotional support.[viii] These challenges highlight the need for tailored policies and interventions that account for the geographic, social, and economic nuances of rural living and the impact these factors have on rural older adults.

Community health workers (CHWs) are uniquely qualified to support age-friendly health care delivery in rural areas. This policy paper provides an in-depth examination of the role of CHWs in enhancing access, quality, and affordability of health care for older adults, specifically in rural areas. It further explores challenges, opportunities, and comprehensive recommendations for integrating CHWs into rural health systems to ensure age-friendly care aligned with the 4Ms framework.

Analysis

The CHW section of the American Public Health Association defines CHW as "a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served."[ix] This trusting relationship enables the worker to serve as a liaison between health and social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.[x]

CHWs function as patient navigators, health promoters, health educators, patient advocates, and/or outreach workers through employment or volunteer work. In these capacities, CHWs are mostly community members serving as frontline health care professionals who connect people with needed health and social services in their communities, help manage chronic conditions, and address the social determinants of health and inequities experienced by their clients.[xi] They generally work with underserved populations and are indigenous to the community ethnically, linguistically, socioeconomically, and experientially.[xii]

It is anticipated that CHWs will play a growing role in care for rural older adults due to the health care workforce shortage caused by distance, low wages, and insufficient numbers of workers. The number of CHWs in the United States is expected to increase by 13 percent in the next decade from 127,100 to 144,100 by 2029.[xiii] This is partly because registered nurses employed in skilled nursing facilities (SNFs) earn on average $10,000 to $15,000 less than their colleagues in hospitals,

outpatient departments, and physicians' offices. This disparity is a major factor driving nurses to leave skilled nursing facilities for higher-paying roles in other health care settings and contributes to the growing shortage of nursing staff in long-term care, particularly in rural areas.[xiv]

However, CHWs face systemic workforce challenges. Statistics by Schmit et al. show that the majority of CHWs are women of color with a high school degree or less and earn an annual salary below the U.S. average.[xv] These realities draw attention to existing gaps in the CHW workforce and highlight the need for greater support and intentional integration of CHWs within health care systems.

The role of CHWs in rural age-friendly care

Given the unique challenges rural older adults face, CHWs advance age-friendly care through improved access, prevention, care coordination, support for social determinants of health, education, and patient advocacy.

Enhancing access to care: CHWs are essential in connecting rural older adults to necessary health care services and addressing systemic barriers such as limited provider availability, transportation, and geographic isolation. University of North Carolina data reveals that CHWs reduce hospitalizations and improve patient outcomes by offering consistent follow-ups and fostering community trust.[xvi]

Promoting preventive health measures: CHWs are critical in educating rural older adults about preventive health practices, managing chronic diseases, and adopting healthy lifestyles. Evidence shows that CHW-led interventions have resulted in improved management of conditions such as diabetes and hypertension and reduced reliance on emergency care.[xvii]

Facilitating comprehensive care coordination: Navigating complex health care systems is particularly challenging for rural older adults. CHWs help streamline this process by coordinating services and aligning care plans with rural age-friendly principles to ensure that interventions meet individual needs.

Addressing social determinants of health: CHWs address underlying social determinants such as food insecurity, low income, transportation, social isolation, and housing instability that disproportionately affect rural older adults. By targeting these issues, CHWs enable individuals to overcome barriers to improve overall health outcomes and enhance quality of life.[xviii]

Health education: CHWs serve as trusted sources of culturally relevant health information and empower rural older adults to make informed decisions about their care. CHWs offer tailored education on managing chronic conditions, medication adherence, nutrition, and wellness to ensure greater health literacy and self-efficacy among aging populations.

Patient advocacy: CHWs advocate on behalf of rural older adults by helping them navigate health care systems, understand their rights, and communicate effectively with providers. Their advocacy

ensures patient voices are heard and respected. This promotes equitable care and supports older adults in achieving their personal health goals.

Challenges in implementing CHW programs

The critical role of CHWs in bridging gaps in health care delivery and increasing equitable access to care has not been fully recognized by the U.S. federal government, insurers, and health care agencies. While CHWs hold significant promise in supporting rural age-friendly care, realizing their full potential requires addressing several persistent implementation challenges, including workforce training and retention, CHW integration into health care systems, sustainable funding, and cultural competency**.**

Integration into health care systems

CHWs continue to face challenges in being fully integrated into health care systems due to variations in certification processes and the lack of uniform implementation across states. While the Affordable Care Act Section 5313 authorizes funding for CHW workforce development, the absence of national standards for certification processes creates disparities across states.[xix] It also creates barriers to defining the CHW workforce globally and results in a limited ability to determine effectiveness.[xx]

A stronger understanding of CHWs' roles and responsibilities is starting to emerge thanks to efforts such as the National C3 Council Project, which has established nationally recognized roles and core competencies.[xxi] Guidance on what should be included in CHW certification is helping states to align core CHW competencies with national standards and update trainings.[3] However, limited federal funding exists to support state certification requirements for CHWs to be licensed for practice.

Further, nationally recognized roles and competencies must be aligned with age-friendly care. It is necessary to develop and implement national age-friendly CHW roles and certification guidelines to ensure uniformity in training and integration into health care systems. Minnesota's successful CHW certification program provides a replicable model for certain age-friendly training courses including dementia training for CHWs.[xxii]

Workforce training and retention

Developing a skilled CHW workforce is impeded by limited funding and inadequate training resources. Federal initiatives aim to support CHW training programs; however, their coverage is often limited and may not fully address the specific needs of rural and aging communities at a state or local level. For instance, Health Resources and Services Administration funding for CHW training is not uniformly distributed, leading to disparities in workforce readiness across different regions. This is particularly concerning as CHWs play an increasingly vital role in delivering

[3] Each state is responsible for approving the CHWs' modules for certification. https://nashp.org/state-tracker/state-community-health-worker-policies/

culturally competent education, care coordination, and social support, especially in rural settings where clinical workforce shortages persist.

However, certain federal programs have been used to focus on integrating CHWs into primary care using the Age-Friendly Health Systems framework. For example, the Oregon Geriatrics Workforce Enhancement Program has been an early adopter of age-friendly training for CHWs by developing a certification pathway in age-friendly care.[xxiii] These modules are now freely available online.[xxiv]

The 4Ms framework offers practical guidelines for CHW involvement in holistic care delivery. For example, the Connected Care for Older Adults pilot in rural Oregon embeds CHWs trained in age-friendly health systems in primary care settings in order to improve care for older adults in rural areas. Preliminary pilot findings suggest this model successfully integrates the 4Ms into primary care clinics and patient care planning, increases advance directive completion, reduces ED and hospital utilization, and improves patient, caregiver, and provider experience.
Source: Connected Care for Older Adults, a pilot project of the Columbia Gorge Health Council. https://connectedcareforolderadults.org

Sustainable funding

Historically, CHW programs rely heavily on short-term grants, which jeopardizes their long-term viability and creates barriers to scaling programs effectively.[xxv] Many CHW programs lack sustainable funding models, including integration with Medicaid and Medicare payment systems.[xxvi] While some states have implemented Medicaid reimbursement for CHW services, these policies are not widespread. As of April 2, 2025, 20 states have implemented Medicaid reimbursement for CHW services through Medicaid state plan amendments.[xxvii] Additional states including Connecticut are in the process of implementation.[xxviii] However, state coverage of CHWs varies, with differences in what services are covered, populations that can receive covered services, payment methods, rates, and how to authorize the coverage. While Medicare does not directly recognize CHWs as providers, it did start reimbursing for community health integration services performed by CHWs when arranged by a Medicare provider in 2024.

The Oregon Health Authority Medicaid reimbursement for CHW services program is working to develop such policies, but further refinement is necessary. The program encourages CHWs who meet certification requirements to become eligible to provide reimbursement services to clients enrolled in the Oregon Health Plan. The goal of this work is to help promote the integration of rural CHWs into health care systems and enhance the long-term sustainability of rural CHW programs.
Source: Oregon Health Authority. *Oregon Medicaid Reimbursement for Community Health Worker Services*. 2020. https://www.oregon.gov/oha/HSD/OHP/Tools/CHW_Billing%20Guide.pdf

Cultural competency

Since CHWs come from the communities they serve, employing them is often considered an

effective strategy to address cultural competency and language access. However, CHWs need culturally tailored training to serve all the diverse rural populations within rural communities effectively. A 2019 report by Hacker et al., indicated that only 57 percent of health coalitions reported using culturally tailored interventions. This highlights gaps in training resources, as a significant proportion of coalitions may not be utilizing culturally tailored interventions appropriate to a rural setting.[xxix]

Policy recommendations

NRHA proposes the following evidence-based policy recommendations, which emphasize the importance of integrated approaches combining educational, regulatory, financial, and professional support strategies.

Integration of CHWs in age-friendly care models: Integrate CHWs within rural health settings to effectively address older adults' unique needs by adding “age-friendly care” as a nationally recognized competency.

Rural CHW workforce development and training: Expand federal and state funding for comprehensive CHW training programs that emphasizing age-friendly care competencies and provide support for state certification training programs.

Sustainable funding models for rural CHWs: Advocate for Medicaid and Medicare reimbursement of CHW services at the state and federal level to ensure financial stability. Collaborate with local governments, nonprofits, and private entities to provide resources, sustain CHW programs, and facilitate innovative solutions tailored to specific community needs**.**

Recommended actions

- State agencies and CMS should review and improve current mechanisms that facilitate sustainable payments to clinics and community-based organizations utilizing CHWs.
- Medicare billing codes should be expanded to allow payment for services provided by CHWs, including travel time, care coordination, and preventative care.
- Clinics should be incentivized to incorporate CHWs as key members of care teams in delivering age-friendly care.
- Additional investment in training and professional pathway development for CHWs should occur at the state and federal level.
- Additional funding is needed to study and expand promising models for CHW integration into age-friendly care.

Conclusion

Community health workers can play an indispensable role in promoting age-friendly care in rural areas. To enhance their effectiveness, policymakers should prioritize workforce development, ensure sustainable funding, and promote system-level integration of CHWs. Addressing these key

areas will enable CHWs to improve health outcomes for older adults and strengthen the resilience of rural health systems.

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