The Community Health Worker - realizing the value of Australia's next health workforce

Sarah Henry

Hugh DT Williamson Foundation Fellowship, 2024

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FOUNDATION

National and International observations of how a professional, non-clinical workforce successfully supports older people with complex social and health needs to manage their health and wellbeing to reduce or avoid hospitalizations.

In the spirit of reconciliation, the author acknowledges and pays respect to the traditional custodians of Country, the Aboriginal or Torres Strait Islander peoples, and their continuing connection to land, waters, and community.

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01 Acknowledgements

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Your generosity, care and compassion are nothing short of inspirational.

02

Executive Summary

My purpose for travelling internationally was to observe the ways in which a nonclinical workforce positively contributes to supporting older people to remain in their homes and out of acute care. What is the problem I was aiming to solve through my research? Simply put, in my day to day work I observed unmet needs that both see older people entering hospital and staying there longer than needed. This is neither good for the older person, our health care system, use of taxpayer money or our clinical workforce who are under strain by the demand and workforce shortages. In the years to come as our older population increases this demand will grow and the flow on effects to the wider community needing acute care are and will be significant. I knew from my own professional experience the value of a nonclinical, well-trained workforce and so my applied research sought to find further evidence of this.

There were several events that encouraged me to do this. I could see further potential to make a difference for older people being hospitalised by the Case Managers I work with in the Out of Hospital Care program, together with a conversation with a colleague in the acute sector who explained that much of the ramping occurring was because older people were unable to return home for nonacute reasons. So, the conversations and ideas began.

Additionally, my CEO had shared a paper that highlighted the opportunity to reduce risk of hospitalisation at assessment and then asked me to consider what this might look like and so I began to design a trial together with another colleague from Access Care Network Australia. This is yet to be tested. The trial design sees a further advancement on the role of the Community Health Worker in Aged Care Assessment (My Aged Care Assessor) and hospital risk reduction, an unrealized opportunity to further increase cross sector support. The benefits are described in further detail within the paper.

As the paper indicates, there are two key recommendations for trial here in Australia, one that would see two pathways of support for the complex older person when presenting at an Emergency Department. The other actively identifying and reducing risk of hospitalisation during aged care assessment.

The purpose of this paper is to demonstrate learnings that support my recommendations to then test and trial the recommendations enclosed by seeking support from Federal and State Health and Ageing Departments, in the form of interest firstly, and then funding to trial.

03 Context

Medical, Nursing and Allied Health roles in the 1980's became increasingly specialised and technical while at the same time, hospital demand increased, Medicare was introduced, and while access to care was improved for many, there was an increased focus on service by cost. This meant focussing on treating the ailment that brought people into hospital and getting them home as quickly as possible to reduce costs. Not as aggressively as in the United States (US), but none the less a change, in approach to care. As a training Registered Nurse at this time, this was very evident, and the gaps in support for older people, along with repeat admissions for certain individuals, could be seen. As a result, over time the root causes of chronic and social health and the holistic needs of the person have not been well addressed due to a lack of focus (and funding). It seemed we were no longer listening to the older person in need as well as we could be – there are exceptions of course.

Today, all States in Australia are faced with an increasing demand on acute care with bed shortages, ambulance ramping, clinical workforce shortages, increasing social determinants of health, increasing chronic diseases and exploding health budgets. Meanwhile there are increasing social and psychosocial complexities.

The complex needs of our older population are increasing at a rapid rate in line with the higher proportion of older people. Hospital beds are blocked by older people who are there not for acute reasons, but for their safety and social reasons, ambulances are ramping, and hospitals are desperately trying one strategy after another to find solutions to reduce admissions or length of stay, particularly for older people. The question is why does the older person go to hospital and get stuck there?

Today, when hospitalised, broadly speaking, the older the person the longer the length of stay. (1) The impact on the Australian health system, and the older person, is significant. Many older people are not aware of what supports are available to them or how to access them. There is a medical model dependence that has evolved rather than an autonomy or self-responsibility for health and wellbeing, and so there is a tendency to wait to be told by either a nurse or doctor what and where to access support. Broadly speaking, acute care staff (medical and nursing) don't know what is available in the community and are time poor to educate and facilitate access. Strategies to address the older persons needs and clinical workforce shortages are required and it is the authors view that solutions can be found by valuing and upskilling nonclinical Certificate 4 level and above Community Health Workers to contribute to meeting the needs of our older community and health system both before and during hospitalisation.

The initial intent of my applied research was to focus on a preventative solution to reduce hospital admissions using a non-clinical workforce, while considering their potential to identify risk of hospitalisation during assessment, (such as the My Aged Care Assessor). What I saw both affirmed

this potential but also provided other alternatives to consider. During my travels, I observed several successful examples of the highly valued role of the Community Health Worker within both a community setting, and an acute health care team with proven return on investment both from a financial, individual and community impact.

The US and Canada were very different in terms of the volume of demand on their health care systems due to population and social factors, however like Australia, both countries are searching for new ways to reduce the burden on their healthcare systems, using a range of approaches to support their ageing communities. The passion, collaboration, energy and effort into supporting the vulnerable across the US is palpable. The need can be seen and felt as you walk the streets in major cities. Community Health workers can be seen to be active at all stages of the health care cycle -preadmission, during admission and post admission to hospital, supporting those who are marginalised.

Canada's community and health system, like Australia is more siloed, resulting in smaller scale successful models and has been investing in exploring social prescribing more. It was evident to me, that Australians are fortunate in the level and accessibility of healthcare in our country but there is also a unique opportunity; to further build on our national aged care system to prepare for what other countries are already experiencing in terms of demand, social determinants, chronic disease and complex challenges.

Australia's Aged Care system which aims to successfully keep older people living in their own homes is well advanced with a new Aged Care Act and Support at Home program imminent. However, keeping someone living at home and keeping them out of acute care is different. It requires not just greater consideration at a federal government level, but collaboration between the hospital and community sectors. Efforts are being made in response to the Royal Commission to improve Access, Navigation and Service Provision, but a key factor missing is how we work together with our Health systems to identify risk, points of action for preventative measures and create an ecosystem that reduces hospitalisation. There are very clever examples of work happening in both sectors, but largely in silos and largely clinically led and delivered often with a top-down approach.

In speaking with those affiliated in the community sector in the US, more than 50 Health systems are choosing to use their hospital funding on Community Health Workers/Case managers due to the evidence of their success in shortening length of stay and reducing readmissions. This is a significant acknowledgement of the Community Health Workers value in that it is a health system that is exponentially more expensive and more budget conscious than Australia.

I was asked if I saw anything that wouldn't work in Australia, and it made me consider what had learnt in my conversations. With the focus on nonclinical community health worker value, what wouldn't work is an inconsistent approach to training, an unstructured approach to implementation, a lack of collaboration and acceptance between acute and community, lack of leadership and governance and the wrong people recruited to these roles. I did learn about adhoc examples that had failed and it was largely for these reasons. We need to understand what will work here and why it works before expansion and so piloting is important.

This paper will review and make recommendations for opportunities where the Community Health worker can have most impact based on observations, evidence seen and in relation to current knowledge of Australia's aged care system and health care system.

- Recommendation 1 – Hospital to Home – Community Health Worker - Navigation, Access and Support
- Recommendation 2 - Aged Care Assessment – Community Health Worker - Identifying and reducing risk – using reablement, coaching and case management

04

Who is the Community Health Worker?

The World Health Organisation (WHO) defines CHW's as *"Community health workers (CHWs) are health care providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors."* (2, P 8)

Health Districts in the US however, have moved well beyond this definition, making CHW's integral and valued members of their multidisciplinary health care team. The definition used by the American Public Health Association 2024 on their website demonstrates this:

> *"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 counselling, social support and advocacy". (3)*

The World Health organization refers to this human resource group having *"enormous potential to extend health care services to vulnerable populations………. to meet unmet health needs in a culturally appropriate manner, improve access to services, address inequities in health status and improve health system performance and efficiency"*. (2) Pg 8

In the US, the Community Health worker is a trusted member of the community who *"meets the person where they are at"*. (Gail Anderson, CHW at Camden Coalition) Gail described a Community Health Worker as a vine spreading across the community, wrapping itself around those in need of support, knowing local services and being always present and available, still at their level, to link to supports or access healthcare or services as needed. She said that people get to know you are there, trust you and they know who to come to if they need support to access services.

Several clinicians I spoke with could not imagine their world without Community Health workers as part of their team. In the words of a Social Worker, Marla from Boston Health, *"I can't believe you don't have them in your multidisciplinary team. I couldn't be without them, they do my busy work, they make things happen……….."* Latif, a patient at Penn Medical centre stated in a promotional video I was shown when at IMPaCT HQ , *"she [CHW] made me feel understood……… she helped me with Food security…………. linking me to a haematologist…………..helped me with managing*

my emotions………….. helped me find permanent housing"

A significant step in the acknowledgement of the value of CHW's in the US happened in January 2024 when a Bill was passed which made it possible for the CHW role to be funded through Outreach programs where a person has two or more underlying health or vulnerability indicators. This was seen as a significant step in validating the role of the Community Health Worker who is seen by many as an integral member of the Health Care Team.

Canada, like Australia does not typically use the term Community Health Worker or even a consistent term for nonclinical CHW's. People with this level of education and skills are more defined by their active role title in the environment they work in, and titles are inconsistent in their use. Examples of where you might see CHW roles in Australia from a document review by Javanparast et al, 2018 can be seen in Figure 1. (4)

However, in Australia, workforces are generally labelled by their base trade. For example, if you are a nurse, you can train, specialise and work in a range of settings – but at the end of the day you are a nurse. If you are a doctor you can train, specialise and work in a range of settings but you are a doctor. Yet the community health worker workforce has largely not been recognised nor accepted as a common member of healthcare teams and there is no clear structure for career development.

The most current and commonly used title today in Australia is Navigator. As you can see from the table above Aboriginal Health Workers are also one of the most commonly known Community Health Worker roles contributing to a range of primary care settings with positive impact. The concept of the Navigator role may be also be applied in a range of primary, social, health, disability, and aged care settings. This paper specifically focusses on the contribution of a nonclinical workforce reducing hospitalisation of the older person but could be theoretically applied in other settings.

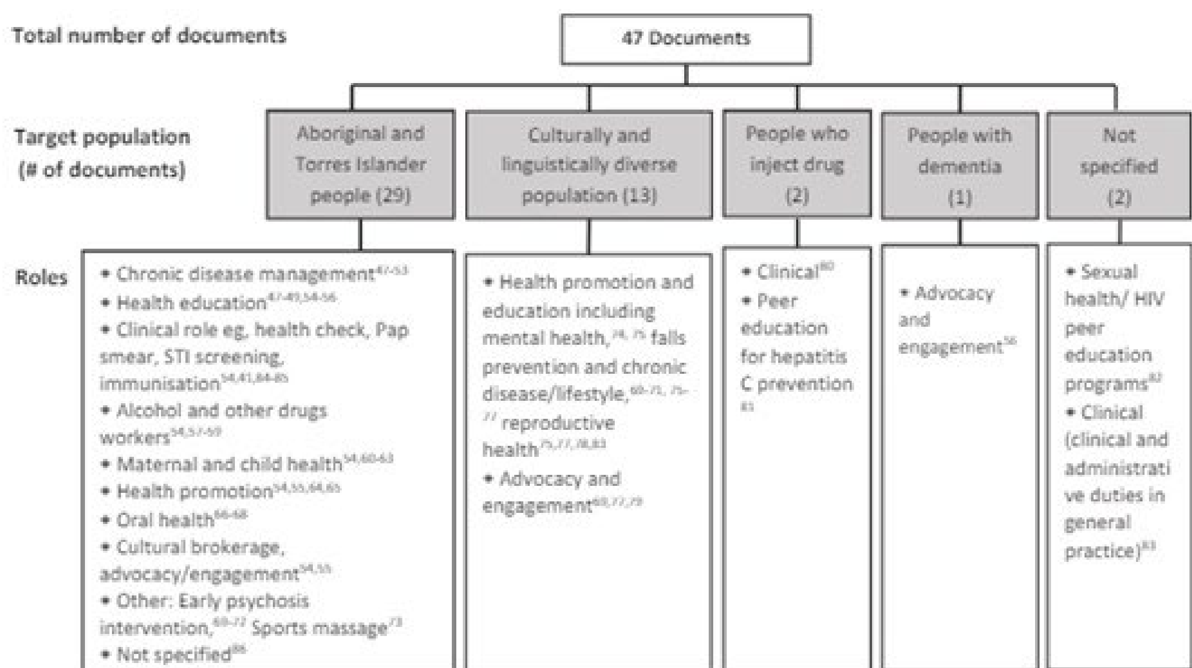

Figure 1. Summary of the CHWs Roles and Positions in Australian PHC.
Abbreviations: CHW, community health worker; STI, sexually transmitted infection; PHC, primary healthcare.
Note: Some papers may be counted more than once in a category, if the position performed a number of roles.

Access to aged care supports has improved with the introduction of the **Navigator role** (previously Aged Care Navigator, now referred to as Care Finders) **which serves to improve access and use of the aged care system** for those in their local communities who may find it challenging or have complex needs. (5) Care Navigators/Care Finders, like My Aged Care Assessors are a successful example of nationally and consistently trained nonclinical workforce who assist older people through a series of interactions to provide support up to the point of assessment or aged care service commencement as appropriate.

While an objective of this national program is to improve integration between the health, aged care and other systems at the local level, its primary purpose is to link a person with the aged care sector, not as an explicit link between the health and aged care sector and not one with a practice that specifically aims to reduce hospital admissions, a statement reinforced by Kruger. J., 2024 (6)

> *"the role does not have a hospital risk reduction framework but there is good collaboration with some hospitals and not others in supporting the care of the older person… focus is more on access to supports in the community and linking with one or more other support services. It's very service driven, rather than building individual strengths through reablement and coaching".*

Australian Healthcare Associates is currently further evaluating the effectiveness of the Care Navigator/Care Finder program. (7) Its first report found further expansion of this nonclinical role would be beneficial (6), and this finding is complementary to the recommendations within this paper. This is progress, but the ecosystem of support is not yet complete in the author's view. What was overlooked in the evaluation was integration of the Care Navigator/Care Finder role with health, which was not a primary evaluation question and yet was an objective.

Today, despite everyone in the sector working incredibly hard to support older people to achieve health and wellbeing, the need for cross sector collaboration is known by both Care Finders and My Aged Care Assessors, but it is not well defined, actioned or led, and so some risks for older people are not addressed. Health and Community largely remain siloed. The older person in Australia is required to follow the "bouncing ball" to get support – if they can. This poses a risk to older people and demands on the health sector.

The models within this paper provide recommendations at various stages of the older person' s wellbeing (in the community and during presentation to hospital, hospitalisation) that go the extra step focussing on creating ecosystem of support where a consistent behaviour of listening, trust and continuity exists between the Community Health Worker and patient/client and the Community Health worker and health as a partner providing connections (Linking), while motivating and coaching the client through to independence and autonomy that sees them take control of their health and wellbeing.

05

International Learning – Camden Coalition

Camden Coalition – Community Health Workers in action.

Camden Coalition is a multidisciplinary non-profit working to improve care for people with complex health and social needs. It does this in a range of ways, including taking leadership to transform fragmented health and social systems into robust ecosystems where organisations, sectors and others work collaboratively to address root causes. This is an important and specific function that requires investment and funding in Australia.

Coalition members are from a range of community, residential, primary care and health care settings in South Jersey, in a variety of roles (including Community Health Workers) who regularly gather to collaborate to improve the health and wellbeing of the local community, and I was fortunate to meet with several of them and hear their evolution and impact. The following words describe their story of how over a 22-year period they evolved from caring and supporting in silos to leading and being part of an ecosystem for their community with nationally recognised impact. It is written with enormous admiration knowing how their combined commitment wonderfully serves a community very much in need. Together we had a giggle at how I came to find them. Thank you, Google!

Figure 1. The Care Team with Sarah Henry (author) - Camden Coalition – Philadelphia

In 2002, the Coalition was literally born out of a community need where high numbers of complex clients were being seen presenting to hospitals' emergency departments. Multidisciplinary representatives from a range of organisations (community and acute) came together **sharing their data and collaborating** to identify those who were Frequent Flyers or Health Care Hot spotters in either admissions or presenting to ED.

After years of collaboration, in 2007 the Camden Core Model was implemented with the support of a new Health Information Exchange allowing all partners in care to access and be informed in real time. They recognised that no one program or service can address all an individual's complex health and social needs, but together they sought to respond to barriers and gaps that people face by addressing them directly and at a systems level. This was just the beginning of their combined works and achievements.

The Camden Core Model is a **care-transition program** designed to improve patient health and reduce hospital use among some of the least healthy and most vulnerable adults in the United States. Participants are enrolled and an interprofessional team of nurses, social workers, and community health workers visits them in the community, helping them to reach their own goals for health and well-being. (9)

It commenced with every Clinical Patient Navigator (or in Australia, Discharge Planner) partnering with a community health worker with access to specialist assistance (eg housing assistance; an increasing problem here in Australia). The CHW's worked to become a trusted partner supporting patients with their meetings and appointments with primary care, motivating, coaching and helping with applications for public benefits, ensuring access to social services and housing agencies. They coordinated the activities of care providers and sought to build the independence of the individual to be autonomous. Importantly they focussed on addressing the root cause of becoming unwell and what the person's own health goals were. Most of the support at this time was either post discharge for short period (usually 4-6 weeks) or in the primary care settings that often focus on a specific chronic disease. (8)

Following a review, it was recognised that there was an opportunity to identify people sooner, begin that relationship development with the CHW to support timely discharge when the person was first admitted to hospital. Australia has this same opportunity. In Australia discharge planning is something that is done with varying degrees of success largely due to the focus/care for the reason for admission, and post discharge needs are often not considered early enough which can sometimes delay discharge. The opportunity to have reduced length of stay by having a Community Health Worker supporting the complex older person in the hospital identifying needs and health goals early during their stay in hospital is significant. (8)

Camden Coalition achieved this, by placing two community health workers permanently into the hospital. It increased the ability to increase the numbers of people they could reach, began to reduce length of stay and it built relationships within the hospital with health system staff. The Community Health workers began to be recognised as valuable members of the health care team. This then allowed the Clinical Teams to focus on treating the clinical reason for admission, the Community Health worker to work on the root causes for admission, share findings with multidisciplinary team, plan for successful discharge, reduce readmissions (Case Management and Coordination) and Care Teams to focus on Community based supports, making efforts more efficient. (8)

The Camden Coalition realised that creating partnerships and performing a supporting and coordinating role was more effective to clients and so their focus began to shift to this from 2007-2011. Using the Health information Exchange (central client record) in 2012-13 they began using a triage methodology which allowed real time patient identification, this was done manually by the Coalition's team members, however the potential to use algorithms here in Australia exists. These work to identify social determinants of health and chronic disease. Camden Coalition specifically sought to mitigate hospital use by delivering care management to those who presented with both medical and psychosocial complexities, including two or more chronic conditions. They learnt who would best respond to the care management and navigation services, excluding those who they knew would not benefit such as those already in residential care, those who do not have the capacity to fully engage in the intervention. (8)

From 2014 -2017 they continued to expand their interventions and began broadly sharing their knowledge and findings. This included adding a staff psychologist who provided additional support to clients, the care team and partners, by providing direct services and training, forming a hospital bedside enrolment and engagement team. It also included building a housing first program because this began to surface as a major barrier to health and stability, something we are seeing here in Australia, particularly for single women over 65. They learnt that patients were often struggling to engage with a primary care provider and so made a 7-day pledge to ensure follow up appointments following hospital discharge. This involved working alongside of GP's to design workflows which would allow this to occur. (8)

Next came partnering with researchers to conduct a randomised trial, wanting to learn more about how the model could affect patient outcomes. During this time, they were being seen as innovators in care management, which led to others becoming interested in their work. Next came the development of the COACH framework – recognising that patients seemed to do better with "authentic healing relationships" having a secure, genuine and continuous partnership with patients. The development of My Resource Pal – a centralised resource that allowed standardisation of methods, developing a comprehensive resource library of all services within the Camden region. Ultimately it became a Toolkit for the Care Team, like the Toolkit we have for Case managers in Out of Hospital Care.

A significant marker was creating the National Center for Complex Health and Social Needs in 2016. It serves as a professional centre to unite, educate and connect individuals and organizations caring for people with complex health and social needs. Partnering and creating relationships across sectors was important to enable access for patients to various supports (9) While my paper does not focus on the model produced at that time specifically, its value is worth sharing because it addresses the importance of cross sector collaboration, recognition of the concept of complex care and someone leading it and I hope it prompts further action in Australia. See below the Blueprint for the Complex Care Ecosystem. (8)

What is Complex Care?

Complex care seeks to improve the health and well-being of a relatively small, heterogenous group of people who repeatedly cycle through multiple health care, social service, and other systems but do not derive lasting benefit

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Evidence of Impact

Researchers conducted a trial to test the difference between the post discharge model and the care transition model. The findings are significant to consider in relation the the Out of Hospital Care Program. What they found was that a model which engages the patient after discharge has little change in readmission rates however care transition programs which start with patients in the hospital, working with them after discharge has shown substantially reduced admissions. (9) Following sharing these results, the Coalition received national attention from the media as well as support from the federal government and the model has been expanded nationally.

A secondary analysis of their findings sought to determine whether outcomes following the Care Team's intervention were different for those patients who were more or less likely to engage with care management. The secondary review of the data about 782 participants showed that greater intervention participation was associated with significantly lower readmission rates 30 to 90 days after hospital discharge and significantly lower 30–180-day readmission counts. In summary, the service is effective and worth trialling here in Australia. (10)

06

International Learning – IMPaCT (Individualised Management for Patient Centred Targets)

> *"the IMPaCT model has been designed and placed through rigorous testing by Dr Shreya Kangovi and colleagues at the University of Pennsylvania. This work has resulted in a model that allows for replication across different groups, diseases and settings and is scalable." (11)*

The IMPaCT model, which focusses on the impact of Community Health workers on the health system and community, began in 2014 and is successfully being used by more than 50 health systems across 20 States in the US. As I write this paper, I am seeing this wonderful, clinically tested and proven model, expand with new leadership roles being advertised. I was fortunate to visit the Community Health Worker team at IMPaCT HQ at Penn Health, Pennsylvania and see the Community Health workers at work in the office. I then met with the leadership team in Nashville who were celebrating with Tenn Care, a new local team of Community Health Workers working to the IMPaCT model.

Figure 2. Dr S Kangovi, Dr M Knight, S Henry(author), D Alley

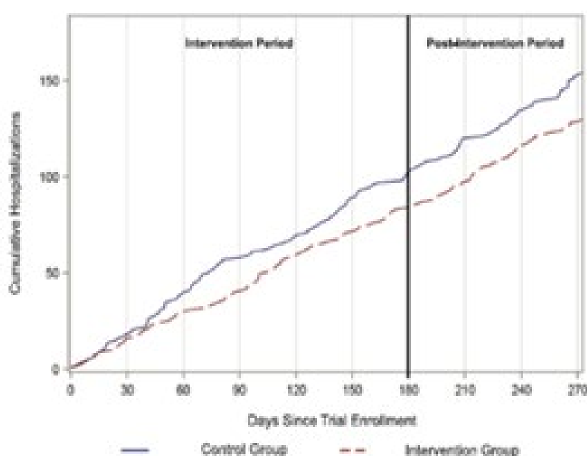
The message was clear to the Community Health Workers – " you are valued and you are making a difference…….". The model was co-designed with patients to improve health outcomes. Instead of a top-down prescription, the designers of Penn's IMPaCT Model listen to patients, connect with the community and highlight people's strengths in a truly community-focused effort to improve health. (12) As I sat in the room with Community Health Workers hearing their stories it was clear to see that truly listening was central to their message and stories of success. I could hear from the various stories that for a lot of patients, partnering with a Community Health Worker was the first time they had felt truly heard or seen. They talked with compassion and described ways to achieve efficient and effective outcomes, guiding clinical integration and ensuring care is patient focused.

In theory it sounds simple because the focus is on authentic trusting relationships, but the success is in the detail. The model has been well planned, standardised, evidenced and tested rigorously by researchers at the University of Pennsylvania. (12) It focuses on a specialised hiring process, standardised workflows, health system integration, has measurable outcomes and is supported by a technology called Home Base which allows Community Health Workers to manage their caseloads, with easy access to their patient's goals and progress. Managers can monitor the performance of their Community Health Workers and patient outcomes and manage CHW workloads.

It began by implementing and testing the Community Health Worker IMPaCT model at Penn Health on a ward where medical and nursing students were also in training. As CHW's shared their stories and results, a cross-sector relationship began to develop, their role becoming highly valued. Today, medical and nursing students at Penn Health can now select to complete the CHW training to get status as part of their courses. This includes going out into the community following the client from admission to home to independence plus their course training. Not only did Community Health Workers tell their stories and share their learnings, they collected data to evidence their value.

Evidence and Impact

IMPaCT has conducted multiple clinical trials on their model and like Camden Coalition continue to improve their model. Their first randomized control trial, published in Journal of American Medical Association (JAMA) Internal Medicine in 2014, focused on hospitalised patients.(13) In August of 2017, the second RCT, published in American Journal of Public Health, showed improvements in hospital admissions, chronic disease control, and mental health for patients with chronic health conditions. (14) The third multi-site RCT, published in JAMA Internal Medicine in 2018 demonstrated improved health, quality and reduced hospital days across multiple outpatient sites. (15) In 2019 they published a seminal cost-effectiveness paper in Health Affairs demonstrating that IMPaCT returns an annual $2.47 for every dollar invested by Medicaid. (16)



- $2.47:1 ROI
  $2,500 savings per person per year
- Higher quality
  CAHPS/HCAHPS
  Primary Care Access
  Chronic Disease Mgmt.
  Mental Health
- 70% Patient Engagement 91% completion of 6-month program
- 94% Net Promoter Score
- 66% of Total Hospital Days
  Compared with matched controls
- 2% CHW turnover

Patient population: adult Medicaid or duals, live in high poverty ZIP code, with at least one hospitalization in past year or ≥2 chronic conditions (e.g. smoking, obesity, DM, HTN)

Of particular interest was the detail in this study that reviewed the effects of a standardized community health worker intervention on hospitalization among disadvantaged patients with multiple chronic conditions. Its intent was to analyse the effects of this practice. The principal findings found that *"Over 9398 observed patient months, the total number of hospital days per patient in the intervention group was 66 percent of the total in the control group (849 days for 674 intervention patient's vs 1258 days for 660 control patients, incidence rate ratio (IRR) 0.66, P < .0001). This reduction was driven by fewer hospitalizations per patient (0.27 vs 0.34, P < .0001) and shorter mean length of stay (4.72 vs 5.57 days, P = .03). The intervention also decreased rates of hospitalization outside patients' primary health system (18.8 percent vs 34.8 percent, P = .0023)" (14 - Abstract)*

Due to increased demand in requests for training, the IMPaCT team is now working with the John Hopkins School of Nursing to develop and deliver standardized Community Health Worker training that can be adapted to the local setting. The success of the model overall has seen expansion of IMPaCT as drivers of change in recent months. The model has some alignments with the CAPABLE model which is a clinically led model using an OT and Nurse to support home successfully.

07

International Learning – CHSSN (Community Health and Social Services Network)

The Community Mobilization Model – Quebec

The Community Mobilization Model was designed through a collective vision of CHSSN and 23 community health and social service networks over several years to create a network to improve the health and wellbeing of English-speaking communities in Quebec. Within these organisations Community Health Workers actively run programs promoting wellbeing and independence. I was fortunate to visit many of these with the team from Montreal. It is another example where a clear Service Model and Vision with strategies, has proven to be effective and again, it has been continuously improved and extended, and they have evidenced their success through data collection. This model has been so successful it has been applied in the education setting also.

Using communities of practice across sectors to support health systems is an important strategy in the model. It includes sharing common concerns and passions, exploring ways to be creative and innovative to ensure the wellbeing of their community, provide support, information and inspiration. It includes problem solving, sharing resources, coordination and synergy – joint efforts to apply for grants etc., discussing developments and change, informal mentoring, training, recognition, relationships and fun and celebrating success. (17) As I visited members of the Network it was clear to see the importance they place on this relationship. **Networking** involves building relationships with health and social service providers. **Representation** meant ensuring that there was a voice at the decision-making tables on behalf of English-speaking communities and that their needs are communicated. Building **knowledge** and evidence of the needs of the English-speaking community and their priorities. Relationship building through **partnerships** with service providers aimed at ensuring access and awareness of services for English speakers.

On a practical level, Community Health Workers were seen to be running journaling and mindfulness sessions to encourage autonomy, social group gatherings, walking groups, exercise classes and craft providing many older people with purpose and connection.

The following diagram from CHSSN demonstrates the ecosystem model very well. (18)

Community Mobilization Model for Improving Health and Well-being of English-speaking Communities in Quebec

AGENTS OF CHANGE

English-speaking Communities

DESIRED OUTCOMES

Increased Access to Services | Improved Health & Well-being

KEY STRATEGIES

Networking | Representation | Knowledge | Partnerships | Outreach

IN COLLABORATION WITH

Health & Social Services System | Governement, Institutions & Municipalities | Community Organizations | Private Sector & Foundations | Education Sector | Social & Cultural Groups

SUPPORTING VULNERABLE POPULATIONS

PRIORITY HEALTH DETERMINANTS

Accessing Health & Social Services | Social Supports & Coping Skills | Healthy Behaviours | Language & Culture

BUILDING COMMUNITY CAPACITY

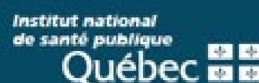
VALUES

Identity | Equity | Diversity | Inclusion

Model developed by

COMMUNITY HEALTH & SOCIAL SERVICES NETWORK

In collaboration with



Financial contribution by

Health Canada Santé Canada

In the city of Quebec, I was fortunate to see where the Liaison officer - Steve (a CHW) visits those who live in remote areas and locally for those with limited English who require hospitalisation. The CHW creates a connection with English speaking patients in advance of admission, supporting them to prepare for treatments and taking them to the hospital as a support person to translate, coordinate transport, accommodation etc and to ensure the person can communicate with Health professionals. He makes sure the person understands what will happen and what to do on return home and coordinate supports that may be needed on discharge.

The language laws in Quebec mean that no information is provided in English even in a Health setting. Hospitals can be overwhelming and the challenges a person who does not speak French can have is immediately evident by the Directory at the hospital entry. All paperwork including consent for procedures is in French and Liaison Officers such as Steve (seen below) are needed to interpret and support understanding by both parties between the Doctor and the patient.

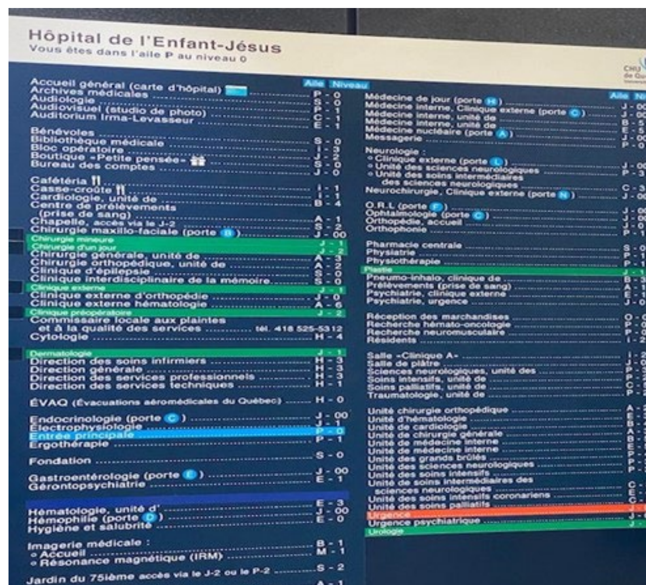


Figure 3. Directory at Entrance to Hospital

Figure 4. Steve (CHSSN Liaison Officer), Patient and support person (also English speaking – Australian)

Key Learnings

Before considering how components of each organisation's use of Community Health Workers could apply in the Australian context, I considered what my key takeaways were from my visits. They were:

1. **The Community Health worker is a valued member of the community and the health care team.** This was reflected across the US everywhere I went – New York, Philadelphia, Tennessee, New Orleans and speakers from the many States who presented at the National Case Management conference I attended. In some cases, the Community Health Worker was paid above award wages due to the value to the community.
2. To quote Gail Anderson (Camden coalition) **Community Health Workers are "your feet on the ground, your foot soldiers meeting people where they are at".** This view made me reflect on the hierarchical nature of acute care and how patients are often passed from one service to the next often with low levels of health literacy and understanding.

3. **Recruitment of the right people into Community Health Worker role** is key. They must be great communicators at all levels, invested in their community, have local service knowledge and committed to supporting others through to independence all while being able to manage professional boundaries well. They can provide insights into how to best service the community.
4. **Training of Community Health Workers must be consistent, but also localised** and competencies reviewed in practice by Team Leaders regularly both face to face and written. Kaiser-Permente were leaders as implementing the role into their health system.
5. **Clear workflows and escalation points** are important in order to ensure Community Health Workers 'stay within their lanes'.
6. **Supervision, Care and Support of Community Health Workers** is important in preventing burnout and to empower them to support others. There has to be fluidity between community and health for Community Health workers, so that they remain trusted partners of both.
7. **Successful models with CHW's were not achieved alone**. Collaboration of roles and sectors must take place, between the State Health, Federal Health, Community and Acute with a shared purpose for their local health district.
8. **Sector Collaboration - Someone must lead and be funded to deliver the strategy, actions and evaluation**. A range of hospital avoidance models were tested having both systemic and/ or individual impact at different rates but to take this support to the next level having more preventative impact an ecosystem that crosses sectors is where even greater impact can be achieved – a step beyond the purpose of my paper.
9. **Trial and continue to improve** - The models most successful were the ones continuously reviewed and improved through learnings and several years – rather than restarting new ones from scratch.
10. **Knowing the needs of your Local Health district** was also highlighted as being very important as each area will differ. Funding and assigning an organisation to be responsible for presenting this to the collaborative group is required for strategic planning.
11. **Understanding who the Complex Client is** important to ensure the resources are allocated to those with the greatest need and greatest ability to benefit.
12. **Access to information and ability to document in central records** is incredibly important to build the story of the person and reduce the need for the person to continually share their story.
13. **Scientific Data Measurement and storytelling to demonstrate outcomes are crucial to recognition of value** to provide evidence of the benefit of the work they do and to reflect on their practice. In Australia, this is something we struggle to do well. Evaluation is important in determining impact to those you serve but it is also important in demonstrating to funders the impact and reach that is made.
14. **Continuous development and career opportunities** are necessary.
15. **Safety Protocols** are crucially important to have in place and be part of their training.

08 Recommendations for Australia

While the concept of an 'ecosystem' is difficult to define and deliver, like Camden Coalition, IMPaCT and CHSSN have demonstrated, you continue to build on what you have learned, not give up.

And, while I fundamentally believe that those funding and providing health and community services in Australia have a willingness to collaborate, the demand on those sectors means resources are easily diverted to 'service delivery'. Meanwhile, the Agency for Research and Quality in the United States has recently committed 25 million dollars of grant money to person centred programs that improve behavioural health and reduce disparities, specifically naming Community Health Worker programs as an example of interventions they want to support.

In formulating my recommendations below, I have focused on how to maximise the potential of existing community health worker workforces and how they can contribute to positive change for the older person and our health system. The two with the greatest potential follow.

Recommendation 1 – Community Health Navigation Support upon arrival at ED – shortening length of stay and reducing hospital admissions and readmissions.

Currently in Australia, the New South Wales Ministry of Health offers an Out of Hospital Care Program for those who suffer from acute or chronic health conditions, disability or terminal illness that impacts on their ability to manage their activities of daily living and therefore puts them at risk of unnecessary hospitalisation. This consists of Case Management support from a non-clinician on discharge home. It is used when:

- a patient requires immediate access to case management and home care for a safe discharge home or to prevent an admission or readmission to hospital
- services are not in place or cannot be immediately accessed through other programs
- no informal support options such as family or friends are available for the patient

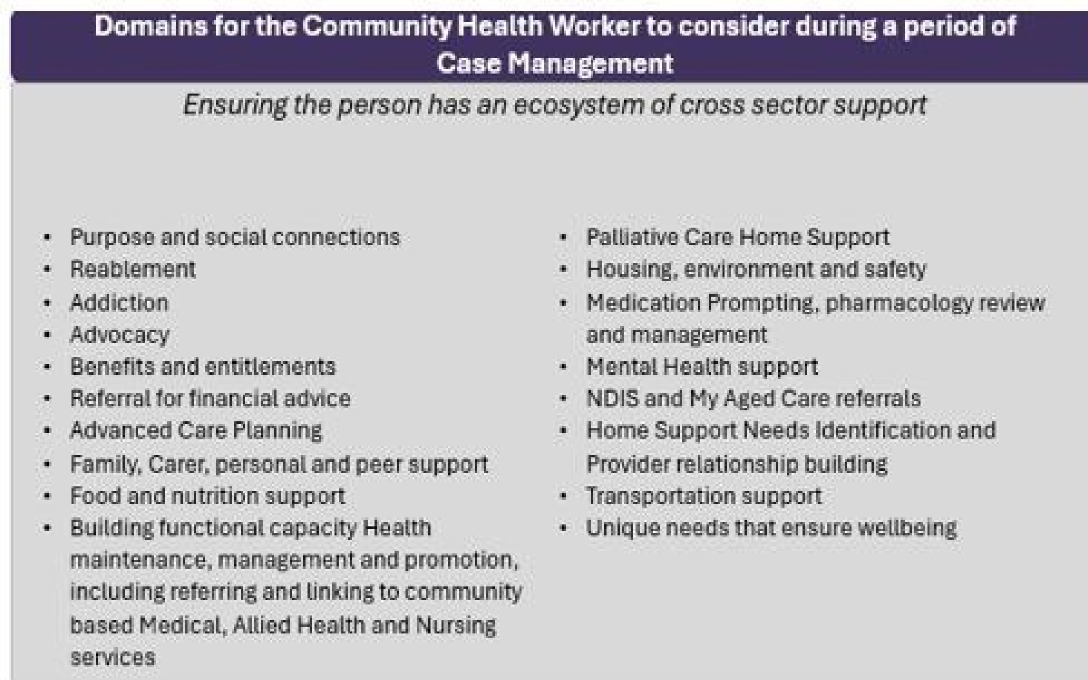
A range of other models are offered in other states which are largely clinically led and delivered but with a primary focus on safe and supported discharge, like the Out of Hospital Care program.

Figure 5. ACNA's Case Manager Hayley on her way to visit a patient at Nepean Hospital

But, as I learned from Camden Coalition and IMPaCT, the potential to prevent hospital admission is significant through the active role of a Community Health Worker. The proposed model (below) expands on the current NSW Out of Hospital Care model as demonstrated by Camden Coalition and IMPaCT by supporting people dealing with complexities, that brought them to hospital for assistance, but who do not require hospital admission and who require support to prevent readmission. It represents a great example of cross sector collaboration to address root causes and therefore prevent hospitalisation.

It sees the expansion of Out of Hospital Care Case Manager roles to be more proactive, providing support at the point of entry to hospital (whether admitted or not) and providing immediate practical assistance (such as transport and food) while providing linkage and support for Social Determinants of Health (SDOH) and health factors that may influence the likelihood of hospitalisation.

Recommendation 1 - Model



"Social determinants of health can either strengthen or undermine individual and community health and they significantly affect our chances of staying healthy as we age". (19) For those who are negatively impacted by SDOH's as you can see from the domains above, the Community Health Worker can play a key role and can positively contribute towards ensuring access, support, coordination when needed, and motivation and education to achieve autonomy and independence. These do not always require clinical intervention and yet in Australia are largely responded to by clinicians. In the US the Community Health worker actively works under the supervision of a Clinician to address the following social determinants of health.

- education,
- unemployment, conditions of employment,
- Income- poverty
- housing instability
- residential environment,
- social capital,
- social exclusion,
- mental health
- early life- child welfare
- criminal justice

Given that risk of hospitalisation algorithms using SDOH's, and Health Indicators are in place and / or are being further developed in other States of Australia within our Health system, the opportunity to identify people suitable for this support is made easier and faster to respond, but this can also be achieved manually through the review of medical records, like Camden Coalition and IMPaCT.

The potential to build on the existing the (Out of Hospital Care) program, existing ACNA workforce (Out of Hospital Care Case Managers), and existing relationships between Case Managers and Out of Hospital Care Relationship Managers at Local Health Districts and their referrers together with existing strong relationships with community service providers means this opportunity to trial is well within reach and, as I learnt on my Fellowship, will deliver even more positive outcomes for both individuals and funders.

Recommendation 2 – Community Health Worker Access and Support through Aged Care Assessment to prevent unplanned hospital admissions

A study by Inacio et al 2021, sought to identify the most common Healthcare-related factors that influenced hospitalisation of over 65's in Australia. It hypothesised that many hospitalisations could have been prevented if additional action to reduce risk was taken at the time of assessment by linking with multidisciplinary teams and geriatricians when needed. (20)

The paper considered the number of hospitalizations (unplanned and potentially preventable hospitalizations with each record treated as a new hospitalization), ED presentations, and cumulative length of hospital stays and whether they had been recently assessed by the Aged Care assessment team. (20)

The data identified the more common health factors were:

- Chronic health conditions – specifically heart and lung related
- History of falls
- Dementia
- Incontinence
- History of delirium
- Medication numbers and types
- Frailty scores
- Location – major city, regional and remote.

Approximately 500,000 older Australians are assessed each year for aged care support with approximately 50% of them assessed by a **non-clinical, national, consistently trained** workforce.

Almost all the factors identified by Inacio et al are currently in the integrated assessment tool used by the Regional Assessment Service- a non-clinical assessment workforce of more than 1000 nationally trained and accredited assessors. However, the role of the assessor currently is to provide access to aged care – not to prevent or delay unplanned hospital admissions.

There is a significant opportunity for this existing, funded workforce to also respond to the known risk factors which may result in hospitalisation, by motivating and coaching people on how to remove barriers which contribute negatively to impact their health, refer them to the right people at the right time and prevent them from presenting at an emergency department.

Funding and training this non-clinical assessment team in preventative actions linked to the issues raised by the nationally consistent, Integrated Assessment Tool (IAT) are likely to reduce the number of people hospitalised as found by Inacio et al. A one-off assessment and referral for services for those at risk of hospitalisation (a subset of those assessed) is not enough. The Aged Care Integrated Assessment Tool currently identifies people who have higher needs than the Support at Home Program will offer, however the ability for the Aged Care assessment tool to also further identify people who are complex and at risk of hospitalisation leading to preventative actions as a result, would see factors influencing hospitalisation being better addressed in the community by the non-clinical workforce (the Community Health Worker).

Currently the model is not adequately funded to support Case Management for the number of complex clients being seen. The principles of reablement (not generally a term used in the US or Canada, although often applied in principle), motivational coaching and case management are successfully used by both the IMPaCT program, Camden Coalition and CHSSN over a short period of time (generally 6 weeks, but can be extended with funding approval) because they focus on what is important to the individual that builds confidence, autonomy and the ability to better manage their own health, in turn reducing admissions and readmissions. The potential for Australia's Aged Care nonclinical assessment workforce to actively contribute towards reducing admissions is an opportunity not yet realised.

While identifying risk and acting is important, responding in a timely manner is also important and this remains a challenge in Australia for the community both with funding and workforce shortages. Importantly, pulling a lever (using a supporting nonclinical workforce) to ensure our clinical workforce is available to do technical clinical work in the community must be recognised, trialled and valued.

Below are abridged examples of Assessment questions used by CHW's with Complex clients that aim to identify what matters to the person in general **and** in health to the person, to learn and respond to the root causes of why the person became unwell and if there are lifestyle or behavioural changes that could be supported to make sustainable change for the individual. The tool also had a scoring method which identifies when a referral for follow up by a clinician should be made. Another standout item not currently being addressed at assessment, is asking the person if they wish to have an Advanced Care directive and supporting them to get it. Many people don't even know they exist and that they can choose to have one in place.

Below are examples of questions using a conversation style by the Community Health Worker at admission include:

- Do you have a primary healthcare provider for your regular physical or psychological needs?
- Have you seen them in the last 12 months? Role……Name…. Date of visit…..
- What made you decide to go to the Emergency instead of your GP?
- Do you think the condition could have been treated earlier?
- Was access to GP a concern?
- Gender, Race, Ethnicity
- Language
- Education Level
- Do you have an Advanced Directive? Would you like to have one? Explain and support to do this.
- Individuals' perception of own health. Excellent, Very Good, Good, Fair, Poor.
- Flu Vaccination Y/N date ….., Pneumococcal Vaccination Y/N date….., Covid Vaccination Y/N date….., Shingles Vaccination Y/N in past 5 yrs date……..
- Would you be willing to use an electronic device to have a video appointment with any of the following – Dr, Social Worker, Physical Therapist, Occupational Therapist Y/N Specify……..
- Can you perform your day-to-day activities without painkillers?
- Do you need assistance taking your medications?
- Have your medications been reviewed by a pharmacist in the last 12 months?
- How many times have you gone to the Emergency Room seeking help?
- Have you been admitted to hospital in the last 12 months, if yes
  - How many times? Within the last month, the past 2-3 months, the past 4-6 months
  - Which One?
  - When was your most recent admission?
  - How long did you stay in hospital?
  - What was the reason for admission? Physical health and mental health reasons
  - Assessment of alcohol use – referral needed

  - Y/N
  - Assessment of drug use, including nonprescribed – referral needed Y/N
  - Activity and Diet
- How a person feels about various aspects of their life (Hardly ever, Some of the time, or often)
  - How often do you feel you lack companionship?
  - How often do you feel left out?
  - How often do you feel isolated from others?
- How often you see or communicate with other people
  - Thinking about your family, friends or neighbours
    - How many of them do you see face to face at least once a month?
    - How many do you communicate with on a personal level by phone or electronically?
    - How many of them do you feel close to on a personal level?
- Thinking about the relationships you have with individuals or groups you are part of
  - Are those relationships fulfilling?
  - Do you feel you belong?
  - Would you like to be more socially involved?
- How the person feels about food security
  - Do you ever worry whether you will run out of food before you have your next lot of money to buy more?
  - Do you ever miss meals because you don't have enough food?
- How the person feels about their living circumstances and safety?
  - Do you have a permanent residence?
  - Do you ever worry about being able to afford to stay in your home?
  - Do you feel safe with your current living arrangements?
- Mental Health
- Cognition
- Falls History
  - Do you feel unsteady on your feet like you could fall? Y/N
  - Are you limiting your outings or travel due to fear of falling?
  - Have you fallen in the last 6 months?
    - How many times?
    - When was your most recent fall?
    - Where did you fall?
- ADL assessment
- What matters Most to you? - This is the most important question of all in the view of those performing these assessments.
  - We've talked about a lot of different health related issues. If you could work on improving one health issue over the next 6 months, what would it be?
  - What one thing generally is most important for you to improve?
    - SMART GOAL
  - ohat is something you love doing that you can't do now?
    - Why?
    - SMART GOAL
- What do you believe are the things are impacting you that made you become unwell?
  - Explore/ Resolve with a SMART Goal.

Summary

- Root cause identified by the individual
- SMART GOALS addressing health and social impacts (root cause)

- Referrals – Service
- Referrals – Health and Social Care
- Case management Actions
- Reablement, Autonomy, Treatment, Confidence, Access, Health literacy, Motivation
- Outcome at 6 weeks

There is significant alignment between these questions/domains and those of the aged care Integrated Assessment Tool. The proactive use of aged care assessors to identify people at risk and provide coaching, mentoring and case management support is likely to have result in similar outcomes achieved by Camden Coalition, IMPaCT and CHSSN.

09 Personal and professional impact

Throughout my travels I sought permission to record the conversations that were had. I have listened to those hours of recordings repeatedly; I have read article after article, I have had many conversations with well-respected peers in Australia, and it all confirms what I have believed and observed in practice, with current and previous nonclinical colleagues for many years.

Through my career I have sought to influence the standard of care and assessment for the older person by upskilling frontline workforce through leadership roles. As a clinician myself, I now have the confidence to publicly want to advocate on behalf of this workforce, to support them to continue to develop, to connect, to collaborate and give them confidence to bridge the gap between sectors and ultimately to ensure older people remain well wherever they choose to be in the community.

I acknowledge that there is no one solution to the challenges we are seeing in Aged Care and Health, but we need to listen more to the person in need. Recommendation 1 is a model that could be implemented quickly as we have a qualified, trained workforce in place. My organisation Access Care Network Australia is ready, it is supportive of trialling, contributing to research and sharing publicly the findings with a longer-term goal of making a significant difference for older people who might otherwise be caught in the acute health system unnecessarily. As a test, I presented my thoughts to a team of 24 Case Managers and the reaction in the room was one of excitement and anticipation in the hope something will result from these findings, with a lot of belief in the benefit it would deliver. I also presented the concept to a clinician at a NSW LHD and the reaction was one of interest and enthusiasm to learn more. Preliminary discussions have commenced with one health district and conversations with researchers are taking place.

ACNA is also well placed to also lead Recommendation 2, working across both Aged Care and Health sectors currently. ACNA is known for placing the client at the centre, being innovative, flexible and being changemakers and is a trusted partner of the Department of Health and Aged Care. I am confident that progress can be made to provide government decision makers with evidence based on the Australian context.

By using the known risk indicators and complexity scoring from the Integrated Assessment Tool there is a significant opportunity to have a greater impact at a very, very minimal cost.

10 Conclusion

This paper has shown that there are international examples of success by the Community Health Worker in addressing the unidentified and unmet needs which present as risks for hospitalisation for the older person. Both recommendations are about authentic partnerships between the nonclinical health worker and the client reducing risk by building their autonomy, health literacy and control over their wellbeing with an ecosystem of support they can confidently draw on when needed which is likely to result in reduced hospital admissions.

Recommendation 1 – Supports the person to recover and achieve independence in their own environment. I will share my paper and learning with the NSW Ministry of Health – Out of Hospital Care, Integrated Health Unit and Local Health Districts in NSW with an intent to further represent the value of a new model of non-clinical case management seeking an opportunity to trial. Additionally, my paper will be shared with researchers at University of NSW and Flinders University who have a keen interest in this topic and have experience in the collection of data and evaluations. What happens next?

- Begin the conversations with Local Health Districts or Networks in NSW where we have a skilled, trained workforce who are excited and eager to make a difference.
- Seek funding to trial. Once a partnership is established, design a more detailed model that meets the needs of patients at a specific health facility.
- Develop a Governance model together with the LHD
- Define supervision and quality framework
- Defining the complex client
- Review career pathways and job descriptions
- Ensure recruitment materials are targeted to the right person, characteristics, and skill sets
- Design workflows that support the CHW, collaborate with clinical teams to design these, collaborate with patients
- Pending the success and ability to create impact from the trial, share the evaluation outcomes nationally.

Recommendation 2 supports the concept of people ageing in place, where older people with complexities have their risks for hospitalisation addressed through assessment and are supported at home instead of in acute care. Again, this aims to impact not only at an aged care sector level, but also at a health system and individual level.

This is available to us to design, trial and evaluate now and has the potential to have both individual and systemic impact. What needs to be done to achieve this?

- Recognise and celebrate those who are already doing this great work in Australia
- Seek acknowledgement of this potential at a federal level and then funding to lead and trial this work

- Seek funding from my CEO and board to respond to the findings of Il Nacio et al.
- Meet with the Assistant Director Aged Care Assessment with my CEO
- Partner with a research team to ensure that clinical trials are run to measure the benefits.
- Define supervision and quality framework
- Ensure recruitment materials are targeted to the right person, characteristics, and skill sets
- Begin discussions with Health faculties to develop consistent National Training.

The Aged Care Sector is currently undergoing a transformation which aims to respond to recommendations from the Aged Care Quality and Safety Royal Commission. The two recommendations I have made respond broadly to several of the recommendations including – funding based on need, workforce improvements, and support for navigation of the aged care system but also go a step further by linking health to community with a positive flow on effect to the acute sector and clinical workforces. I acknowledge it is not a singular solution, hence my two recommendations based on what I know.

The new Support at Home design is continuing to be developed to help provide support that is more accessible and more responsive to the older person's needs in terms of home support services, but it fails to address all known root causes of complexity from a hospitalization risk perspective because it is largely service driven. Enabling the assessor to partner with the individual (under the supervision of a clinician where required) to ensure social determinants of health and health risks are negated appropriately and coach to build knowledge and autonomy for wellbeing, can reduce the risk of unplanned hospitalisation.

There is no doubt in my mind, based on the evidence I saw on the Fellowship and what I have learnt over the years, there is significant potential in expanding the role of the My Aged Care Assessor to reduce hospitalisation and readmissions, and further extending the role of the Out of Hospital Care Case Manager.

I appreciate the Federal Government has recently made significant investments in the development of the aged care assessment tool and workforce and may seek to see the benefits of their recent improvements before embarking on additional change. But that only inspires me to speak with the decision makers and to my own CEO and Board to fund pilot project/s to test the validity of my recommendation.

I look forward to bringing these two concepts to Australia for the benefit of all Australians.

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12 Glossary

Aged Care Act 2024 - https://www.health.gov.au/our-work/aged-care-act/about

The new Act aims to improve the ways services are delivered to older people in:

- their homes
- community settings
- approved residential aged care homes.

It will:

- outline the rights of older people who are seeking and accessing aged care services
- create a single entry point, with clear eligibility requirements
- include a fair, culturally safe single assessment framework
- support the delivery of aged care services
- establish new system oversight and accountability arrangements
- increase provider accountability through a new regulatory model
- strengthen the aged care regulator.

Case Management

Case Management is a process, encompassing a culmination of consecutive collaborative phases, that assist Clients to access available and relevant resources necessary for the Client to attain their identified goals. Key phases within the case management process include: Client identification (screening), assessment, stratifying risk, planning, implementation (care coordination), monitoring, transitioning and evaluation.

Marfleet, F., Trueman, S. & Barber, R. (2013). 3rd Edition, National Standards of Practice for Case Management, Case Management Society of Australia & New Zealand.

Community Health Worker (CHW) – definition within document

My Aged Care - My Aged Care is the entry point to the aged care system for older Australians. Search | Australian Government Department of Health and Aged Care

Out of Hospital Care Program - The NSW Health Out of Hospital Care (OHC) Program supports patients discharged from NSW public hospitals and prevents avoidable admissions by delivering short and medium-term packages of non-clinical care and case management. These packages offer low to medium levels of care which include non-clinical case management and home care services such as assistance with personal care, housework, meals, transport, respite and social support. Eligible patients may also transition between package types depending on their changing needs. Out of Hospital Care (nsw.gov.au)

Reablement - Reablement refers to short-term or time-limited support that helps a person adapt to changed circumstances, such as functional loss

after an illness or accident, or to regain confidence and capacity to return to their previous level of activity. The goal of reablement is to assist people in maximizing their independence.

Reablement is often seen as a time-limited intensive approach, using strategies, assistive technology, and/or equipment to help improve independence and confidence. Reablement practices can also be used in many areas of service delivery as a technique to promote wellness and empower people to do more everyday tasks for themselves.

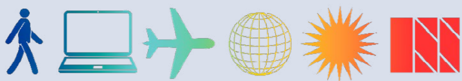
identifying-opportunities-for-reablement.pdf (health.gov.au)

Regional Assessment Service – RAS - The Australian Government funds two assessment programs to provide aged care assessment services – Regional Assessment Services and the Aged Care Assessment Program. Trained assessors carry out aged care assessments to work out whether an older person is eligible for government-subsidised aged care. The Regional Assessment Service performs home support assessments for people who may need entry level support at home.

About the aged care assessment programs | Australian Government Department of Health and Aged Care

Support at Home Program - The new Support at Home program will replace the Home Care Packages Program and Short-Term Restorative Care Programme from 1 July 2025. Support at Home will ensure improved access to services, equipment and home modifications to help older people remain healthy, active and socially connected to their community. Support at Home program | Australian Government Department of Health and Aged Care

Figure 6. Photo at Cummings Community Centre of a community member engaging in a rehab program with a volunteer



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