Received: 5 December 2023 | Revised: 24 April 2024 | Accepted: 14 June 2024

DOI: 10.1111/jgs.19077

EDUCATION AND TRAINING

Journal of the American Geriatrics Society

Community health worker training on older adults: A qualitative needs assessment

Nora Spadoni BA[1] | **Aliza Baron AM**[2] | **Elizabeth Zavala MD**[2] | **Maureen Burns BA**[3] | **Kandis Draw BA**[3] | **Wandy Hernandez BA**[4] | **Jenil Bennett BECE**[2] | **Lauren J. Gleason MD, MPH, AGSF**[2] | **Stacie Levine MD**[2]

[1]Pritzker School of Medicine, University of Chicago, Chicago, IL, USA

[2]Section of Geriatrics & Palliative Medicine, Department of Medicine, UChicago Medicine, Chicago, IL, USA

[3]The HAP Foundation, Oakbrook Terrace, IL, USA

[4]National Association of Community Health Workers, Boston, MA, USA

Correspondence
Lauren J. Gleason, 5841 S. Maryland Avenue, MC 6098, Chicago IL 60637.
Email: lgleason@uchicagomedicine.org

Funding information
National Institute on Aging, Grant/Award Number: 5T35AG029795-16; Health Resources and Services Administration, Grant/Award Numbers: K01HP39479, U1QHP28728

Abstract

Background: Community health workers (CHWs) are frontline public health personnel who serve as liaisons between vulnerable patient populations and the healthcare system. They are instrumental in health promotion and education for urban-dwelling older adults. However, no research exists on training that CHWs receive on age-friendly health care. This article explores CHW education on the 4Ms of an Age-Friendly Health System and identifies areas where additional training may be necessary.

Methods: As part of a two-pronged qualitative needs assessment, four focus groups were held with a total of 17 CHWs and semistructured interviews were conducted with 10 clinicians, including both healthcare providers and social workers. Focus group and interview transcripts were then analyzed for major themes in Dedoose, a qualitative coding software.

Results: Clinicians most often identified Mentation and Mobility as areas where CHWs can have the greatest impact. Correspondingly, CHWs felt under-equipped to assist patients in these areas and expressed strong interest in additional training. In general, CHWs and clinicians agreed that Medications and What Matters do not fall under CHW scope of practice.

Conclusions: Our findings confirm the critical role that CHWs can play in promoting the health and well-being of urban-dwelling older adults. However, we also demonstrate that many CHWs lack adequate training in age-friendly care. To meet the social and medical needs of a rapidly aging US population, there is a pertinent need to develop a novel community health worker training curriculum on Mentation and Mobility.

KEYWORDS

age-friendly health, community health workers, geriatrics education

Lauren J. Gleason and Stacie Levine are the co-senior authors.

INTRODUCTION

The US population of adults aged 65 and older is projected to rise from 54.1 million in 2019 to 94.7 million in 2060.[1] Health disparities among older adults are particularly apparent in diverse urban centers, where neighborhoods are often stratified by race and socioeconomic status. In Chicago, for example, the populations of older Black adults living on the city's South and West Sides experience higher rates of chronic disease and shorter overall life expectancy compared with their non-Hispanic White counterparts.[2] There is an increasing need for community-based approaches to meet the complex medical and social needs of an aging population.[3]

One such approach involves the use of community health workers (CHWs) as conduits between patient populations and the medical establishment. CHWs do not provide clinical care but can facilitate outreach programs for health screening and education. They are often trusted members of the communities they serve and, as such, are uniquely positioned to address health disparities among older adults through advocacy and cultural understanding.[4,5] By partnering with the CHW workforce in diverse urban centers, hospital systems can further expand the Age-Friendly Health Systems (AFHS) movement into underserved aging populations. Launched in 2016, the AFHS movement seeks to improve the care of older adults by focusing on the "4Ms": Mobility (helping older adults move safely), Mentation (identifying dementia, delirium, and depression), Medications (using age-friendly medications when possible), and What Matters (aligning care with older adults' health goals).[6]

Previous studies have successfully implemented CHW-led interventions to monitor medication safety, assess fall risk, screen for depression and dementia, and help older adults manage chronic conditions such as diabetes and hypertension.[7–12] More recently, attention has shifted toward the potential of CHW to facilitate conversations about advance care planning (ACP) and promote ACP documentation among older adults.[13] However, much of this preexisting research focuses on CHW working with rural communities and populations outside of the United States. No published literature exists on the education and training that CHWs, specifically those practicing in major cities, receive on age-friendly care.

The present study addresses a gap in the existing literature by addressing the age-friendly training needs of CHW who work with diverse urban populations of older adults. Through a qualitative needs assessment involving focus groups with CHWs and interviews with clinicians, this study aims to identify areas of older adult health in which CHWs require further education, specifically within the 4 M's framework. We explore the potential of urban CHWs as public health paraprofessionals, their experiences collaborating with geriatric-focused clinicians to meet the needs of community-dwelling older adults, and the relevance of the AFHS 4 M's framework to the future development of CHW training programs.

Key points

- Community health workers are frontline public health personnel and are often instrumental in health promotion and education for vulnerable patient populations.
- This study finds that although urban community health workers regularly assist older adults with medical and social needs, many receive little to no training on age-friendly care.
- Based on their scope of practice, community health workers would benefit from additional education on age-friendly topics such as recognizing dementia and delirium, assessing for fall risk, and addressing mobility concerns.

Why does this paper matter?

Community health workers can serve as trusted liaisons between populations of urban-dwelling older adults and the healthcare system. It is necessary to design a novel age-friendly training curriculum for community health workers to help meet the needs of a rapidly aging US population.

METHODS

Study design

This qualitative study received approval from the Institutional Review Board (No. IRB22-1410) to identify possible gaps in CHW knowledge regarding the 4Ms of the AFHS. We conducted four in-depth, semistructured focus groups with CHW to understand their experience working with older adults, their prior training on older adult health, and their desire for additional training on the 4Ms. Participating CHWs primarily work or volunteer at organizations that serve communities on Chicago's South and West sides. We also conducted 10 semistructured interviews with clinicians—social workers, nurse navigators, and physicians—who work with older adult patients and who currently utilize or might benefit from CHW support. All participating clinicians work in Chicago-based

hospital systems that range from private academic to public county.

Recruitment and eligibility criteria

Study investigators formed an advisory board of four experienced CHWs who work in underserved communities in Chicago. Advisory board members played a key role in assisting with creating study instruments and recruiting a diverse group of participants, in part by contacting CHWs through their own professional communities. CHWs were considered eligible if they had a caseload of at least 50% older adults, one-year minimum work experience, and spoke English or Spanish. Clinicians were considered eligible if their clinical practice was comprised of at least 40% older adults. The methods of CHWs and clinician recruitment included flyer distribution and snowball sampling, in which potential participants disseminated recruitment materials to their networks. Interested participants completed an online screening and consent form. Eligible participants were invited by email to participate over Zoom.

Focus group and interview methodology

CHW focus groups took place between March and May 2023. Each lasted approximately 90 min and was recorded for transcription purposes. Three of the focus groups were held in English and one in Spanish. To reduce bias in data collection, focus groups were conducted by trained facilitators. One facilitator was fluent in Spanish and able to lead the Spanish focus group. At least one study team member was present at every focus group to serve as a timekeeper and notetaker. The focus group facilitator's guide included a series of open-ended questions developed collaboratively by the research team and CHW advisory board. The guide allowed for adjustments as the discussion proceeded. The questions were designed to probe into participants' prior training on the 4Ms and their comfort level implementing the 4Ms in daily practice. The focus groups also provided opportunities for CHW to respond to one another's perspectives and generate a rich commentary about their lived experiences.

Clinician interviews took place between April and July 2023. Each lasted between 30 minutes and an hour and was recorded for transcription purposes. Interviews were conducted by various IRB-approved study personnel. The interview guide asked clinicians to reflect on the structure of their practice, including current or potential areas for CHW contribution to team-based care, and opportunities to strengthen CHW training in the 4 M's.

Data analysis

Focus groups and interviews were transcribed verbatim and compared with the original recordings for accuracy and clarity. The Spanish CHW focus group transcript was translated into English. Transcripts were then entered into Dedoose, a qualitative data analysis software. One member of the study team coded the transcripts for major themes and subthemes; the resulting codebook was amended, adapted, and consolidated as data analysis progressed. Additional study staff validated code applicability through inter-rater reliability tests within Dedoose.

RESULTS

Seventeen CHWs participated in four focus groups, each comprised of three to seven participants, and 10 clinicians participated in semi-structured interviews. Table 1 shows the demographic characteristics of all participants. Sixteen CHWs reported that over 50% of their clients are older adults, while 13 reported that their CHW training included topics pertinent to older adults. All of the clinicians stated that over 50% of their patients are older adults. At the time of their interview, five clinicians were employed as social workers, four were employed as physicians, and one was employed as a nurse navigator.

CHW reflections on their current practice, specifically as it pertains to older adults, were categorized into three major themes:

1. Prior education and experience regarding older adults (Table 2)
2. Desired additional education on older adults (Table 2)
3. General reflections on older adult care needs and cultural norms

Clinician perspectives on the capabilities of CHWs were categorized into two major themes:

1. Perceived roles and strengths of CHW (Table 3)
2. Desired changes in CHW training (Table 3)

CHW themes and quotes

Prior education and experience regarding older adults

CHW reflections on their previous training were subdivided into each of the 4Ms (Table 2). The majority of CHW were unfamiliar with the 4Ms as a conceptual framework, although some described learning about

TABLE 1 Demographic characteristics of study participants ($N = 27$).

Community health workers ($N = 17$)		
Characteristic	**Subcategory**	***N* (%)**
Gender	Female	17 (100)
Age (years)	20–29	4 (23)
	30–39	2 (18)
	40–49	2 (12)
	50–59	6 (35)
	60–69	1 (6)
	Prefer not to say	1 (6)
Race	Hispanic	10 (59)
	Asian	1 (6)
	Black	6 (35)
Highest education level	High school	1 (6)
	2-year college	5 (29)
	4-year college	7 (41)
	Graduate	4 (24)
Primary language spoken	English	6 (35)
	Spanish	6 (35)
	Other or bilingual	5 (30)
Length of CHW work experience	6 months–1 year	4 (24)
	1–2 years	2 (12)
	2–4 years	6 (35)
	>4 years	5 (29)
Percent of clients aged 65 and over	Less than 50%	1 (6)
	More than 50%	16 (94)
Did your CHW training include topics specific to older adults?	Yes	13 (76)
	No	4 (24)
Clinicians ($N = 10$)		
Characteristic	**Subcategory**	***N* (%)**
Gender	Female	10 (100)
Age (years)	20–29	1 (10)
	30–39	6 (60)
	40–49	2 (20)
	50–59	1 (10)
Race	Hispanic	1 (10)
	Asian	3 (30)
	White	6 (60)
Percent of clients aged 65 and over	More than 50%	10 (100)
Type of clinical practice	Hospital-based practice	4 (40)
	Ambulatory clinic	6 (60)
Role	Social worker	5 (50)
	Nurse navigator	1 (10)
	Healthcare provider	4 (40)
Length of employment in current position	<1 year	1 (10)
	1–3 years	1 (10)
	3–5 years	3 (30)
	>5 years	5 (50)

older adult health issues related to Mobility and Mentation. One CHW said her training "taught us the difference between dementia, Alzheimer's, and the different signs. ... it was more or less how to relate to the person."

CHWs mainly shared anecdotes about on-the-job learning experiences, rather than formal education, relevant to Mobility and Mentation. While in patients' homes, CHWs said they felt comfortable identifying fall risks and assisting patients with obtaining a walker or other mobility devices. Some CHWs were trained to screen for depression with a Patient Health Questionnaire-9 (PHQ-9), but none were trained to screen for dementia. "I never received formal training," said one CHW, "but from experience, I think I can identify signs of mental impairment."

Compared with Mobility and Mentation, few CHWs had received training on Medications or What Matters. Some stated that while visiting older adults at home they helped organize pill boxes or notified the patient's care team about a needed refill. Additionally, as CHWs are often able to spend significant time with their clients, some said they informally speak with older adults about care goals. One CHW with prior experience working in a nursing home said she focused on "asking what was important to them and where they were trying to get back to in terms of their health, like with mobility."

Desired additional education on older adults

CHW perspectives on desired education were subdivided into each of the 4Ms (Table 2). Regarding Medications,

TABLE 2 CHW perspectives on prior and desired education on geriatric care.

	Prior education and experience regarding older adults	
	Summary points	**Representative quotes**
Medications	• Few had formal training	"I don't think I've ever received any direct training as a community health worker. We always redirect patients to have that conversation with the provider."
	• Some described helping patients keep their medications organized	"We remind clients there needs to be strict control regarding how much a certain medication to take and a method to organize." (*trans. from Spanish*)
Mobility	• Few had formal training	"My training was more so resources on getting assistance with mobility. ... getting the cane or walker, things along those lines."
	• Some had on-the-job experience assessing fall risk in patients' homes	"I have very little experience in this specific area, but. ... sometimes it comes up with, like, they're having difficulties with their activities of daily living."
Mentation	• Few had formal training or experience	"Some things I learned with experience, not necessarily training, is to just be patient and reassure the person that it's OK. Take your time to remember."
	• Some had taken a mental health first aid course	"We screen some of our patients with a PHQ9 and then assess if there needs to be a referral to psychotherapy."
What Matters	• None had formal training in advance care planning • Some described initiating informal conversations about care goals	"I might ask them if there are any goals that they're working on, and that may give me some clues as to what matters most to them, who's important to them."
	Desired additional education on older adults	
	Summary points	**Representative quotes**
Medications	• Interest in training on common chronic conditions in older adults and their associated medications	"I would like to know more about. ... how to address like some of these medication concerns in the population, where sometimes they refused to take the medication, how to navigate that."
Mobility	• Interest in learning how to screen for fall risk and other mobility issues	"Maybe if there was a tool that could help us better assess mobility in and out of the home, I think that would be super helpful."
Mentation	• Interest in learning the differences between cognitive issues such as dementia and delirium	"It may have been nice to have learned how to recognize potential signs of mood conditions like depression. ... requiring referral to a psychologist." (*trans. from Spanish*)
What Matters	• Interest in learning how to navigate conversations about end-of-life care with older adults	"Just the overall education of what the person is currently going through and the possible end results, and what resources to help aid them through that process." "For us being taught how to have that conversation, we can be very impactful." (*trans. from Spanish*)

TABLE 3 Clinician perspectives on the current role of CHWs and desired changes in CHW training.

	Perceived roles and strengths of CHW	
	Summary points	**Representative quotes**
4 M's	• CHW play a minimal role in helping patients with medications or advance planning	"If there was an issue where someone realized like, someone's out of medication or there was an adverse reaction, I don't doubt that [the CHW] wouldn't bring it to us."
	• However, CHW can bring concerns about medication non-compliance, fall risk in a patient's home, or sudden cognitive changes to a provider's attention	"If mobility comes up, [the CHW] would probably talk about it, but ... they're not having deliberate conversations about mobility."
		"[The CHW] is not necessarily focused on helping manage mood, but more kind of noticing if mood may be factoring into an issue, then she'll highlight it to the social service team."
Resource navigation	• Most clinicians we spoke to felt that the most important role of CHW is working with patients to obtain social services	"We have community health workers who can help patients navigate Pace and homemaker services and things that are a bit time consuming for us [social workers]."
In-home interaction	• CHW are uniquely positioned to make observations about a patient's home environment and social needs	"We're dealing with patients who are in and out of the hospital a lot because they're complicated, and so just having yet another way to give them support and to understand what they're dealing with at home and how that has an impact on their health, I think is pretty invaluable."
Cultural bridging	• CHW can bring cultural awareness and sensitivity to their relationships with patients	"I do feel like a lot of consumers relate to CHW's more than they do to social workers or any other profession, just because they're sort of like the bridge between the hospital and the community. They trust them in a different way."
	Desired changes in CHW training	
	Summary points	**Representative quotes**
Medications	• Most clinicians said that CHW involvement in medications should be minimal and limited to helping patients with organization	"Right now the role of CHW is not so much focused on medication, but could there be more push on home visits and then checking with the patient in-person in the home to see if they are taking their medication."
Mobility	• Some clinicians said that CHW need formal training on specific mobility hazards to look out for in patient homes	"It would be relatively easy to teach the information that was needed for them to be able to then intervene. And I think that would be great, because they're already asking lots of questions about the patient's living situation."
Mentation	• Most clinicians said that CHW would require formal training on cognitive decline in older adults in order to screen for them	"We've trained the CHW's in how to escalate things like suicidality and homicidality, but not general concerns about memory impairment."
		"One gap that I've noticed is in the memory piece of things. I think that's not something that [the CHW] is particularly well versed at assessing."
What Matters	• Most clinicians said that CHW involvement in advance care planning should be minimal and limited to informal conversations around care goals	"As long as they have the communication skills that can help to facilitate the goals of care discussion, it doesn't have to necessarily be a goals of care discussion – just maybe a conversation about what's important to a patient."

CHWs expressed interest in basic training on common chronic conditions and the risks of polypharmacy in older adults. Regarding Mobility, while some CHWs felt they could intuitively identify fall risks in an older adult's home, others expressed interest in a concrete screening "tool that could help us better assess mobility."

While some CHWs had taken a broad mental health first aid course, most were interested in learning more about cognitive decline in older adults. One CHW described her uncertainty about how to approach mood fluctuations in older adults, stating that she wanted to know "what is it that I could do to accommodate and be

flexible to how [a client's] behavior might be that day." Finally, CHWs expressed interest in basic training on the various long-term care options available for older adults to better navigate conversations about What Matters. "You know with hospice," asked one CHW, "what comes along with those lines of hospice? Or, if they need to be in a nursing home for a specific reason, what comes along with those lines? So, I guess just the overall education of what the person is currently going through and the possible end results."

General reflections on older adult care needs and cultural norms

Across all focus groups, CHWs made similar observations on the care needs of older adults, particularly those who live in low-income urban communities. Many said that older adults lack adequate support at home and need help accessing resources to remain independent. Other common challenges included low health literacy, difficulties using technology, and pandemic-induced social isolation. One CHW who primarily works with Chinese Americans stated that "among my serving population. ... they usually deprioritize mental health."

CHWs observed that stigma around mental health and memory loss seemed to intersect with older adults' varying cultural norms. "My opinion of older adults," said one CHW in the Spanish focus group, "they have the mentality and culture, especially Latinos, they think, I'm OK, I don't have depression or dementia. ... I just had a lapse in memory" (English translation). Similarly, a CHW who works with predominantly Black populations of older adults told us that ACP is "one subject that they really don't want to talk about. So, we have the conversation but it's like pulling teeth. It's taboo."

Clinician themes and quotes

Perceived roles and strengths of CHW

According to most clinicians we interviewed, a key role of CHW is helping patients access resources such as housing, transportation, public benefits, and homemaker services. By assisting with lower level social needs, CHWs enable clinicians to focus on more complex, high-acuity issues. "It becomes this triage process of, okay, here are some things I certainly know a CHW could address and could probably address quicker than me," said one social worker. Clinicians also highlighted the ability of CHWs to visit homebound patients and keep them connected to their care team.

Most clinicians said they were unaware of any formal training CHW received on the 4Ms but felt that CHWs were capable of noting concerns about Medications, Mobility, or Mentation—particularly during home visits—and elevating these concerns to the patient's healthcare provider. At some institutions, clinicians said that CHWs help patients obtain mobility devices; at others, nurses manage mobility equipment. Most clinicians said that CHWs were not responsible for discussing What Matters with older adults.

Desired changes in CHW training

Most clinicians we interviewed saw the potential benefit of implementing additional training for CHWs on the 4Ms. Clinician reflections were subdivided into each M (Table 3). Clinicians felt that CHW involvement in Medications should be limited to being the "eyes and ears [in patient homes] to then report back to the clinical staff." Regarding What Matters, one social worker said she felt "very territorial" about working with patients on ACP, while another clinician thought that CHW could be trained to facilitate informal "conversation[s] about what's important to a patient."

Clinicians identified the greatest opportunity for CHWs to be involved in Mobility and Mentation. Regarding Mobility training, clinicians felt that CHWs should know how to identify fall risks in the home and discuss mobility challenges with patients. "We can't be in their house with them," said one clinician, "so anything that [the CHW] would notice that could potentially prevent the patient's falls." Regarding Mentation, clinicians felt that CHWs did not have adequate training in dementia, delirium, and other forms of cognitive decline that affect older adults. One said that CHW required "some basic education about like, what is mild cognitive impairment, what is normal aging, what is dementia. They don't have to be necessarily a specialist, but even just equipping them with enough kind of baseline knowledge to kind of have a sense that okay, these patients are going to have problems with short term memory."

DISCUSSION

This study confirms the unique role that CHW can play in building trust with older adults, facilitating community-based health interventions, and helping patients access critical social services.[14] Furthermore, we demonstrate that urban CHWs already assist older adults with Medications, Mobility, Mentation, and What Matters, even if they are unfamiliar with the broader

conceptual framework of the 4Ms. Among the CHWs and clinicians we interviewed, Mobility and Mentation had the greatest consensus as two areas where CHWs, based on their scope of practice, are poised to make the greatest impact.

By combining multiple qualitative sources, this article contributes a novel perspective on the strengths of CHWs working with older adults in resource-poor urban communities. CHWs expressed enthusiastic interest in learning how to better care for older adults, and many spoke passionately about working with aging patients who feel "invisible." CHWs told us that, during home visits, they informally check for fall risks and make observations about changes in a patient's mental status. Despite this, most CHWs feel that they do not have the tools to confidently identify mobility concerns or distinguish between normal and abnormal forms of memory impairment. This lack of knowledge could pose problems, as many clinicians pointed out, because CHWs can have a strong influence on their patients' well-being. As the number of older adults with Alzheimer's is projected to double between 2020 and 2060, it is imperative that CHWs are trained in recognizing the basic signs of dementia and its impact on patient decision-making.[15] CHW training programs do not typically include dedicated education on the general concept of age-friendly health nor on the unique medical concerns of an aging population. As such, we recommend that CHWs receive broad training on the principles of age-friendly health and concrete education on all 4Ms, with a particular focus on Mobility and Mentation.

Recent literature has also demonstrated that Black and Hispanic older adults receive less ACP compared with older white adults, perhaps due to racial and cultural discordance between patients and providers.[16] These disparities suggest that community-based approaches to ACP may help destigmatize and promote the importance of discussing end-of-life care. The clinicians we spoke to largely felt that What Matters, particularly more technical aspects of ACP documentation, should remain under the purview of social workers and physicians. It is also possible, however, that bolstering CHW training and engagement in this space could empower marginalized patients and facilitate meaningful dialogue between older adults and their providers. Further research is needed to determine the extent to which CHWs should be involved in conversations around ACP with older adult patients.

Despite the strengths of this study, some caveats deserve mention. Because we only collected data from CHW and clinicians based in Chicago, it may be difficult to translate this study's findings to other urban centers. Nonetheless, the reflections of CHW were not specific to their experiences working in Chicago, but rather spoke to the spectrum of medical and social challenges that older adults face in cities across the United States. Second, the study's small sample size could limit generalizability. However, from our in-depth conversations with participants, we were able to achieve theme saturation while also recruiting and enrolling a diverse study population. Third, our assessment of CHW education and experience was based on participant recollection; as a qualitative study, we could not account for the significant variability in CHW training programs. More urgently, however, this study's qualitative nature enabled us to gain insight into CHW lived experience, including "'non-traditional' sources of knowledge" that might not reveal themselves through quantitative analysis and are necessary to inform next steps in curriculum development.[17] The heterogeneity of community health work also raises further questions about embedding CHWs in larger networks of healthcare professionals. Although these concerns are beyond the scope of this study, further research is necessary to elucidate the barriers to integrating CHWs into health systems.

In summary, this study supports previous findings that, as CHW scope of practice evolves, there are many ways that CHWs can positively impact community-dwelling older adults. By focusing on the knowledge gaps of urban CHWs, this study also establishes CHWs as important targets for continuing education on the 4M model of older adult care, with a special focus on Mobility and Mentation. Next steps include designing a novel CHW training curriculum based on the input of geriatrics providers, pilot testing it with the intended audience, and determining how to best make such a curriculum freely and publicly available.

AUTHOR CONTRIBUTIONS

Drs. Stacie Levine and Lauren J. Gleason (co-senior authors) oversaw the process of project proposal and grant acquisition. Maureen Burns, Kandis Draw, Wandy Hernandez, and Jenil Bennett, as community health workers with valuable experience and insight contributed to the development of study materials (i.e. focus group and interview guides) and assisted with participant recruitment. Aliza Baron facilitated study logistics such as obtaining participant consent, recording and transcribing focus groups and interviews, and scheduling team meetings. Nora Spadoni, Aliza Baron, Dr. Elizabeth Zavala, Dr. Gleason, and Dr. Levine collected qualitative data by leading focus groups and/or one-on-one interviews. Nora Spadoni reviewed all transcribed qualitative data for accuracy, developed the project's codebook in Dedoose, and coded each transcript. Dr. Gleason and Aliza Baron validated code application through inter-rater reliability tests in Dedoose. Nora Spadoni wrote up

the manuscript. All authors separately read the manuscript and provided feedback.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest, financial or other, to report.

FINANCIAL DISCLOSURE

This article received funding from the Retirement Research Foundation, Health Resources & Services Administration (Grant #U1QHP28728 & #K01HP39479), and National Institute on Aging (Grant No. 5T35AG029795–16).

SPONSOR'S ROLE

None.

REFERENCES

1. Projected Future Growth of Older Population. U.S. Administration for Community Living. 2022 Available from: https://acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population
2. Laflamme EM, de Maio F, Harper-Jemison DM, et al. *Healthy Chicago Databook: Older Adult Health*. Center for Community Health Equity; 2019 Available from: https://www.chicago.gov/content/dam/city/depts/cdph/statistics_and_reports/CCHE-001_OlderAdults_Databook_r5a.pdf
3. Jeste DV, Blazer DG, Buckwalter KC, et al. Age-friendly communities initiative: public health approach to promoting successful aging. *Am J Geriatr Psychiatry*. 2016;24(12):1158-1170. doi:10.1016/j.jagp.2016.07.021
4. Forti EM, Koerber M. An outreach intervention for older rural African Americans. *J Rural Health*. 2008;18(3):407-415. doi:10.1111/j.1748-0361.2002.tb00905.x
5. Kim K, Choi JS, Choi E, et al. Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: a systematic review. *Am J Public Health*. 2016;106(4):e3-e28. doi:10.2105/AJPH.2015.302987
6. Cacchione PZ. Age-friendly health systems: the 4Ms framework. *Clin Nurs Res*. 2020;29(3):139-140. doi:10.1177/1054773820906667
7. Wang CJ, Fetzer SJ, Yang YC, Wang JJ. The impacts of using community health volunteers to coach medication safety behaviors among rural elders with chronic illnesses. *Geriatr Nurs*. 2013;34(2):138-145. doi:10.1016/j.gerinurse.2012.12.013
8. Rahmawati R, Bajorek B. A community health worker–based program for elderly people with hypertension in Indonesia: a qualitative study, 2013. *Prev Chronic Dis*. 2015;12:E175. doi:10.5888/pcd12.140530
9. Han HR, Park SY, Song H, Kim M, Kim KB, Lee HB. Feasibility and validity of dementia assessment by trained community health workers based on clinical dementia rating. *J Am Geriatr Soc*. 2013;61(7):1141-1145. doi:10.1111/jgs.12309
10. Beck C, Fausett JK, Krukowski RA, et al. A randomized trial of a community-based cognitive intervention for obese senior adults. *J Aging Health*. 2012;25(1):97-118. doi:10.1177/0898264312467374
11. St. John JA, Shubert TE, Smith ML, et al. Developing an evidence-based fall prevention curriculum for community health workers. *Front Public Health*. 2015;2:209. doi:10.3389/fpubh.2014.00209
12. Alegría M, Frontera W, Cruz-Gonzalez M, et al. Effectiveness of a disability preventive intervention for minority and immigrant elders: the positive minds-strong bodies randomized clinical trial. *Am J Geriatr Psychiatry*. 2019;27(12):1299-1313. doi:10.1016/j.jagp.2019.08.008
13. Litzelman DK, Inui TS, Griffin WJ, et al. Impact of community health workers on elderly Patients' advance care planning and health care utilization: moving the dial. *Med Care*. 2017;55(4):319-326. doi:10.1097/MLR.0000000000000675
14. Kennedy MA, Hatchell KE, DiMilia PR, et al. Community health worker interventions for older adults with complex health needs: a systematic review. *J Am Geriatr Soc*. 2021;69(6):1670-1682. doi:10.1111/jgs.17078
15. Alzheimer's Association. 2023 Alzheimer's disease facts and figures. *Alzheimers Dement*. 2023;19(4):1598-1695. doi:10.1002/alz.13016
16. Lou Y, Carr D. Racial and ethnic disparities in advance care planning: assessing the role of subjective life expectancy. *J Gerontol B Psychol Sci Soc Sci*. 2022;77(8):1508-1518. doi:10.1093/geronb/gbac003
17. Thompson K, Soo B. Community health workers and care of older adults: how to learn what we need to know. *J Am Geriatr Soc*. 2021;69(6):1466-1468. doi:10.1111/jgs.17186

How to cite this article: Spadoni N, Baron A, Zavala E, et al. Community health worker training on older adults: A qualitative needs assessment. *J Am Geriatr Soc*. 2024;1-9. doi:10.1111/jgs.19077