AltaMed Health Services: The Evolution of our Community Health Worker Program

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AltaMed has embedded community health works since organization’s inception

Multiple uses: community advocacy, disease specific education topics, youth services
“Sometimes were too focused on just their health, but we overlook what they’re experiencing at home” – AltaMed CHW

**Strengths:**
- Had the “right staff”
- In-clinic counseling, education and some resource navigation

**Challenges:**
- Too focused on patient health and medical needs
- Lacked defined patient eligibility criteria
- Limited evaluation
- Lacked standardized structure
Hit “RESET” with IMPaCT Model

Over the last year, the Health Education & Wellness department has been working with consultants from Penn Medicine’s Center of Excellence for Community Health Workers (PCCHW) to adapt and implement their scientifically-proven CHW model called IMPaCT.

Results and statistics
Delivered to over 7,000 patients across disease types, in inpatient and outpatient settings, in academic hospitals and clinics.

Utilized by over 1,000 organizations

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<thead>
<tr>
<th>COST</th>
<th>ACCESS</th>
<th>QUALITY</th>
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<tbody>
<tr>
<td>↓30%</td>
<td>↑12%</td>
<td>↑13%</td>
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fewer hospital admissions*
increased access to post hospital primary care**
increased quality of communication**

*Published in American Journal of Public Health, 2017  **Published in JAMA Internal Medicine, 2014
At AltaMed, we call our CHWs or promotoras:

Community Health Specialists (CHS)
It’s crucial for CHWs to be well supported

- **Directors**: leaders who oversee hiring, budgets, and quality of the CHW program.

- **Managers**: typically social workers who supervise CHWs, ensuring effective patient care and integration with care teams.

- **Coordinators**: individuals who identify and aid in enrolling eligible patients, and collect data to evaluate the program.

- **CHWs**: natural helpers who work directly with patients to set and achieve goals that help patients improve their health
How Does It Work?

The Community Health Specialist (CHS):

- **Enrolls patients into the CHS program** *(currently telephonic only recruitment)*
  - Patients have a starting A1c value of ≥ 10.0
  - Caseload of 25-30 patients

- **Connects with enrolled patients weekly** *(currently only via phone)*
  - Connects patients to resources such as food assistance & transportation
  - Helps patients manage medications & refills

- **Graduates patients after 6 months**
  - Connects them with a long-term support system such as a church or community group

Communicates with PCP via EMR at onset, 3 months, and 6 months
**BEFORE**

Focused on Health Education and patient medical needs

In-clinic counseling & education with some navigation and resource connection

Open to all

No set timeline, intervention loosely structured

Evaluation limited to reach-only (ie. visits + unique pts serviced)

**AFTER**

**FOCUS**

Socially-focused needs

**TOUCHPOINT**

Meeting the patient where they are

**CRITERIA**

Well-defined patient criteria

**STRUCTURE**

Tailored, three-part intervention approximately 6 months (50-60 pts/CHW per year)

**EVALUATION**

Evaluation expanded to: Patient Experience, Patient Needs Assessment & Resolution, Chronic Disease Control
# Measures of Success

## Process Measures:

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<thead>
<tr>
<th>Measure</th>
<th>Definition</th>
<th>Target</th>
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<tbody>
<tr>
<td>% weekly contact</td>
<td>What % of patients are contacted by their CHS each week</td>
<td>100%</td>
</tr>
<tr>
<td>Active caseload</td>
<td># of patients actively enrolled with each CHS</td>
<td>25-30 per CHS</td>
</tr>
<tr>
<td>Enrollment rate</td>
<td>Proportion of eligible and contacted who enroll in the program</td>
<td>none at this time</td>
</tr>
<tr>
<td>Graduation rate</td>
<td>Proportion of patients who enroll and complete the program</td>
<td>none at this time</td>
</tr>
<tr>
<td>% short-term goals achieved</td>
<td>Proportion of short-term goals set with patients that are achieved</td>
<td>60%</td>
</tr>
<tr>
<td>% Patients who achieve long-term goal</td>
<td>Proportion of patients who achieve their long-term goal</td>
<td>55%</td>
</tr>
<tr>
<td>Likelihood to recommend</td>
<td>How likely is it that patient would recommend CHS to family or friend (1-10)</td>
<td>9-10</td>
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# Measures of Success

## Outcome Measures:

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<tr>
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<th>Definition</th>
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<tr>
<td>Chronic disease progress</td>
<td>Reduction in A1c, blood pressure, and/or weight</td>
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<tr>
<td>Preventative health care completion</td>
<td>Proportion of patients who complete recommended preventative care measures within 12 months of program enrollment</td>
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Outcomes to date:
We are still in the process of building and validating clinical outcome reports from our EMR. Below are two examples of patient successes:

Norma Plancarte, Community Health Specialist at Garden Grove, has been working with a 38-year-old patient since early March. In January, the patient’s A1c value was 13.7, and they worked with her PCP to set the long-term goal of reducing her A1c to 8.0 over the course of six months. In the time that they’ve worked together, Norma has connected the patient to food banks, helped the patient navigate her specialty appointments, provided healthy recipes, and encouraged the patient to increase her physical activity. In mid-June, the patient’s A1c was 6.8, surpassing the long-term goal and falling into the “controlled” range!

In early June, a 35-year-old patient was connected with Luz Flores the Community Health Specialist for Orange Chapman and Santa Ana Main. He started the program with an A1c >14.0. They set up a goal to reach 8.0 by the end of their time together (6 months). The patient received nutrition information by mail, and started eating healthily. He started taking medication as prescribed, received a free glucometer, and started a diabetic journal. He started the program unemployed and Luz helped him get a job. His most recent A1c on 08/27/2020 was 6.6.
THANK YOU!

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