How Community Health Workers Can Make a Difference

Case Examples

Case Example 1: Eastside Urgent Care Center

RW is a 43-year-old who has presented 3 times in the last month for "scary high blood sugar and feeling dizzy". He has had trouble getting to his clinic appointments at Family Medicine Eastside and struggles to keep his medications organized. He has missed several shifts at work over the past month because of his health issues. Every time he comes to the Urgent Care Center, he gets a bag of IV fluids, a shot of insulin, and instructions to "eat healthier, take your medicines as prescribed and follow up with Family Medicine Eastside within 7 days"

How can a CHW break this cycle?

- Provide chronic disease self-management training to RW and his family at their home to equip them with real skills for healthier living (including how to measure blood glucose properly and make adjustments)
- Organize meds and strategize how to remember to take them
- Organize an appointment reminder system that RW and family can understand and use.
- Assess for all possible social barriers leading to poor outcomes and provide resource referral and case management for those issues (transportation assistance, healthy food programs etc.)
- Attend primary care appointment with RW as needed

Case Example 2: Saving Smiles Program

JD is a 9-year-old in the third grade at Metcalfe elementary. She has had to miss 10 days of school this year because some days she wakes up with her mouth hurting due to 3 severe cavities. Although she has dental coverage through Medicaid, mom has not been able to get her to a dental appointment because her work schedule is constantly changing.

JD can get her 3 problem teeth treated at several different housing authority properties through Saving Smiles and she can have the rest of her teeth sealed while at school through the school-based sealant program…she just needs to get a consent form signed and help with the scheduling process

How can a CHW help connect her to care?

- Call mom to ensure consent form made it home and provide assistance understanding the form in order to ensure informed consent

- Help arrange transportation to Saving Smiles program if mom's schedule is still a challenge
- Provide in home teaching on oral health care and strategies for preventing cavities
- Make sure consent form returned to school for sealant program
- Check on JD after procedures and check on how the oral health strategies discussed are being implemented
- Screen mom and kids for any other needs present (food assistance, childcare issues, personal safety concerns etc.)
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Case 3: Alachua County Health Department

MC is a 52-year-old with HIV, high blood pressure and severe dental decay. She is in an unstable living situation and is often unsheltered. She had previously received treatment through the Ryan White program at the health department but stopped attending appointments due to her many overlapping social barriers.

The ACHD has several programs that can meet her health needs, but there needs to be someone to help bridge the care gap.

Can a CHW help?

- CHW connects with MC not in an office but on the street where she spends much of her time and then connects with daughter by phone afterward
- Works with MC and daughter to collect qualifying info for Ryan White program to get re-approved for the program
- Links MC to We Care dental program and assists with the application paperwork and transportation to intake meeting and ultimately to the dental appt.
- Once MC is approved for Ryan White, helps provide medication courier services for HIV meds and coordinates monthly lab work at either ACHD or nearby Mobile Outreach Clinic
- Helps connect MC to GRACE outreach team to pursue permanent stable housing