QUALITATIVE SNAPSHOT

QUARTER ONE 2024

Beaufort-Jasper-Hampton Comprehensive Health Services (BJHCHS) Okatie, South Carolina

CENTER FOR COMMUNITY HEALTH ALIGNMENT

In this first section, Andrea[1], a CHW at BJHCHS, describes how she supports Julio and his wife Emelia after they were evicted, and Julio visited the ER.

This snapshot provides a glimpse into the work of community health workers (CHWs) at BJHCHS in Okatie, South Carolina.

Andrea: *I [work with] one man that was evicted from his house. He and his wife have high blood pressure. He never thought that the pain that he felt [was a problem] until one day he was hospitalized. His blood pressure was extremely elevated. Now, he always stops by my office to talk after every doctor's appointment. They have their blood pressure under control now. Thanks to the work of the entire team, they are on the right path. They joined a gym, started eating healthier, and took the changes with stride.*

Part of being a CHW, education and health literacy, changes lives. *[Health] is not just about going to doctor's appointment and taking medication. The role of a CHW is to help the patient, just as much as the doctor, achieve the goal [improved health]. Doctors ask patients if they understood everything, but sometimes [patients] don't really understand. [Patients] are afraid to ask more questions, admit they didn't understand. When [CHWs] visit patients at home, they tell us things. We ask them, "Did you say that to the doctor?" If not, we make a note for the doctor. We help doctors make decisions about referrals based on what we know about patients.*

...we have this empathy with people *that we can talk with them and they can tell us how they feel. This empathy makes people open up, tell us things. Often when we go to patients' homes the environment is different than in the office...with the education that we provide, letting people know how important their health really is, that we care about their health here in the clinic, so that they can continue working, fighting for their family...we show them that you don't just go to the clinic to pay for services, you go to achieve your [health] goals. [translated]*

Results: Julio and his wife Emelia enrolled in the BJHCHS remote blood pressure monitoring program, worked with Andrea to access housing, received information on healthy eating practices and the importance of regular exercise, were connected with—and actively consult with—a primary care provider (PCP), and collaborate with a pharmacist at BJHCHS to continue a blood pressure control regimen. **Julio and Emelia continue to work with Andrea to improve their blood pressure and have made great progress on their journey to improved health.**

1- All names are pseudonyms.

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Interviews with CHWs at BJHCHS demonstrate that health isn't just about visiting a doctor. Building trusting relationships with community members allows CHWs to serve as advocates and guides for their participants. CHWs at BJHCHS work as part of the CHWs Changing Outcomes in SC program funded by the state of South Carolina. Awarded the funding, BJHCHS focuses on hypertension, highly prevalent in the communities served.

This snapshot is part of a larger qualitative study that the Center for Community Health Alignment (CCHA) is conducting with CHWs involved in the CHWs Changing Outcomes in South Carolina program. The study involves semi-structured interviews in English and Spanish and ethnographic fieldnotes collected to document the observed day to day activities of CHWs.

A CHW builds community trust & relationships

This section examines select quotes from interviews with BJHCHS CHWs and a medical doctor.

Antonia: *We have a remote patient monitoring program. If the patient has a problem with the monitor, we go to their house to help.... The pharmacist also monitors readings to determine if the medicine is working. They determine if the patient needs a higher dosage or different medicine. Together, the doctor, pharmacist, and CHWs, work to improve blood pressure. [translated]*

Hope: *...we had a patient...we weren't getting readings back for his blood pressure machine, so [the CHW] would actually go to the home...[she] called them, and said, "Hey, you haven't been taking your readings for a while, what's going on? Can I stop by?" She visited the patient to see, well, maybe he didn't understand how to use the blood pressure machine or "Does the machine need batteries?"... they might find out the patient doesn't have running water, they got their lights cut off, their car broke down and so they haven't been able to go pick up their medications at the pharmacy. [CHWs] find out what things are stopping the patient from being able to continue getting the care. They are the ones that really help us drill down on the barriers to care for patients that prevent them from carrying out a care plan. [original]*

Antonia: *We ask [patients] if they have a PCP if their children have a PCP, and if the entire family does, because it is very important that they can access the different services that we offer, because we have dentists, gynecologists, pediatricians, adult medicine, nutritionists, and counselors, in the same building. If when the doctor is attending to them, there is some need that emerges, the doctor will call us to join them in the room so that we can connect them to the appropriate resource. [translated]*