

# REDEFINING ANNUAL CHECKUPS: HEALTH WORKERS COME TO YOU

## THROUGH CARES SFV

By Scarlett Diaz, Community Health Worker

In 2024, my colleagues and I visited a home of a single father who works long hours as a construction worker to support his family. Despite his busy schedule, we were able to talk to him early one morning, just as he was heading to work, and completed a household assessment—the cornerstone of the CPHT project to identify needs and address them.



In our conversation, he told us about numerous medical bills that totaled more than his monthly rent and that he did not have a medical home (continuous, comprehensive primary care). He explained that these challenges made it difficult for him to manage his diabetes and other health concerns. He felt unsure of where to turn and overwhelmed by navigating the healthcare system alone.

As a Community Health Worker on the CARES SFV CPHT, I recognized his need for health insurance, a primary care provider, and support for navigating the healthcare system. That same day, I contacted San Fernando Community Health Clinic, created a direct referral, and marked his case as urgent. Our relationship with the clinic allows Community Health Workers to reduce barriers and build trust between community members and their medical home. Thanks to our strong partnership, I quickly coordinated with clinic staff to connect him with a primary care provider. Instead of being handed brochures or phone numbers, this client was supported and provided a medical home right in his neighborhood.



Photographer: Carlin Stiehl / The L.A. Times

In CPHT, we conduct home visits annually to respond to the ongoing needs of our community members. This helps them feel less overwhelmed and offers periodic points for support. When we followed up with this client in the new year, he wanted help to arrange a physical exam. In coordination with San Fernando Community Health Clinic, we reviewed his case and learned he had not received care in over a year, highlighting the urgency of reconnecting him to services.

Since my last visit, he's had an appointment to check his blood pressure and review his medications, and a separate appointment scheduled for a diabetes checkup. San Fernando Community Health Clinic also informed him that he will receive a glucose monitor with follow-up every three months. This case proves that consistent connection, strong partnerships, and care coordination reduces barriers to healthcare, supports community members in managing chronic conditions, and improves quality of life.

**“I'm very satisfied with the Community Public Health Team. I appreciate how Providence and San Fernando Community Health Clinic worked together to support me. San Fernando Community Health Clinic is even helping me manage my diabetes with a new glucose monitor. I truly value their efforts.”**

