

Report to the Community

January - April 2025

Maximizing the Impact of Community Health Workers



CHWs Pat Hardy and Michelle Conner with
Healthy Housing Program Manager Natalie Harper

MetroHealth's Community Health Workers (CHWs) are vital contributors to the mission of the Institute for H.O.P.E.™ They reach over the social barriers in their communities and guide their neighbors to the help they need to achieve the best possible health outcomes.

CHWs, frontline public health workers who often live in the communities they serve, understand their neighbors' circumstances, and they bring this valuable perspective to their work. The Institute for H.O.P.E. has established the Center for Community Health Innovation and Integration, which will lead an effort to define the role of CHWs, ensuring their skills are utilized most effectively to impact patient health outcomes.

CHWs work in various capacities throughout MetroHealth. Those who serve with the Institute for H.O.P.E. are helping patients as part of the Trauma Recovery Center, Food as Medicine and Senior Malnutrition programs. Their work includes supporting the Institute's social drivers of health (SDOH) screening, which assesses patients' risk for challenges like food security, transportation, utilities, housing and interpersonal violence. They also help patients who screen at risk for those challenges to connect with services and resources.

Now, as part of a pilot program launched at the beginning of this year, CHWs are joining select MetroHealth Primary Care Practices to work with patients, helping them schedule and arrange transportation for follow-up appointments and testing. They also conduct SDOH screening and respond to health-related social needs.

The Primary Care CHW Collaborative Care pilot program, funded through a \$434,400 grant from the Health Assurance Foundation, establishes CHWs as true liaisons between providers and the community. The program will allow the Institute to add three additional CHW positions, bringing the team to eight.

CHWs assigned to primary care practices will spend part of their time with patients in the clinic setting and the rest of their time out in the community, at events and locations where residents gather.

Brittany Shrefler, MD, internal medicine, has championed the Primary Care CHW Collaborative Care pilot program at the Buckeye Health Center. This location was chosen because social needs and corresponding health concerns are high among the patient population.

"The Community Health Workers help patients to navigate what can be a complicated system," Dr. Shrefler said. This location was chosen because social needs and corresponding health concerns are high among the patient population.



CHWs Juan Silva and Dayleen Rodriguez helping
Buckeye residents at the Financial Expo

Filling Gaps, Improving Health

In its first few months, the Institute for H.O.P.E. Primary Care Community Health Worker (CHW) Collaborative Care pilot program already has helped improve the health of MetroHealth patients.

A 63-year-old patient of Brittany Shrefler, MD, experiences chronic pain as the result of multiple surgeries and osteoarthritis in his knee. During one of his recent appointments with Dr. Shrefler at Buckeye Health Center, he mentioned that he was having trouble sleeping. He said the mattress of his at-home hospital bed was ripped and worn down to the point that it felt like he “was sleeping on the bed frame.”

This would make getting a good night’s sleep difficult for anyone. But for this patient, who also has Type 2 Diabetes, the situation was more than uncomfortable. Yet, he wasn’t eligible to receive a new mattress through his medical coverage until April 2026.

“The bed that was supposed to be a place for this patient to find comfort and rest was actually increasing his pain,” said Sarah Woernley, BSN, RN, CCCTM, Director of the Institute’s Center for Community Health Innovation and Integration. “And adequate sleep is important in managing his Type 2 Diabetes. But he couldn’t afford a better mattress.”

So, Dr. Shrefler referred him to Rachel Berchak, CHW, who recently joined the practice as part of the CHW primary care pilot program. Rachel contacted **MedWish**, a Cleveland-based organization that collects surplus medical supplies and equipment and distributes it to those in need. She confirmed that MedWish had a mattress available for the patient and helped him arrange for it to be picked up from the organization’s warehouse.

Healthcare providers often are frustrated to know that their patients have these sorts of needs, which directly impact their health, but they may not have the capacity or means to help. “That is the gap CHWs can step in to fill, and this program makes that possible,” Rachel said.

Program Updates



Case Western Reserve University has been awarded a five-year, \$3.8 million grant from the National Institutes of Health to address the alarming rates of infant and maternal mortality in Cleveland. This groundbreaking research project, in partnership with the **Greater Cleveland Food Bank, MetroHealth and University Hospitals**, will provide medically tailored groceries and supportive services to 360 food-insecure pregnant patients recruited by CHWs. To read more about the Nourishing Tomorrow program, [click here](#).



As one of the Art and Music Therapists at the Center for Arts in Health, Dwyer Conklyn, MM, LPMT, MT-BC, assists patients in reconnecting with the beat, rhythm and joy of life following a traumatic injury or illness. To learn more about his transformative rehabilitation work using music interventions to restore function and empower patients, [click here](#).



Rachel Berchak

Inpatient Social Drivers of Health Screening by the Numbers

As of October 2024, we expanded our social drivers of health (SDOH) screening to include patients admitted at four MetroHealth locations. During admission, nurses assess SDOH risks in five areas: food security, transportation, utilities, housing, and interpersonal violence.

Patients seeking help and screened at-risk are referred to MetroHealth’s Care Management team for support. Once discharged, patients may connect with CHWs to continue to address their health-related social needs.

- Since starting this work, 75% of all hospital admissions have included a complete SDOH screen.
- 23% of SDOH screens had at least one risk identified.
- 1,137 patients have had their health-related social needs addressed by the Inpatient Care Management team.