Community Health Worker (CHW) Referral

Refer via ORCHID Message to Dr. Gezman Abdullahi using referral template below.
Please obtain verbal consent from patient prior to referral.

Referral Template:
1. Clinic:
2. Resident PCP:
3. Attending:
4. Age and summary of chronic medical and behavioral health conditions:
5. Known social stressors and/or barriers to care:
6. Number of ED/UC visits in last 1 year:
7. Number of hospitalization in last 1 year:
8. Reason for referral/goals for patient:
9. Has patient been consented prior to referral? (REQUIRED)
10. Are there any other concerns or anything else the CHW should be aware of before the initial home visit?

Community Health Workers assigned to Clinic A and P:
-Liliana Sunn: pager: 818-529-4299 (preferred), cell: 213-587-3078
-Clara Nunez: pager: 818-529-1884 (preferred), cell: 213 298-5802
-Walfred Lopez: pager: 818-529-3989 (preferred), cell: 213-298-5804

Who qualifies?

High-Utilizers = 2 acute care utilization equivalents* within the past year

OR

Uncontrolled Chronic Condition and Avoidable Utilization

= 1 acute care utilization equivalent* within the past year PLUS any one of the following "high-risk" conditions:

Diabetes with HbA1c>9; Uncontrolled Hypertension with cardiac and/or renal complications; CAD; CHF; COPD; Asthma; PVD; Cerebrovascular disease; End-stage Liver disease; End-stage Kidney disease; Dementia that is progressive with worsening function; Failure to Thrive; Age >90 years old; Depression with functional impairment; Anxiety disorder with functional impairment/somatization; Bipolar disorder with functional impairment; Psychotic disorder; Substance use disorder

OR

Uncontrolled Chronic Condition with Mental Illness or substance use disorder

Note: One acute care utilization = 1 Hospitalization **OR 2 ED visits **OR** 4 UC visits **OR** 1 ED and 2 UC visits*

Services provided:

- Perform baseline needs assessment and develop care plan with patient
- Stress health promotion/harm reduction through education, skills building, support, and accompaniment
- Address basic social needs of patient with assistance of social work and case managers
- Assist with transitions of care (post ER/hospital admission)
- Accompany patient to appointments (medical, behavioral, social)
- Review medications monthly and provide counseling regarding adherence
- Assist with disease monitoring and health maintenance activities
- Communicate regularly with PCMH team on patient progress