# Oakland Community Health Network Hospital Liaison Referral Process

This process ensures timely and efficient response to referrals provided to the Oakland Community Health Network (OCHN) Hospital Liaison Team. The Hospital Liaison Team is responsible for assisting crisis providers, emergency departments and inpatient facilities with mitigating admission, discharge and placement barriers for individuals serviced by OCHN. The following process should be followed when submitting referrals to the Hospital Liaison (HL) Team:

- An encrypted email should be sent to hl@oaklandchn.org
- The email must contain the following information
  - Name of individual served
  - Date of birth
  - CON ID (generated from ODIN), if available
  - Current location (ER, inpatient, crisis unit)
  - Presenting/clinical concern
  - Contact information
- Upon receipt, a confirmation email will be sent to the sender outlining that the referral was received
- The Hospital Liaison Team will respond within 1 business day to all referrals
- Referrals submitted on the weekends and holidays will receive a response on the next working business day

## What to expect

The following services are provided by the Hospital Liaison Team upon receipt of a referral:

- **Familiar Faces:** Hospital Liaisons can assist in alleviating barriers for individuals served who are frequent utilizers of services within the crisis continuum. The assigned HL will review treatment records, meet with the individual served and discuss alternative options with treatment providers to help reduce utilization. Clinical oversight and resource coordination are services associated with type of referral.

- **Clinical Follow Up**: Hospital Liaisons provide clinical assistance to service providers upon discharge and resolution of the crisis episode. Services provided include coordination of care and follow-up, clinical collaboration, and connection to outpatient services.

- **County of Fiscal Responsibility**: Hospital Liaisons will assist local hospitals with identifying the fiscally responsible county when an individual in crisis requires authorization for a higher level of care, but the county is unknown. The team will coordinate with the tri-county PIHPs and follow established guidelines for responsibility. Examples include individuals identifying as homeless but having Medicaid from another county and having a treatment history, people coming from dependent settings such as specialized residential homes, nursing facilities, and jail/incarceration.

- **Delayed Placement**: Hospital Liaisons will partner with crisis providers and emergency departments to locate an inpatient facility for individuals waiting more than 24 hours for inpatient behavioral health admission.

- **Placement/housing:** Individuals who do not meet acute care criteria for behavioral health services and need placement/living environment. Extensive coordination with the CPA, hospital, family/Legal guardian, internal OCHN teams and the individual is typically required. The OCHN crisis team will escalate and coordinate safe discharge planning from ER and acute behavioral health care settings by following up regarding necessary authorizations and credentialling, hosting meetings with all responsible parties, and advocating that the individual's needs are being addressed.