

Chapter: Clinical Practice
Title: Complex Case Management- Referrals

Prior Approval: N/A

Current Approval: 10/20/2026

Proposed by: Traci Smith 10/20/2026
Chief Executive Officer Date

Approved by: Al Lorenzo 10/20/2026
County Executive Office Date

I. ABSTRACT

This policy establishes the standards of Macomb County Community Mental Health (MCCMH), an official agency of the County of Macomb, to describe the case management system functions used by MCCMH complex case managers to receive and manage referrals.

II. APPLICATION

This policy shall apply to direct and contracted providers of MCCMH.

III. POLICY

It is the policy of MCCMH that MCCMH complex case management (CCM) maintains multiple avenues for person served to be considered for CCM services. This policy describes documentation activities completed for those receiving complex case management services and how referrals are received, documented, reviewed for eligibility, and followed through to an offer or documented disposition. It applies to referrals from medical management programs, discharge planners, members or caregivers, and practitioners.

IV. DEFINITIONS

Complex Case Management:

A program of coordinated care and services for person served who have experienced a critical event or diagnosis that requires extensive use of resources. MCCMH uses behavioral health diagnosis of schizophrenia, schizoaffective disorder types, and/or bipolar; along with a medical diagnosis of hypertension and/or diabetes. MCCMH also looks that the person served had a recent behavioral health admissions.

V. STANDARDS

The CCM program identifies a person served, based on need through monthly data pulls and an open referral program. This need is found based on diagnosis combinations and use of behavioral health in-patient stays. Identified person served are systematically assessed using standardized, evidence-based tools. Assessment findings, person served priorities, care goals, interventions, follow-up activities, progress, and outcomes are documented in the person served record and used to develop and update an individualized care plan.

VI. PROCEDURES

A. Referral intake and disposition

1. For each referral, the receiving staff member records the source, date received, person served identifier, reason for referral, and date routed to CCM. CCM team member review available information against MCCMH's current CCM eligibility criteria. If additional information is needed, the team member documents the request and follow-up. The person served is contacted using an approved outreach method (phone, mail, or email), offered CCM when eligible. The offer, acceptance or refusal, and next action are documented in the electronic health record (EHR). A referral that does not meet criteria is closed with the reason and any appropriate alternative information or referral documented. All person served are provided with 2 outreach calls and an attempt via mail if available, person served who are not able to be contacted are provided by mail a way to self-refer.
2. Documentation for outreach and if the member accepts the program is completed in the electronic health record (EHR). Recording of the date of referral and eligibility is recorded in CCM internal tracking records.

B. Data Report and Referrals

Data Report if a person served had 2 or more behavioral health hospitalizations in the past 90 days and one of the targeted diagnosis, they are identified on a report pulled by CCM team members on the first business day of each month.

1. Outreach is completed for those on the report each time identified, unless already in the CCM program.

C. Referral Pathways

Referral Source	How the Referral is Received/Processed	CCM staff Document Retention
Medical Management Program	A medical management program within MCCMH or a health plan may refer a person served for CCM consideration. The CCM program records the referring program, person served identifier, referral date, reason, and disposition,	Referral Log and/or documentation in the EHR showing source, date, and disposition.

	then screens against current CCM eligibility criteria.	
Discharge Planners	A hospital or other discharge planner may refer a person served by the secure referral method found on the MCCMH website. CCM staff record the referral and evaluate the person served under the same eligibility and outreach process. This process is communicated via newsletters.	Referral Log and/or documentation in the EHR showing source, date, and disposition. As well as copies of newsletters.
Person served/Caregiver	Person served or caregivers may request consideration through the self-referral route described in member communications and on MCCMH's website. The Customer Service Line and QR code on flyers and the member handbook can be used as access routes. Customer Service or the secure website form routes the request to CCM for logging and review.	Referral Log and/or documentation in the EHR showing source, date, and disposition.
Practitioner	A practitioner may refer a member through the secure referral form found on the MCCMH webpage. MCCMH communicates the referral process to practitioners using newsletters and routes referrals to CCM staff for logging and eligibility review.	Referral Log and/or documentation in the EHR showing source, date, and disposition. As well as copies of newsletters.

D. Communication to Persons Served

Information available for CCM is located on the resource section of the MCCMH webpage as well as communicated to person served via the member handbook which is offered at initial services and annually.

E. Communication with Practitioners and Discharge Planners

Information about CCM and the referral process are communicated through newsletters.

F. Reporting and Oversight

The CCM program supervisor or designee review referral activity annually by source, volume, timeliness, eligibility disposition and unresolved referrals. The CCM program supervisor or designee documents the reporting period, denominator, data source, review date, and corrective action (if necessary), and ensures that referral avenues are operational monthly.

G. Records

1. CCM Program team members retain documents for each year including but not limited to:
 - Referrals logs and communications of referrals coming into the program

- Eligibility data
- Referral communications to person served and practitioners as well as distribution information
- Monthly data reports used to reach out to potential CCM candidates.

VII. REFERENCES / LEGAL AUTHORITY

None

VIII. EXHIBITS

Annual Revision Attestation/Revision History

Revision #	Review Date	Revision Summary/Policy Update Notice Date	Reviewer/Department
1	10/19/2026	Creation	CCM Program Supervisor