

Chapter: Clinical Practice
Title: Complex Case Management Systems

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 when providing and documenting services.

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 documentation that supports assessment and ongoing management.

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 individual has had recent behavioral health admissions.

V. STANDARDS

The CCM program uses a system and evidence-based assessment support within the Electronic Health Record (EHR).

VI. PROCEDURES

A. Evidence based assessment and follow-up support.

1. MCCMH identifies the case management system used to document person served interactions and assessment and management activity: Level of Care Utilization System (LOCUS) assessments at beginning and discontinuation of CCM services found in the MCCMH EHR module, And PHQ-9 depression questioner during follow-up documentation in progress notes. The system supports assessment and management through the evidence-based guidelines, measures, or algorithms listed below. For each component, MCCMH identifies the clinical guideline or source, the corresponding system field, prompt, or workflow, and how staff use it in assessment or follow-up when applicable.

B. Tools and Guidelines

<u>Guideline, Measure, or algorithm</u>	<u>Workflow and/or System Function</u>	<u>Evidence</u>
LOCUS	Completed during original assessment and upon completion or person served's wishes to leave the program.	Documentation in the EHR showing use of tool. Screenshots that the tool has been in the system.
PHQ-9	Completed during follow-up documentation by CCM staff.	Documentation in the EHR showing use of tool. Screenshots for how the tool resides in the system.

C. Automatic User and Date-Time Documentation

For each case entry and person served interaction, the system records the staff's unique identifier and the date and time of the action or interaction. These values are system-generated, and will show whether the document has been edited, and the systems also logs the number of times a document has been adjusted and by whom. The system retains this information as part of the permanent record.

D. System Evidence and Retention

MCCMH retains annotated screenshots and has a controlled system demonstration with a system generated non-client that can be used to show each function, system name and version, configuration or effective date, and records showing the feature is and has been available. Screenshots are de-identified and annotated to identify the relevant functionality without exposing identifying protected health information.

E. Function

<u>Required Function</u>	<u>Process Description</u>	<u>Evidence</u>
Evidence-based guidance for assessment and	PHQ-9 and LOCUS scoring are used to elevate	Dated screenshots, system configuration, workflow

management	treatment concerns to additional providers, such as psychiatrists or clinical therapists, or in some cases to a higher level of care.	documents, and applicable guideline/version
Automatic staff ID and date/time capture	The user ID, date and time are captured at the bottom of the electronic document, when a document is created on the left side, and on the right side of the screen when the document is completed.	Deidentified case-entry and interaction screenshots plus audit-trail evidence.

F. Approval

The above functions are available and have been available as validated by CCM program supervisor.

VII. REFERENCES / LEGAL AUTHORITY

Sowers, W., George, C., & Thompson, K. (1999). *Level of care utilization system for psychiatric and addiction services (LOCUS): A preliminary assessment of reliability and validity*. Community Mental Health Journal, 35(6), 545-563.

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). *The PHQ-9: Validity of a brief depression severity measure*. Journal of General Internal Medicine, 16(9), 606-613.
<https://doi.org/10.1046/j.1525-1497.2001.016009606.x>

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