

Chapter: Clinical Practice
Title: Complex Case Management- Assessment

Prior Approval: N/A
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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 conduct and document assessments.

II. APPLICATION

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

III. POLICY

To define and describe the MCCMH's Complex Case Management (CCM) Program's operational guidelines for assessments and care goals.

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 reviews person served who had recent behavioral health admissions. CCM Program services are provided by a Nurse Case Manager (CM).

V. STANDARDS

The CCM program identifies a person served based on need through monthly data pulls and an open referral program. Assessments are completed on those that agree to the program and meet

MCCMH identified eligibility for the CCM program.

VI. PROCEDURES

A. Initial Assessment

1. The case manager will conduct and document an assessment of the person served current health status, including:
 - Identifying the presence of current comorbidities and their current status
 - Documenting the Member's self-reported health status and self-reported health issues
 - Documenting the event or diagnosis that led to the member being flagged or referred to CCM
 - Completing medication reconciliation for current medications, including schedules and dosages and any allergies the individual may have.
2. The CM will document historical information, including dates of;
 - Past hospitalizations, including behavioral health hospitalizations, major procedures and surgery.
 - Significant past illnesses past illnesses, treatments, and
 - Relevant past medications related to the member's condition and if they worked and/or resulted in side effects.

If a person served is not able to provide dates for such historical information the CM will complete Coordination of Care documents for all treatment providers that the individual is willing to sign a consent to exchange health information, as per MCCMH Policy 2-042 Coordination of Care/Follow up to obtain dates of historical treatments.

3. **Activities of Daily Living (ADL)**
The CM will conduct and document an assessment of the individual's ability to complete ADLs and if the individual requires assistance, what type of assistance and who provides that assistance, or who could provide that assistance if the individual required that in the future. These 6 ADLs will be assessed- bathing, dressing, going to the toilet, transferring, and feeding.
4. **Behavioral Health Status**
The CM will conduct and document an assessment of the person served behavioral health status and cognitive functions, including the individual's ability to communicate and understand instructions, and ability to process information about their illness(s). The CM's assessment includes identification of mental health conditions or symptoms and any existing or historic substance use disorders.
5. **Social Determinants of Health/Social Drivers of Health**
The CM will conduct and document an assessment of person served social determinants of health and document any that may pose risks to the person served ability to meet goals.

6. Life Planning Activities

If life planning activities are determined to be appropriate, the case manager will document what activities the person served has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management records. Every individual is provided with the MCCMH Life Planning Brochure that shares the types of life planning and how to start these activities.

7. Cultural and Linguistic Needs

The CM will conduct and document an assessment of the person served culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. In doing so, the CM considers the person served's cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

8. Visual and Hearing Needs

The CM will conduct and documents an assessment of the person served's vision and hearing to identify potential barriers to effective communication or care.

9. Evaluation of caregiver resources

The CM will conduct and document an assessment of the adequacy of caregiver resources.

10. Evaluation of available benefits

The CM will conduct and document an assessment of the adequacy of the person served health benefits regarding the ability of those benefits to fulfill the goals of the treatment plan.

11. Evaluation of community resources

The CM will conduct and document an assessment of community resources for which they are eligible and which could supplement those which MCCMH has been contracted to provide.

These include but are not limited to:

- Community Mental Health Services, or
- Transportation assistance/public transportation, or
- Area wellness programs, or
- Palliative care programs, or
- Nutritional support services from local organizations and/or the Macomb County Health Department.

12. Safety and risk of harm assessment

Safety and Harm risks- individuals that answer in the affirmative for safety and/or risk of violence during the assessment are rated on the CDC recommended "Assault & Homicidal Danger Assessment Tool" and/or the CM completes the CDC safety "Triage Tool".

B. Case Management Plan and Prioritized Care Goals

Based on the results of the initial assessment the CM creates a personalized care goal plan that meets the person served's needs and includes:

- Prioritized goals, which consider member and caregiver needs and preferences
- Time frame for reevaluation of goals.
- Resources to be utilized, including the appropriate level of care.
- Planning for continuity of care, including transition of care and transfers.
- Collaborative approaches to be used, including level of family participation
- Consideration of clinical guidelines such as those used for the treatment of diabetes and/or hypertension.

1. Identification of barriers to meeting care goals

The CM identifies and documents barriers to the person served receiving or participating in a case management plan. Potential barriers that the CM considers includes but are not limited to:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

Even if no barriers are identified, the CM will document they performed a barrier analysis.

2. Referrals to available resources

When appropriate, the CM facilitates referrals to other health care organizations. In doing so, the CM utilizes the MCCMH Commonwealth database CCM team member refers individuals to agencies that have Memorandum of Understanding (MOU) with the Certified Community Behavioral Health Clinic (CCBHC) service, other Macomb governmental agencies, organizations and offices in network with the persons served insurance as well as any community organizations that are available.

3. Developing Follow-up schedules

Follow-up is indicated when assessment findings identify a clinical concern, change in health status, care gap, medication issue, unmet service need, safety risk, barrier to care, recent hospitalization or emergency department visit, missed essential appointment, or when the person served requests additional support. The follow-up plans will be documented at the end of each contact note. The CM documents when and how the CM will follow-up with the individual when appropriate. The case management plan will contain a follow-up schedule that includes, but is not limited to:

- Counseling
- Follow-up after referral to a disease management program
- Follow-up after referral to a health resource
- Member education
- Self-management support
- And determining when follow-up is not appropriate.

If the individual is no longer engaging with the CCM services, the CCM team member follows the outreach procedure found within MCCMH Policy 2-010 “Standards for Clinical Service Documentation”

4. Development of Self-management plans
Self-management plans are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers. The CM assists a person served to develop a self-management plan as part of the treatment planning process and communicate this plan to the person served and/or caregiver verbally, or in writing if the individual prefers, but the plan must be documented in the health record.
5. Assessing Progress
At least monthly, or as frequently as determined through assessment, the CM team member meets with the person served to assess the degree of the person served progress toward overcoming barriers to care and meeting treatment goals. Based on the assessment, the CM adjusts the care plan and goals as needed.

VII. REFERENCES / LEGAL AUTHORITY

2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ ACPM/AGS/AMA/ASPC/NMA/PCNA/
SGIM Guideline for the Prevention, Detection, Evaluation and Management of High
Blood Pressure in Adults

America Diabetes Association Improving Care and Promoting Health in Populations: Standards
of Care in Diabetes—2026

MCCMH MCO Policy 2-010 Standards for Clinical Services Documentation

MCCMH MCO Policy 5-002 Cultural and Linguistic Competency

MCCMH MCO Policy 2-042 Service Referrals/Recommendations, Coordination of Care and,
Follow-up/ Advance Directive

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
