St. Clair County Community Mental Health
Providing Opportunities for Health, Wellness, & Connection

Administrative Policy

Policy Title:	**Referrals for Collaborative Treatment**
Policy #:	**03-002-0075**
Effective Date:	01/29/2025
Approved by:	Telly Delor, Chief Operating Officer
Functional Area:	Service Delivery
Responsible Leader:	Kathleen Gallagher, Chief Clinical Officer
Policy Owner:	Kristen Thompson, Adult Services Director
Applies to:	All SCCCMH Staff, Direct Operated Programs, Network Providers, Contractors

Purpose: It is the purpose of St. Clair County Community Mental Health (SCCCMH) to ensure a collaborative approach to care through the coordination of care, treatment and community-based services based on the individual's served needs.

I. Policy Statement

It is the policy of St. Clair County Community Mental Health (SCCCMH) to ensure a collaborative approach to care through the coordination of care, treatment and community-based services based on the individual's served needs. This administrative policy applies to all internal and external referrals. This includes but is not limited to ancillary services, dental care, health education & promotion, mental health services, self-management support, specialty care services, substance use disorders, and transitions to another level of care.

II. Standards

A. Referrals made externally or internally will be documented in the electronic health record. Follow up on any referrals will also be documented and will be completed within 14 days of referral at the latest.

B. A copy of the referral and follow up documentation is maintained in the individual's medical record/electronic health record (EHR). Referrals are monitored and tracked by the Primary Caseholder. Compliance with the standards will be monitored by a tracking report to ensure that referral follow-up timeliness standards and proportion of referrals are completed.

C. In certain clinical situations individuals may be referred to providers for regular treatment of a particular condition. Examples of conditions referred for regular treatment include but are not limited to cancer, uncontrolled diabetes, kidney failure, transplantation, etc. In these situations, SCCCMH establishes coordination of care agreements with the other provider(s) to ensure care is effectively managed reducing fragmented or duplicative care or services. This mutually agreed upon agreement may define specific expectations in exchange of information and the method in which this exchange occurs.

D. Referrals include a Transition of Care/Continuity of Care Document that is generated and sent to the release queue for medical records staff to process pending provided that a valid authorization for release of information has been signed in the EMR.

E. Individuals served information is subject to privacy and confidentiality requirements and must be consistent with the individual's preferences and needs. An individual has the right to refuse a referral or decline to follow up.

III. Procedures, Definitions, and Other Resources

A. Procedures

Responsibilities

Position	Responsibilities
Treatment Team Member	Initiate referrals to internal and/or external providers and assures follow up occurs including assisting individual and outreaching to all parties as needed.

Actions – External Referrals

Action Number	Responsible Stakeholder	Details
1.0	Primary and/or Treatment Team Member	1. Refer the individual to an appropriate healthcare facility/provider. (When the needs of the individual are outside the scope of services provided by SCCCMH.) 2. Discuss the referral with the individual and completes the referral, which includes pertinent information about the individual's medical condition, reason for referral, the provider's assessment, and the request for treatment/services. 3. Document the referral, the coordination of services and maintains tracking of the referrals. 4. Coordinate the requested care, treatment or services within a time frame that meets the needs of the individual, as well as the recommendations of the provider and

Action Number	Responsible Stakeholder	Details
		schedules appointments with the "referred to" provider or community resource when at all possible. 5. Coordinate and/or notify the individual of the appointment, if support is required, and track the status of the referral until completed. (Completed is defined as the care or service was received or all communication attempts with the provider and/or individual have been exhausted, yet the care or service was not received.) Referrals are tracked regardless of the urgency of the referral. a. Immediate/Urgent/Routine: The provider is responsible for managing all immediate healthcare referrals and coordinates directly with the "referred to" provider. b. Community Resource Referrals: At the next individual visit. These referrals are tracked for frequency and type of referral only to evaluate whether available community resources are sufficient and appropriate to meet individual needs. 6. Give the individual a copy of the referral form, which contains the contact information of the referral provider, facility, or community resource. 7. Initiate outreach to contact the individual; in the event the individual chooses not to follow through with the appointment scheduled for them and assist in rescheduling the appointment and/or determining reason why individual did not attend 8. Ensure a copy of the consultation report, notes, or other documentation about the status or outcome of the referred service is documented in the medical record/EHR.

Actions – Internal Referrals

Action Number	Responsible Stakeholder	Details
1.0	Treatment Team Member	1. Implement internal referral(s) when the individual requires assistance from a specialty provider within SCCCMH, such as InShape or other program when available. 2. Implement internal referrals when an individual's current treatment plan or service setting is deemed insufficient to meet their clinical needs, for example, when an individual with mild-to-moderate diagnosis presents with worsening

Action Number	Responsible Stakeholder	Details
		symptoms. The decision to initiate a referral to a higher level of care must be based on a comprehensive assessment by the individual's treatment team. 3. Discuss the referral with the individual (when appropriate) and complete the referral in accordance with SCCCMH's internal referral protocols, which includes pertinent information about the individual's medical condition, reason for referral, the provider's assessment, and the request for treatment and services. 4. Initiate communication with the provider to whom the individual is being referred to discuss the individual's needs, in addition to sending the provider a written, verbal, or electronic referral. 5. Ensure the referral or transition occurs smoothly to avoid any major disruptions to the individual's treatment.

Actions – Self-Referrals

Action Number	Responsible Stakeholder	Details
1.0	Treatment Team Member	1. Inquire at each visit with the individual and/or families, as appropriate if they have scheduled or received care or services outside of SCCCMH. 2. Enter into the medical record, health center information, if the patient/family has been scheduled or received services since the previous office visit. 3. Obtain information from the provider in which the patient received care or services, when applicable.

B. Related Policies

N/A

C. Definitions

1. *Health Information:* Any information, whether oral or recorded in any format or medium that: (1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present or future physical or mental health or condition of the individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual in CFR 45 § 160.103.

D. Forms

N/A

E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

N/A

F. References

1. CCBHC Expansion Grant

IV. History

- Initial Approval Date: 03/2019
- Last Revision Date: 09/2023 BY: Kristen Thompson
- Last Reviewed Date: 10/2024
- Non-Substantive Revisions: N/A
- Key Words: Referral, collaboration, coordination of care