ST. CLAIR COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE POLICY

Date Issued 09/23;
Administrative Directive on 12/24

CHAPTER Service Delivery	**CHAPTER** 03	**SECTION** 002	**SUBJECT** 0075
SECTION Records	**SUBJECT** Referrals for Collaborative Treatment		
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I. APPLICATION:

☐ All SCCCMHA Staff
☒ Network Providers
☒ Direct Operated Programs
☒ Contractors
☐ Residential Programs
☐ Specialized Foster Care

II. PURPOSE STATEMENT

St. Clair County Community Mental Health Authority (SCCCMHA) shall 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 and promotion, mental health services, self-management support, specialty care services, substance use disorders, and transitions to another level of care.

III. DEFINTIONS:

A. 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.

IV. 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

Case Holder. 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 SCCCMHA 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.

V. PROCEDURES:

Primary Caseholder/Nurse/Designee

A. External Referrals:

Treatment Team Member

1. Refers the individual to an appropriate healthcare facility/provider. (When the needs of the individual are outside the scope of services provided by SCCCMHA.)

2. Discusses 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. Documents the referral, the coordination of services and maintains tracking of the referrals.

4. Coordinates 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 schedules appointments with the "referred to" provider or community resource when at all possible.

5. Coordinates and/or notifies the individual of the appointment and tracks 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 is sufficient and appropriate to meet individual needs.

6. Gives the individual a copy of the referral form, which contains the contact information of the referral provider, facility or community resource.

7. Initiates outreach to contact the individual, in the event the individual chooses not to follow through with the appointment scheduled for them, and assists in rescheduling the appointment.

8. Ensures 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.

B. <u>Internal Referrals</u>:

Treatment Team Member

1. Implements internal referral(s) when the individual requires assistance from a specialty provider within SCCCMHA, such as InShape or other programs, 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 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, the 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.

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C. <u>Self-Referrals</u>:

Treatment Team Member

1. Inquires at each visit with the individual and/or families, as appropriate if they have scheduled or received care or services outside of SCCCMHA.

2. Enters into the medical record, health center information, if the patient/family has been scheduled or received services since the previous office visit.

3. Obtains information from the provider in which the patient received care or services, when applicable.

VI. <u>REFERENCES:</u>

A. CCBHC Expansion Grant

VII. <u>EXHIBITS:</u>

None

VIII. <u>REVISION HISTORY</u>:

Date issued 03/19, 07/20, 09/21, 09/22, 09/23 with administrative directive on 12/24.