



## Multidisciplinary Team (MDT) Guide and FAQ

### What is Kids' Mental Health Pierce County (KMHPC)?

Kids Mental Health—Pierce County (KMHPC) is a community collaborative in Pierce County that is joining together to achieve our community-wide goal of improving children's mental health services.

The mission of KMHPC is to develop a coordinated, responsive behavioral health system that serves the needs of children, youth and families at the right time, in the best place, with the best outcome for every family.

### What is the KMHPC Multidisciplinary Team (MDT) (Phase I)?

The KMHPC MDT is a community-based, family-focused multidisciplinary team of community stakeholders, providers, and advocates who aim to assist providers and families with complex behavioral health presentations, care coordination and case planning. The MDT can assist with tasks such as: outpatient service recommendations, care coordination needs, behavioral management strategies, safety planning strategies, transitional planning, discharge planning and family engagement strategies for youth and families who reside in Pierce County.

This is a pilot program through Kids' Mental Health Pierce County. The theme of Phase I will focus on: Community Collaboration and Crisis Treatment Planning.

There are two MDT Pathways: Crisis Pathway vs Community MDT. The Crisis Pathway is for emergent meeting needs that need to occur within 24-72 hours. This meeting will convene via conference call (WebEx) or in the community when able. The Community MDT will be held monthly on a set schedule or as requested for consultation regarding complex cases and behavioral health high utilizers.

### Who Participates in the KMHPC MDT?

The KMHPC MDT is composed of volunteer community stakeholders from local community organizations including but not limited to: Managed Care Organizations (MCO), Comprehensive Life Resources, Greater Lakes Mental Healthcare, SeaMar, Multicare, Mary Bridge Children's Hospital, Behavior Bridges, Developmental Disabilities Administration (DDA), Catholic Community Services, A Common Voice, Department of Child, Youth and Families (DCYF), Oasis Youth Center, Beacon and Pierce County Juvenile Court (PCJC). There is an additional network of specialty providers to include: special education advocates, Substance Use Disorder Professionals, behavior analyst, and faith-based organizations that can be requested to attend as needed.

When an MDT is requested to include the family, the family will be able to identify other supports they would like to attend the meeting.

## Who is eligible for a KMHPC MDT (Phase I)?

Complex Cases defined as youth with high risk behaviors or risk factors, youth involved in two or more systems (juvenile justice, mental health, substance use disorder, foster care, etc.).

High Utilizers viewed as youth with multiple Emergency Department (ED) presentations, multiple inpatient hospitalizations.

Any other complex psychosocial presentation that would benefit from multidisciplinary team review.

The youth and family must reside in Pierce County.

## What can I expect when attending a KMPHC MDT?

Meetings generally will be scheduled for one hour. The team will provide introductions. The referent and/or family will provide history and question for the MDT. Upon history and need identification the team will be able to ask clarifying questions. The team will share recommendations related to the request of the team (discharge planning, safety planning, etc.). Additional recommendation may be made by the team if there are appropriate resources in the community that may be available to the family that support the identified needs and support the family's strengths.

## What happens following a KMHPC MDT?

The facilitator will document the team's recommendation and provide it to the referent or family via email. The MDT **cannot** make referrals on the youth's behalf or ensure acceptance into a service based on the team's recommendation.

## How Can I access the KMHPC MDT?

The referent may complete a KMHPC MDT referral through the Kids' Mental Health Pierce County Website: <https://kidsmentalhealthpiercecounty.org/> and must have a completed release of information prior to the meeting. If you are unable to complete the online referral the written referral can be submitted to Ashley Mangum via email at [amangum@multicare.org](mailto:amangum@multicare.org).

If you have questions or need additional assistance, please call Ashley Mangum at 253-403-1363 or email at [amangum@multicare.org](mailto:amangum@multicare.org)

**Disclaimer:** The Kids Mental Health Pierce County Multidisciplinary Team (MDT) is a collaboration of community volunteers with the shared purpose of being a community resource for youth and families. The recommendations of team members do not necessarily reflect their associated agency or organization. The recommendations of the MDT do not guarantee acceptance into services or provider acceptance.

## Kids' Mental Health Pierce County Community Team (MDT) Referral Form

### Child/Youth Information:

Name:

DOB:

Address:

Phone Number:

Is it okay to leave a voicemail at this number?

Yes

No

Email:

### Insurance Provider:

Medicaid – Provider One or Subscriber Number:

Commercial – Company Name (Example: Regence, Tricare, etc.):

None

### I would like to consult with the Team About:

Outpatient Service Navigation: I am looking for recommendations regarding outpatient behavioral health and/or substance use disorder treatment resources.

Care Coordination Needs: I am looking for assistance with care coordination for a youth enrolled in various services or multiple system involvement (Juvenile Justice, Behavioral Health, Foster Care, etc.)

Behavior Management Strategies: I am looking for recommendations for behavioral management strategies to support safety within the community

Transitional Planning: I have a child/client who is transitioning back into the community from placement (inpatient unit, CLIP) who needs additional supports or recommendations for transitioning back into the community

Discharge Planning: I need assistance with developing a discharge plan from an Emergency Department

Family Engagement Ideas: I need assistance with engaging a family in services or to address barriers in access to services

Safety Planning: I am a provider who would like consultation to complete a safety plan

Other:

### Referent Information:

Name of Person Making the Referral:

Name of Clinic/Hospital/Organization:

Telephone Number:

Email:

Additional Information:

To maintain the privacy of youth and family a release of information (ROI) is required. A Release of Information is required to be signed by youth over the age of 13. Do you currently have a signed Release of Information (ROI)?

Yes

No

How did you hear about Kids' Mental Health Pierce County?

A friend or family member

A provider

Online Search

Social Media

Flyer/Print

Other

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION  
FOR THE KIDS' MENTAL HEALTH PIERCE COUNTY COMMUNITY MULTIDISCIPLINARY TEAM (MDT)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

By signing below, I authorize the Community Collaboration Workgroup, which includes staff from the following entities:

|                                 |  |                                  |   |
|---------------------------------|--|----------------------------------|---|
| CHI Franciscan                  | Central Pierce, East Pierce, Gig Harbor, Graham, Orting and West Pierce Fire Districts | Puyallup Tribal Health Authority | Amerigroup                              |
| Beacon                          | Multicare  | A Common Voice                   | Coordinated Care                        |
| Comprehensive Life Resources    | Behavior Bridges   | Molina Healthcare                | Pierce County Juvenile Court            |
| Greater Lakes Mental Healthcare | Developmental Disabilities Administration (DDA)  | United Healthcare                | Department of Child, Youth and Families |
| SeaMar                          | Catholic Community Services  | Consejo                          | Other:                                  |

To communicate with and disclose to one another the following information (*Please check all appropriate boxes*):

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Initial and subsequent evaluations of my service needs by the Community Collaboration and its members</li> <li><input type="checkbox"/> Current and past Mental Health Treatment Programs, with dates</li> <li><input type="checkbox"/> Current and past Substance Use Disorder Treatment Programs, with dates</li> <li><input type="checkbox"/> Current and past Emergency Department visits, with dates</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Past or present Mental Health Problems or Diagnosis</li> <li><input type="checkbox"/> Past or present Substance Use Disorder Problems or Diagnosis</li> <li><input type="checkbox"/> Past or present Physical Health Problems</li> <li><input type="checkbox"/> Other: _____</li> </ul> |
|--|---|

The purpose of the release/disclosure is to coordinate the following treatment activities: assessment, referral, medical, substance use disorders, mental health, vocational, shelter or housing services.

By signing this authorization, I understand the following:

- When I am asked to fill out this authorization, I am entitled to a copy.
- I have the right to revoke this authorization at any time. Any revocation will not take effect if action has already been taken based on the original authorization. Without my express revocation, this authorization will expire in one year from the signature date below.
- The information disclosed and redisclosed may contain information on my current/past: Mental Health, substance or alcohol use, and/or HIV status, and I authorize the disclosure and redisclosure for the purposes of this authorization.
- The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by, with the exception of, Substance Use Disorder records which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2.
- I understand that this authorization is voluntary and that I may refuse to sign this form. My refusal to sign will not affect the treatment or services I receive from specific providers but will limit the ability of the workgroup members to discuss my needs and to coordinate my care.

|  |             |
|--|-------------|
| <b>Signature (Patient or Person Authorized to give authorization)</b>  | <b>Date</b> |
| <hr style="border: 1px solid black;"/> <p><i>If signed by person other than patient, please print your name, provide reason, relationship to patient, &amp; description of authority</i></p> |             |

**All disclosures and redisclosures must be accompanied by the following notice:** “This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.”

