Intake Processes for Missouri Organizations

1. Truman Medical Centers Behavioral Health (TMC)

TMC is one of the two Community Mental Health Centers (CMH) who began implementing the RECONNECT model and TIP practice in the first year of the pilot study. During the grant period the HTI program moved into a new building located in the crossroads district called the "Healing Canvas" and is the home to the Loft. The Loft is where youth and young adults receive services, as well as drop in to watch movies, exercise, and socialize.

TMC Intake process between Adult and Future's Departments serving HTI (transition age) is practically seamless. This is done in several ways:

TMC has an open access period which is usually Monday - Friday from 8:30am to 11am. This is a time when young people can walk in the Center and ask for assistance. If a young person or family member happens to come outside of this time period, they are seen by a Qualified Mental Health Professional (QMHP) if time permits, and if time does not permit, a brief contact with the QMHP is made and a follow up appointment is scheduled. The open access approach was not in existence before the grant period but was implemented in Year 3 of the project.

Each person is seen by a QMHP who conducts a risk and needs assessment. The emphasis from the beginning is to listen to the person's needs whether that is for medication, therapy, or other services. Each person is given information about the array of TMC Behavioral Health services and Consumer involvement opportunities in the event he/she were not aware of the opportunities.

If they are referred to medication or therapy services, they leave with an appointment. If they are interested and eligible for the CPR program (case management) the QMHP will complete a referral for outreach. If needs are acute, they are assigned to a Community Support Specialist (CSS) for outreach. If the young person or family member/support person is interested in participating in consumer involvement within the Futures program advisory councils of HOPE and FAITH), a referral to the youth council (HOPE) or family council (FAITH) is made.

Each Monday morning from 10a - 12p, the Futures Department supervisors (of which there are three) review a list of the referrals from the QMHPs who conducted the open access assessment and they all go through them together using the QMHP's input. The purpose of this joint effort is to match the young person with an outreach worker which in TMC structure may be a CSS, Recovery Coach or Engagement Specialist. During the outreach period the young person and CSS determine if enrollment into the Futures Program is a good fit. If so, the outreach CSS informs the supervisor of the enrollment status at which time an initial CPR assessment is conducted within 30 days.

Referrals for HOPE/FAITH are provided to the membership chair or co-chairs of HOPE, and are then contacted by these HOPE members to follow up on the referral, inviting them to attend, explaining the Councils, etc. Referrals for FAITH are sent to the Family Support Providers who then contact the family members to follow up on the referral, inviting them to attend and explain the role of the council.

2. Comprehensive Mental Health Services (CMH)

During the second year of the pilot study CMH moved into their new building located in Independence MO and established a "Transition Program" within the Youth Community Support and Residential Program.

CMH Intake process for admission into the Transition program begins with a young person or someone on their behalf will inquire about services and are transferred to the Intake department where a series of questions and answers occur.

The intake person who is a Licensed Clinical Social Worker (LCSW) talks to the young person and family members to determine their need. This may be inquiries for medication, therapy or any number of services CMH provides. After interviewing the young person and/or family members the intake person determines if the young person is both eligible and interested in case management services. If the young person is interested, a referral form is completed and submitted to the Children's Services Coordinator/Director who reviews the case with the Transition Team Leader. Eligibility for CMH Transition Team services typically requires that a young person has Medicaid. However, if a young person does not have Medicaid and there is money available from the Mental Health Levy tax fund, that young person can be admitted into the Transition Team. Another Transition Team eligibility criterion is that a young person must have certain mental health or emotional disturbance diagnoses. Under age 17 and 9 months a young person can qualify under Daily Living Activity-20 (DL-20) which is an assessment that measures functional impairment.

Once the young person has been deemed eligible the outreach process of the HTI project begins. A young person is tracked using a blanket chart. During the initial outreach phase for clients, a blanket chart was used so that CSS could at least document and bill for their time. The client would have an opened chart once they signed up for the program and the intake department would assign them an active chart number. However, CMH no longer uses a blanket chart because they have discontinued the outreach phase of the program. CMH encountered difficulties and the organization realized they were losing money.

Once a young person's case has been reviewed by the Children's Coordinator/Director and Transition Team Leader he/she is assigned a Community Support Specialist (CSS) who in turn contacts the young person and family for an initial meeting to be held at the CMH office. This

initial step is taken as a measurement of the young person and/or family's level of interest in being engaged in services. An intake assessment is conducted at which time the young person is officially enrolled into the Transition Team program. Within 30 days of the enrollment date a CPR assessment is conducted. Using this process has been very beneficial in streamlining the enrollment process both for the recipient and the staff.

On occasion a young person is discharged for one of three reasons: 1) the young person has reached/achieved the treatment goals; 2) CSS and family have mutually agreed to conclude the services; and 3) the young person is non-compliant (e.g. no contact for 90 days or more). Before the third option is finalized a letter is mailed to the young person asking them to re-engage.

When a young person ages out of the Transition Team program, they are given the option to transition to Adult Services. A referral form is completed by the CSS Transition Team and notifies the Adult Services to let them know a young person has aged out who wishes to continue services within their department. A case worker from each department schedules a mutual first time meeting with the young person to discuss the continued treatment goals the young person has identified.

3. Swope Health Services Behavioral Health (SPBH)

SPBH is the largest of the Community Mental Health Centers (CMHC) participating in the pilot study and was the last of the four CMHCs to implement the Healthy Transition Initiative pilot study. HTI is housed within the Children & Youth Comprehensive Psychiatric Rehabilitation Center (CPRC) department. They are located in mid-town Kansas City and serve the metropolitan area.

SPBH Intake process begins when Intake inquiries are routed to the Behavioral Outreach Engagement Specialist who will ask the person questions about what services are needed and conduct a brief assessment. This process is referred to as Triage. Those interested in case management are referred to the intake therapist or QMHP who sets up an appointment for an intake assessment if they are physically present during the initial intake step.

The criteria for eligibility of services are being eligible for CPR services and having a mental health diagnosis. After the intake process is completed the case is assigned to a supervisor who subsequently assigns the case to a Community Support Specialist (CSS). If the young person's case is eligible to participate in the Healthy Transition Initiative, the QMHP will send the referral to HTI Site Coordinator who is responsible for recording the process information for the evaluators. The same information is sent to a supervisor and follows the same route of assignment to a CSS. The one intake therapist and two QHMP have been TIP trained.

When a young person has either aged out or is discharged from Children's Services and is being transitioned to Adult Services an electronic file is sent to the intake specialist where a brief adult assessment is conducted. Once the assessment is completed the young person is referred to a TIP trained adult CSS.

4. ReDiscover Mental Health Services (RD)

As a member of the pilot study, ReDiscover provided planning input during the first year and was positioned to begin implementation during the second year of the project. ReDiscover has multiple sites serving the Raytown and Lee's Summit Missouri area. ReDiscover initiated the pilot study within their Transition Living Program which is grounded in the Adult Division.

ReDiscover Intake process usually begins with an initial contact made through the Behavioral Health Administrative Center office located at the main office in Lee's Summit. The information is processed through the intake department. An intake person conducts an initial assessment to determine if the young person qualifies for Children & Youth Comprehensive Psychiatric Rehabilitation Center (CPRC). The young person is then referred to the appropriate unit; to either one of the Adult Units located in the Lee's Summit and Grandview locations or the Children and Adolescent Unit located in Lee's Summit. The referral is given to Program Managers. To date, one of the two program managers is TIP trained. A TIP informed form is used by program managers to assign young people to the team leaders. These forms originate directly from intake however during the HTI pilot study these forms also pass through the HTI-Site Coordinator who collects the process data and informs the HTI evaluators of the names of young people enrolled in HTI who are now eligible for NOMs outcome data.

Once the program manager receives the referral the young person's file is given to a team leader/supervisor who is TIP trained. The team leader/supervisor assigns the young person to a Community Support Specialist (CSS) who is also TIP trained. This process is done for young people who are 16-25. On occasion it may be possible for a young person who is under 18 years old to be assigned to the Adult Services to determine if CPR services are appropriate. This decision is primarily based on if the placement makes clinical sense.

Another initial contact also occurs when the supervisor of the Transition Living Program (TLP) receives a phone call from a parent or young person in the community who needs an apartment. The TLP supervisor determines if the young person is eligible for CPR services and has Adult Medicaid. If these criteria are met, the young person is referred to BHAC to start the official intake process as described above.