SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

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Policy 125 – Person-Centered/Family-Centered Service Planning

I. POLICY

It is the policy of Southern Highlands Community Mental Health Center that an individual service plan is required for all consumers requiring Coordinated Care Services. Consumers requiring Coordinated Care are those with severe and/or chronic behavioral health conditions that necessitate a team approach to providing medically necessary care. (Care Coordination services include: SUD Residential, MAT, ACT, CSU, and CCSS.) The treatment is usually provided on a more intensive basis, several times a week if not daily. The purpose of the service plan is to promote positive outcomes for the member, to develop goals and objectives to measure progress, and monitor to guide the consumer and service providers through the course of treatment and to document such efforts in a formal, written plan.

II. DISCUSSION

It is the goal of Southern Highlands to provide quality and meaningful treatment for our consumers. The treatment planning process will be person and family centered with the consumer driving the process from the beginning of treatment to the end of treatment. As well, the service planning process including the team meeting is to be a shared-decision making process meaningful and helpful to the consumer. The goal of the service is to integrate prevention, intervention, substance related, behavioral health and physical health goals endorsed by the consumer and family or significant others to the degree the consumer desires. Therefore, by incorporating these principles in the following policy, we will ensure that the consumer and family or representatives of the consumer (upon consumer's consent) are an integral part of the service planning process and involved in any decisions made for treatment and care.

The Service Plan is developed based on the consumer's initial assessment/ comprehensive evaluation. Although the development of the Service Plan is the responsibility of the entire treatment team, the Case Manager may provide Targeted Case Management Services in assisting the Team with the preliminary development of the Service Plan. This would include meeting with the consumer/guardian/representative and other staff before the actual meeting date. It is the responsibility of the Case Manager to enter in a draft version of the Service Plan in Avatar, or the Electronic Health Record. The Therapist, or other designated clinician, will be the lead in presenting the information in the Service Planning meetings. The Therapist will ensure that the objectives specific to individual and group therapy are appropriate and will assist the Case Manager in the

development of them for each consumer. Finally, the meeting is the formal time when the team reviews, makes any revisions, and finalizes all problems, goals, and objectives.

III. PROCEDURE

A Master Service Plan for all consumers receiving Coordinated Care services will be completed within 24 hours of admission to a service and no later than seven (7) days per Medicaid guidelines.

A. The Master Service Plan will contain the following:

- Identified problems, goals, and both outcome and component objectives.
- Goals and objectives that are based on problems identified in the initial assessment/comprehensive evaluation or in subsequent assessments during the treatment process.
- Goals that are consumer centered and are stated positively with an anticipated outcome/end result.
- A listing of specific objectives that the service providers and the consumer hope to achieve or complete. Objectives are to be specific, measurable, realistic, and capable of being achieved in the time available in the projected duration of the program or service. Objectives will focus on reducing behavioral health and substance use disorder symptoms but may also include primary care goals (such as to obtain a primary care physician or improve wellness) and consultation/referral with outside resources when appropriate.
- Outcome objectives describing how the member will be different at the completion of treatment by measuring how closely the member is to attaining the identified goal. There is to be one outcome objective for each listed goal.
- Measurable component objectives that provide steps toward achievement of specified outcomes, with realistic dates of achievement specified for each.
- Technique(s) and/or services (intervention) to be used in achieving each objective and the identification of the individuals responsible for implementing the services relating to the statement(s) of objectives and their frequency of intended delivery.
- Discharge criteria.
- A signature page inclusive of credentials, the date, and start/stop times of attendance of all participants in the development of the plan.

B. The Service Planning Team consists of the following:

- Consumer and/or guardian or consumer's representative (if requested or designated)
- Case Manager
- A representative of every service being provided to the member
- Physician (or Extender--a PA or APRN may serve on the committee in place of the physician) or Psychologist (or Supervised Psychologist) or Approved Licensed Professional Clinician (LPC/LICSW) must be physically present when one of the following criteria is met:
  1. Receive psychotropic medications prescribed by the Agency.
  2. Have a diagnosis of major psychosis or major affective disorders.
  3. Have an Intellectual/Developmental Disability (I/DD Diagnosis).
  4. Have an Autism Diagnosis
  5. Have major medical problems in addition to major psychosis and medications;
  6. The presence of the physician, PA, or APRN has been specifically requested by the case manager or the member.

C. Participation in the Service Planning Team is as follows:

- All members of the team must receive adequate notice of the service planning meeting.
- Service planning meetings must be scheduled at times and places that facilitate contribution to the team process.
- Service planning meetings must be scheduled at times and places that facilitate the inclusion of the consumer.
- Any Southern Highland's staff that is involved in providing services to the consumer may bill for participation in the service planning session. (Participation by family members is not billable.)
- Participation time by staff persons may vary depending on the nature of their involvement and contribution to the team process.
- If a member of the team does not attend, the team decides whether to proceed in his or her absence. If the team elects to proceed, documentation must describe the circumstances for the absence of the team member.
- If a consumer is served by multiple behavioral health providers, all providers must be invited to participate in the service planning session as documented.

The following are staff that need to be present for Service Planning Meetings for various Departments:

SUD Residential 3.7: Medical Provider, Therapist, Case Manager, Nurse, PRSS
SUD Residential 3.1 and 3.5: Therapist, Case Manager, Nurse, PRSS
MAT: Medical Provider, Therapist, Case Manager, Nurse, PRSS
CSU: Medical Provider, Therapist, Case Manager, Nurse, PRSS
CCSS: Medical Provider/Psychologist, Case Manager
ACT: All Core Members need to be present (Medical Provider, Team Leader, Therapists (2), Case Manager, and RN
CHILDREN: Medical Provider, Therapist, Case Manager, Nurse, PRSS (if applicable)

D. The following are the responsibilities of the Case Manager for the service planning process:

- Scheduling and coordination of service planning meetings.
- Monitoring the implementation of the service plan.
- Initiating service planning meetings as the needs of the member dictate.
- Justification for the presence of each staff person participating in the meeting is the responsibility of the case manager. As such, the Case Manager is responsible for ensuring all team member participants complete the signature portion of the signature page with credentials if applicable, start and stop times, duration, etc. It will also be the responsibility of the Case Manager to finalize the service plan document at the conclusion of the service plan meeting and no later than 72 hours after the final review.
- When Case Managers participate in a service planning, he/she must bill Mental Health Service Plan Development rather than Targeted Case Management Services.

E. The Signature Page must contain the following:

- Original, dated signatures (with titles and credentials) of all participating members of the treatment team, the member, their guardian, and/or the member's requested representative
- The actual time all individuals listed participated by listing the start-and-stop times of their participation. (However, staff may participate for different lengths of time, depending on the nature of their involvement and contribution to the team process).
- This document is to be placed in the consumer's clinical record along with the completed service plan or service plan update.
- If a staff person from another agency participates in the service planning session, he/she must also list the agency they are representing on the signature page.

- Documentation must contain the physician's, psychologist's, PA's, or APRN's, dated signature and credential on the completed service plan or service plan update and the actual time spent providing the service by listing the start-and-stop times of his/her participation.
- If the member, their guardian, or the member's requested representative does not attend the service planning meeting, the reason for the member's absence must be documented in the clinical record. If unable to attend, the service plan must be reviewed and signed within seven calendar days by the member or their guardian. If the clinical record does not include a valid signature page with required signatures, the service plan will be invalid, and subsequently, no services provided under its auspices will be billable.
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- **If Physician/Psychologist/Licensed Clinician is not required to be present, s/he must review and sign the signature page within 72 hours.**

F. The Master Service Plan should be updated at least every 90 days.
- The Service Plan Review must address whether objectives are to be continued, modified, or discontinued, a summary of treatment provided during the period under review that addresses barriers to progress and identify whether those barriers are agency or member based.
- Services plans must be updated more frequently at critical treatment junctures, if necessitated by the consumer's needs.
- Service plans must be flexible documents that are modified by the team as necessary.
- Service plans must be revisited at critical treatment junctures including changes in level of service to more intensive or less intensive types of care.
- When an intervention proves to be ineffective, the service plan must reflect consideration by the team changes in the intervention strategy.

G. Service planning may also occur at any of the following critical junctures:
- There is a proposed change in placement including admission, transfer, or discharge;
- There is ongoing non-compliance with treatment;

- Significant new symptoms are experienced or there are major changes in a consumer's condition;
- There is significant change in the consumer's environment, functional ability, health status;
- Funding for the consumer's service is significantly reduced or eliminated;
- The consumer loses eligibility for the service;
- There is an increase or decrease in service intensity or frequency;
- An even occurs that will have a negative effect on services provided to the consumer or his or her response to services; or
- The consumer or DLR requests and alteration in the services he or she is receiving.

H. Documentation

- Individual program plans for Day Treatment and other organized programs are not billable as a separate activity but are considered part of the services for which the plans were developed and are covered under the definition that the process took place.
- A written service plan is a product of that process and serves as substantiation that process took place. However, Southern Highlands also requires for any staff that participated in a service planning session to complete an individual progress note to bill for their time in addition to the service plan documentation.
- Any Advanced Directives must be included as an addendum to the plan.