Service: Service Plan Development

Service Definition

Youth/Families access this service when it has been determined through an initial screening that the youth has mental health or substance use disorder concerns. The Individualized Recovery/Resiliency Plan (IRP) results from the Diagnostic and Behavioral Health Assessments and is required within the first 30 days of service, with ongoing plans completed as demanded by individual need and/or by service policy.

Information from a comprehensive assessment should ultimately be used to develop, together with the youth and/or caretakers an IRP that supports resilience and that is based on goals identified by the individual with parent(s)/responsible caregiver(s) involvement. As indicated, medical, nursing, peer, school, nutritional, etc. staff should provide information from records, and various multi-disciplinary assessments for the development of the IRP.

The cornerstone component of the youth IRP involves a discussion with the child/adolescent and parent(s)/responsible caregiver(s) regarding what resiliency means to them personally (e.g., the youth having more friends, improvement of behavioral health symptoms, staying in school, improved family relationships etc.), and the development of goals (i.e. outcomes) and objectives that are defined by and meaningful to the youth based upon the individual's articulation of their recovery hopes. Concurrent with the development of the IRP, an individualized safety plan should also be developed, with the individual youth and parent(s)/responsible caregiver(s) guiding the process through the free expression of their wishes and through their assessment of the components developed for the safety plan as being realistic for them.

The entire process should involve the youth as a full partner and should focus on service and resiliency goals/outcomes as identified by the youth and his/her family as well as collateral agencies/treatment providers/relevant individuals.

Recovery/Resiliency planning shall set forth the course of care by:

- Prioritizing problems and needs;
- Stating goals which will honor achievement of stated hopes, choice, preferences and desired outcomes of the youth/family;
- Assuring goals/objectives are related to the assessment;
- Defining goals/objectives that are individualized, specific, and measurable with achievable timeframes;
- Defining discharge criteria and desired changes in levels of functioning and quality of life to objectively measure progress;
- Transition planning at onset of service delivery;
- Selecting services and interventions of the right duration, intensity, and frequency to best accomplish these objectives;
- Assuring there is a goal/objective that is consistent with the service intent; and
- Identifying qualified staff who are responsible and designated for the provision of services.

Admission Criteria

1. A known or suspected mental illness or substance-related disorder; and
2. Initial screening/intake information indicates a need for additional undetermined supports and recovery/resiliency planning; and
3. Youth meets DBHDD eligibility

Continuing Stay Criteria

The youth's situation/functioning has changed in such a way that previous assessments are outdated.

Discharge Criteria

Each intervention is intended to be a discrete time-limited service that modifies treatment/support goals or is indicated due to change in illness/disorder.

Required Components

1. The service plan must include elements articulated in the Community Requirements chapter in this Provider Manual.
2. As indicated, medical, nursing, peer, school, nutritional, etc. staff can provide information from the youth and family, records, and various multi-disciplinary resources needed to complete the service plan. Time spent gathering this information may be billed as long as the detailed documentation justifies the time and need for capturing said information.

Clinical Operations

1. The individual (and caregiver/responsible family members etc. as appropriate) should actively participate in planning processes.
2. The Individualized Resiliency Plan should be directed by the individual's/family's personal resiliency goals as defined by them.
3. Safety/crisis planning should be directed by the youth/family and their needs/wishes to the extent possible and clinically appropriate. Plans should not contain elements/components that are not agreeable to, meaningful for, or realistic for the youth/family and that the youth/family is therefore not likely to follow through with.
4. Detailed guidelines for recovery/resiliency planning are contained in the "Community Requirements" in this Provider Manual and must be adhered to.
5. For youth at or above age 17 who may need long-term behavioral health supports, plan elements should include transitional elements related to post-primary education, adult services, employment (supported or otherwise), and other transitional approaches to adulthood.
6. Individualized Recovery/Resiliency Plans (or portions of the plan) must be reassessed as needed, in accordance with changing needs, circumstances, and responses of the youth and family/caregiver (see content regarding the IRP in Part II of this manual). For any change in medical, behavioral, cognitive, and/or physical status of the youth that potentially impacts goals, objectives and/or interventions in the plan, or that would necessitate the addition of new goals, objectives and/or interventions, Service Plan Development would be used to support the youth and family/caregiver in revisiting their goals and objectives.

Service Accessibility

To promote access, providers may use Telemedicine as a tool to provide direct interventions to individuals for whom English is not their first language. Examples of this include:

- The use of one-to-one service intervention via Telemedicine, connecting the individual to a practitioner who speaks the individual's language versus use of interpreters; and/or
- The use of an interpreter via Telemedicine to support the practitioner in delivering the identified service.

Telemedicine may only be utilized when delivering this service to an individual for whom English is not their first language. The individual/family must consent to the use of this modality. This consent should be documented in the individual's record. The use of telemedicine should not be driven by the practitioner's/agency's convenience or preference.

Billing & Reporting Requirements

When Telemedicine technology is utilized for the provision of this service in accordance with the allowance in the Service Accessibility section of this definition, the code cited in the Code Detail above with the appropriate GT modifier shall be utilized in documentation and claims submission.