Cornerstone Behavioral Healthcare
Section 9. Client Service Plan

Cornerstone Behavioral Healthcare (CBH) will comply with the following requirements for client service plans. To the extent an organization is subject to other Department rules (e.g., 10-144 CMR Ch. 101, MaineCare Benefits Manual,) and/or existing contracts with the Department, the organization's compliance with the following requirements will also be in conformance with those other rules and/or contracts.

A. Service Plan: The service plan is the client's mutually developed and agreed-upon plan to address co-occurring conditions, including acute or chronic medical conditions, trauma, or other conditions through identification of area resources or referral. The service plan is also known as Individual Treatment Plan (ITP), Individual Support Plan (ISP) or Plan of Care (POC). CBH will ensure that service plans are developed initially and provide ongoing reviews of each client's service plan.

B. Client Participation: CBH will involve each client to the greatest degree possible, unless contraindicated, in development and ongoing review of the client's service plan.

C. Service Plan Team: Client's service plan team will include the client, the client's guardian or legal representative, clinicians, representative(s) of the organization providing services, natural supports, and other persons chosen by the client, as appropriate.

1. The service plan team will provide input and participate in the development and periodic review of the client's service plan.
2. When the client does not participate on the service plan team, CBH will document efforts to engage the client and the reason why participation did not occur in the client's service plan.

D. Coordination of Services: CBH will coordinate service planning with the client's other service providers to minimize duplication, and to maximize integrated care and coordination, in compliance with applicable confidentiality laws.

E. Personal Responsibility and Self-Determination: CBH will conduct service planning in a manner that supports the client's personal responsibility and self-determination as much as possible, or as desired by the client. This includes, at minimum, involving the client's "Voice and Choice" in setting and prioritizing treatment goals and in deciding how to measure progress toward treatment goals.

F. Explanation of Service Options: CBH will explain the client's service options, including, but not limited to, the following:

1. Available service options
2. How CBH provides support for clients to achieve desired outcomes
3. The benefits, alternatives, and risks or consequences of planned services

G. Time Frame for Completion of Service Plans:

1. CBH will complete service plans consistent with assessed needs and within time frames outlined in Sections 22 or 23, program-specific standards. CBH shall document good faith efforts to involve guardians, representatives, or legally responsible parents in Service/Treatment Plan meetings.
2. When a service plan is not completed in required timeframes, the reason(s) for the delay will be documented in the client's record.

H. Service Plan: CBH will follow all rules and regulations regarding the service plan. CBH will develop a written, time-limited, goal-oriented, individualized service plan for each client.

1. The client's service plan must be based on needs identified during the assessment process and completed within 30 days of admission, unless otherwise specified in program-specific standards.
2. The service plan begins at the date the client consents to the plan. Consenting to a service plan can happen verbally, electronically, or through a physical signature.
3. The service plan will include the following:
    a. Problem/needs statements;
    b. Short- and long-range goals based upon client need with a projection of when such goals will be obtained;
    c. Objectives stated in terms which allow objective measurement of progress; multi-disciplinary input and specification of treatment responsibilities;
    d. Methods, frequency and duration (appointments) of treatment, rehabilitation, and support;
    e. Client's agreed-upon plan to address co-occurring conditions and unmet needs, including medical conditions, trauma, or other conditions through referral to outside resources;
    f. List of identified needs that are not addressed in plan and explanation of why they are not addressed;
    g. Identification of those responsible for implementing/coordinating service plan and services provided by outside providers;
    h. Role of family and natural supports;
    i. Description of any disability and accommodations necessary to provide the same or equal service/treatments and benefits as those afforded non-disabled individuals;
    j. Strengths/resources and barriers;
    k. Criteria and plan for discharge;
    l. Input and signature by client or legal representative; signatures of all people participating in the development of the plan; and
    m. Dated signature(s)s and credentials of participating CBH staff and supervisor, if applicable.
4. Within five working days after the service planning meeting, CBH will offer the client a copy of their written service plan, documenting that it was offered or documenting an explanation if client does not receive or declines a copy.

I. Crisis Plan: When appropriate, CBH will develop a written crisis, relapse, or safety plan

1. The plan will include the following:
    a. The client's own words to describe the problems and interventions that may alleviate the crisis, whenever the client has the ability to express such concepts verbally;
    b. A description of possible crisis needs and concrete steps that may be taken by the client, the community integration worker, crisis service staff, other providers, family members and others, if appropriate and applicable, to prevent or minimize escalation of a crisis or relapse;
    c. A list of crisis service providers or hospital emergency departments made available by the organization within the client's service plan, crisis, or relapse plan; advance directives; the name of the prescriber of psychiatric medication; and contact information, as appropriate;
    d. Procedures for coordinating care during a behavioral health crisis, including procedures for informing other providers, maintaining communication during the crisis evaluation,

and following through on interventions when the client returns to the program;

- During referral and intake, each client is evaluated for potential crisis/relapse/safety risk. If a client is at risk, CBH will make referrals or give them information for supports. CBH will develop a crisis/relapse or safety plan during intake or assessment session(s).
- Supports (Family, Friends and other Providers) are identified during this process.
- If client presents in crisis/relapse, CBH will review or refer to the crisis/relapse or safety plan for steps that are applicable to the crisis/relapse.
- CBH requires a review of the plan every 90 days or 12 sessions, and after a Crisis Event.
- Depending on the plan, CBH will contact supports and follow-up with supports based on the releases we have in place.
- If client doesn't have a plan in place, CBH will work with them to deescalate the event. After the event, CBH will work with the client to develop a plan.
- Appropriate staff will receive training in crisis/relapse management.

e. A behavioral support plan, as appropriate

2. In addition to the plan, the following steps will be taken
   a. CBH will use strategies to prevent frequent unnecessary client utilization of emergency services, including emergency room, police, and ambulance services, when such a pattern is known.
      - CBH will use various methods to identify high users of emergency services.
      - When identified, providers will be notified
      - For high utilizers, case discussions will be reviewed with an interdisciplinary team and strategies or techniques implemented to try and reduce ER/ED use.
   b. Clients will be offered the opportunity to develop a psychiatric advanced directive or will be asked to provide their advanced directive if they already have one.

J. Progress Notes: CBH's progress notes will be completed within 72 hours for all client related contact. Progress notes will relate to specific problems or goals on the service plan and serve as the basis for evaluating treatment outcomes. Progress notes include, without limitation:

1. Documentation of implementation of the service plan or focus of treatment;
2. Documentation of client's location during session and participants;
3. Documentation of all treatment rendered to the client;
4. Documentation of progress the client is making toward attaining the goals or outcomes identified in the service plan; and
5. The date, signature and professional qualification of the individual making the entry in the medical record.

K. Periodic Review and Update of Service Plan: CBH will periodically review and update each client's service plan per specific service requirements.

1. Service plans are reviewed at least every 90 days, unless otherwise specified in the program-specific standards. See Sections 22 Mental Health Programs & 23 Substance Use Disorder Treatment Programs.
2. The periodic review process is consistent with the process used to develop the initial

service plan.

3. CBH will assess the appropriateness and medical necessity of continued services for a client during its periodic review of the client's service plan and as indicated.
4. CBH will conduct an expedited service planning process when an urgent need or significant change has been identified, as needed or applicable. Following a crisis episode, a review of the crisis plan and/or service plan is required.

Sharon Jordan _____ 09/08/2025 _____

Clinical Director Date