BHRS Interagency Service Planning Team
Meeting Summary
All Counties

PART 1: Interagency Service Planning Team Sign-In and Concurrence Documentation

Member Name: DOB: Date of Meeting:

Parent/Guardian/Member: In completing the question "Date behavioral health services first requested", please fill in the date that you (or someone else with your consent) first asked any BHRS (wraparound) provider, county MH/MR worker or behavioral health managed care organization (MCO) for assistance in obtaining these services. Also fill in the name of the agency, county or MCO that was asked for assistance, the name of the person (maybe you) who asked and that person's relationship to your child.

Date behavioral health services first requested: To which county, provider, or CCBH:

By Whom: Relationship to Member:

I agree with the information above (Parent/Guardian/Member Signature): _____

Confidential information will be discussed during this Inter-Agency meeting. My signature below signifies that I agree that I will not disclose this information without the appropriate written consent of the parent/guardian and/or the member and as permitted by state and federal laws and regulations. At the end of the meeting, I also indicated whether I agree or disagree with the goals of the treatment plan, recommended services and the plan of care summary developed during the meeting.

Name (Include title or credentials if applicable)	Agency/Phone (if applicable)	Relationship to Child/Adolescent	Method of Particpation ☐ Meeting ☐ Input	Agree	Disagree
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

* P= In Person S= Speakerphone RO= Report Only (Not present, but submitted information) NP= Invited but not present, note reason

Notice for Members and Families: Any complaints and problems associated with access to services should be initially directed to providers, counties or Community Care. Complaints and problems not resolved in a timely manner, can be directed to the following contacts in the Commonwealth's regional field offices of the Office of Mental Health and Substance Abuse Services:

REGIONAL FIELD OFFICE	TELEPHONE NUMBER
Central (Harrisburg) Field Office	717-772-6835
Western (Pittsburgh) Field Office	412-565-5226
Northeast (Scranton) Field Office	570-963-4335
Southeast (Norristown) Field Office	610-313-5844

Documentation of Disagreement:

Member Name:

Any member of the interagency team in disagreement with the goals of the treatment plan, recommended services, and Plan of Care summary developed during the meeting is to briefly note the reasons for their disagreement below and sign name.

PART 2: Summary of the Interagency Service Planning Meeting

A. ISPT Meetings is for: ◯ Initial POC ◯ Continued Stay POC ◯ Amended POC ◯ Transfer POC

B. Discussion of Child and Family Strengths:

_____ ISPT facilitator's initials to verify discussion of Child and Family strengths at the ISPT Meeting

Please list any *additional* Child and Family's Strengths discussed by the Interagency Team that have not been noted elsewhere. Please incorporate these into the BHRS treatment plan:

1. Child Strengths:

2. Family Strengths:

c. Discussion of Child and Family/Caregiver Goals for Recovery/Independency and the Progress Made Over the Last Treatment Period

_____ ISPT facilitator's initials to verify discussion about child and family/Caregiver's goals for recovery/independency and what they hope to achieve, i.e., learn new information, acquire new skills, fine tune skills, etc., over this treatment period to further enhance their independence, all of which is documented in the attached BHRS treatment plan.

_____ ISPT facilitator's initials to verify discussion about child/family/caregiver progress at ISPT meeting, which is documented in the attached BP evaluation and BHRS treatment plan.

Please describe the progress made by the Child and Family/Caregivers over the last treatment period discussed by the Interagency Team that has not been noted elsewhere. Please incorporate this information into the BHRS treatment plan:

1. Child's Progress:

2. Family Progress:

3. Caregiver Progress:

Member Name:

D. Discussion of Child's Symptoms/Behaviors for Which Recommended Services are Being Prescribed

_____ ISPT facilitator's initials to verify discussion of symptoms/behaviors as related to prescribed services

Please list the Child's Current Symptoms/Behaviors discussed by the Interagency Team that have not been noted elsewhere or have significantly changed since the BP evaluation. Please describe how the symptom/behavior looks, domains in which it is occurring, frequency and severity. Please incorporate this information into the BHRS treatment plan:

E. Summary of Significant Changes or Stressors Since the BP Evaluation:

F. Coordination of Current Services
Current Treatment Services (Please check all that apply)

☐ Inpatient MH	☐ Diversion/Stabilization	☐ RTF	☐ IRT/TFC/CRR	☐ Partial Hospital
☐ School-based PHP	☐ FBMH	☐ FFSB	☐ FFT	☐ BHRS (MT/BSC/TSS)
☐ BHRS-STAP	☐ BHRS-Social Skills	☐ BHRS-Other	☐ MST	☐ BHRS Exception Program
☐ Outpatient Therapy	☐ Medication Mgt	☐ D&A	☐ Admin CM	☐ ICM/RC/Blended/Targeted
☐ Mobile Crisis	☐ PCP/Medical	☐ ISC	☐ Habilitation Aide	☐ Other MR Services
☐ Speech/Language	☐ OT	☐ PT	☐ Early Intervention	☐ Group Home
☐ Other (describe):				☐ None

G. Review of Recommendations from the BP Evaluation/Re-evaluation:
The evaluation recommends the following BHR Services (please check all that apply and fill in blanks):

☐ BSC @ ____ hrs/ week ○ month ○ (please indicate if the RX is weekly or monthly)

☐ MT @ ____ hrs/per week

☐ TSS @ ____ hrs/per week; which includes ____ at home/community and/or ____ at school

☐ STAP @ ____ hrs/per week for the following time period From: ____ To: ____

☐ Other BHRS Exception Program (please specify type & amount): ____

H. Current Barriers to Treatment Progress (please check all that apply):

Member	☐ None ☐ Trauma	☐ Physical Health Issues ☐ Lack of Participation in TX	☐ Cognitive Challenges ☐ Developmental Challenges
	☐ Other (describe):		
Parental	☐ None ☐ Cognitive Challenges ☐ Legal Issues ☐ Parenting Challenges	☐ MH Issues ☐ Substance Use/Abuse ☐ Employment Issues ☐ Lack of Participation in Tx	☐ Physical Health Issues ☐ Domestic Violence ☐ Absent Parent ☐ Lack of Phone
	☐ Other (describe:):		
Environmental	☐ None ☐ Lack of Transportation	☐ Housing ☐ Neighborhood Safety Issues	☐ Financial ☐ Other (describe):
	☐ Other (describe):		
Provider	☐ None	☐ Staff Turnover	☐ Inconsistent Service Delivery
	☐ Other (describe:):		

_____ ISPT facilitator's initials to verify discussion about current barriers to treatment and development of a plan to overcome identified barriers, which is documented in the attached BHRS treatment plan and/or BP Evaluation

Member Name:

I. Delineation of Task Assignments to ISPT Members:

Follow-Up Task	Responsible Person	Target Date for Completion

J. Discussion of Discharge & Aftercare Planning:

_____ ISPT facilitator's initials to verify that the ISPT discussed discharge planning, identified discharge criteria, and identified resources and services needed at discharge, all of which is documented in the attached BHRS treatment plan and/or BP Evaluation

Anticipated Date of Discharge from BHRS:

Anticipated Needs for Resources and Services at Discharge (Check all that apply and fill in blanks as indicated):

MH Services	☐ None	☐ Admin CM	☐ ICM/RC/Blended/Targeted	☐ Mobile Crisis	☐ CACTIS
	☐ Outpatient Therapy	☐ Med Mgt	☐ BHRS-(MT/BSC/TSS)	☐ BHRS-STAP	☐ BHRS-Social Skills
	☐ MST	☐ FBMH	☐ BHRS-Exception	☐ Partial Hospital	☐ School-based PHP
	☐ FFSB	☐ FFT	☐ IRT/TFC/CRR	☐ RTF	☐ Inpatient MH
	☐ D&A	☐ Other (describe):			
MH Services	☐ None	☐ ISC	☐ MR Services	☐ Other (describe):	
Other Service Systems	☐ None	☐ CYF	☐ JPO	☐ Education (describe):	
	☐ Other (describe):				
Natural Resources (describe):					
Community Resources (describe):					
Other (describe):					

K. Plan for Next Interagency Service Planning Meeting:

Date of Next ISPT Meeting: Below, list any additional participants needed for next ISPT meeting who did not attend today's meeting

_____ ISPT facilitator's initials to verify that a copy of the completed ISPT Summary has been given to the Member (age 14 or older) and/or Family/Guardian

Member Name:

L. ISPT Recommendations for Behavioral Health Services, including levels of care and/or service intensity (please check all that apply):

☐ SAME AS BP EVAL: The ISPT recommends the same service and service intensity as reported in the current BP Evaluation and TSS Schedule Form (PLEASE NOTE: If you have chosen this option the ISPT Summary is complete; Part 3 & 4, Final TSS Schedule Form and Prescriber Collaboration does not need to be completed)

☐ DIFFERENT FROM BP EVAL: Please clearly specify all changes in service recommendations that differ from the evaluator's recommendations, e.g., the addition of a service, an increase or a decrease in service intensity:

Rationale for changes indicated above (please be specific in your explanation):

*****PLEASE NOTE: THE FINAL TSS SCHEDULE MUST BE COMPLETED AND INCLUDE ALL RECOMMENDED TSS HRS (not just the recommended changes in hours) FOR ANY CHANGE IN TSS HOURS, ACTIVITY AND/OR DOMAIN**

M. Signature of ISPT Facilitator/Lead Clinician conducting the ISPT:

My signature below confirms that I have completed all expectations requiring verification via my initials to the best of my ability.

_____ _____

(Name, Degree, Title) **(Agency)**

_____

(Date)

PART 3: FINAL TSS Schedule Form for Prescriber/Family and ISPT Collaboration

TSS Schedule Form for Prescriber/Family & ISPT Collaboration All Counties

Member Name:

Today's Date

Prescriber:

MA Level Evaluator (if applicable):

Child/Family Member(s) Involved in the TSS Discussion:

TSS Service Request (please select one): ◯ Initial POC ◯ Continued Stay POC ◯ Amended POC ◯ Transfer POC

Day/Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7AM							
8AM							
9AM							
10AM							
11AM							
12PM							
1PM							
2PM							
3PM							
4PM							
5PM							
6PM							
7PM							
8PM							
9PM							
Total TSS Hrs/day							

Total TSS Hrs/week

- Please discuss the child & family's goals for recovery, resiliency, and independence & how TSS can be used for the purpose of skill building/transfer to attain these
- Please assure that the family and/or caretaker(s) are able to participate as guided by the Tx plan with the goal of skill transfer for all prescribed TSS.

Time	Write in Day(s) below on the first line & Activity and Behaviors/Symptoms/Focus of Treatment on the second line. (please use to document activity and behaviors/symptoms which are the focus of treatment for TSS intervention during each day and time period on page 1 when additional space is needed) **Note**: Days & times for the same activity with the same focus may be documented together.
	Day(s): Activity & behaviors/symptoms/ treatment focus:
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	Day(s): Activity & behaviors/symptoms/ treatment focus:
	Day(s): Activity & behaviors/symptoms/ treatment focus:

Member Name:

PART 4: Communication and Collaboration with the Prescriber

A. Review of Service Recommendations from the Interagency Service Planning Team including service types and intensity, and rationale for recommendations when different from the BP evaluation.

_____ Prescriber's initials to verify review of Service Recommendations from the ISPT, which are documented in Part 2, Section L, of this document.

B. Final Recommendations and Prescription for Services (to be completed by Prescriber)

☐ Same as reported on the psychiatric/psychological evaluation (Please note that it is not necessary to have prescriber sign-off if the evaluation and ISPT recommendations are the same)

☐ In Full Agreement with the recommendations of the Interagency Service Planning Team as listed in Part 2, Section L

☐ Revised after consideration of the information presented by the interagency team. The final prescription for services is as follows: (Please note that if TSS hrs are different from the recommendations in the BP Evaluations and different from the ISPT recommendations, an updated "Final TSS Schedule" is required to be completed by the prescriber and submitted with the BHRS packet)

Prescriber's Name: _____
(Please Print Name, Degree)

Prescriber's Signature: _____ **Date:** _____
(Name, Degree