TREATMENT PLAN

This procedure has information for entering the first treatment plan to the client's case and also on creating another version of the treatment plan for a client who already has one (i.e. - Client transferred level of care, etc.)

The ASAM needs to be updated before completing the clients initial Treatment Plan. See Appendix A for more information on updating the ASAM.

If the Treatment Plan cannot be finished in one session then at least try to get the Overview Screen information completed. You can then go back and finish the rest of the Treatment Plan at the next session.

Entering in a Treatment Plan:

1. At the client's Activity List, left menu bar click on "Treatment"

2. Left menu bar, click on "Tx Plan"

3. At the Treatment Plan List screen, click on *Add New Treatment Plan Record* yellow hyperlink.

4. Profile Screen –
   a. Enter in Plan Name – usually numeric (1, 2, etc.)
   b. Enter in Plan Start Date- this box is generated with the date that you start the plan.
      i. NOTE: if you do not finish your treatment plan on the first day you create it, you will need to remember to update this date every time you update the plan until the day you actually finish the plan and sign off on it.
   c. Enter in Next Review Date- the next review data is usually so many days after the treatment plan is made. For OP=30 days, IOP=7 days, After Care= 90 days, Res=7 days and Hwh = 30 days. This is in terms of the Tx Plan Review.
   d. Enter "Yes" for the 'Client Participated in TX Plan Development' question.
      i. NOTE: even though you have answered 'Yes' to this question, you still need to document that in all sessions (entered Encounter Notes) that you worked with the client on the Tx Plan.
   e. Click "Save" and "Next"

5. Overview Screen- fill in each box with appropriate information
   a. Assessments Reviewed – this box can be left blank. It is up to your Director/Supervisor if they want you to fill this in or not.
   b. Strengths/Resources/Abilities/Interests/Barriers to Success – Use to list strengths, needs and areas to be improved.

c. Transfer/Discharge Criteria – What client needs to do to complete treatment successfully (i.e. complete treatment plan goals/objectives, provide negative urinalysis, services to be provided, etc.)
d. Client Comments Regarding Treatment Goals – What client wants to get out of treatment (get off probation, get license back, quit using, etc), client's motivation for treatment or anything else they have to say. This does not need to be in client's own words and it does not need to be in quotes.
e. Clinicians Comments/Recommendations – Recommending group sessions, if client verbalizes a desire to make changes, etc.
f. Click "Save" and "Next"

6. Diagnosis Screen. Make sure this screen has the diagnosis(s) listed. Update or enter if necessary. Click "Next".

7. Treatment Plan Problem/Goal List screen- click *on Add new Treatment Plan Problem/Goal Record* yellow hyperlink. At least one goal should be substance related. This Treatment Plan also can look kind of standardized. In order for it to become more individualized you need to utilize the comments boxes.
   a. Select correct Program Name – this is the client's current Program Enrollment.
   b. Problem/Goal Status = this field defaults to "In Treatment", please leave it as this.
   c. Problem Category = select appropriate answer.
   d. Problem = select appropriate answer.
   e. Comments – enter if necessary.
   f. Strengths/Resources = select appropriate answer.
   g. Comments- enter if necessary.
   h. Goal = select appropriate answer.
   i. Comments- enter if necessary.
   j. Projected Achievement Date – this is the date the goal should be reached.
   k. Click on "Save".
   l. Click *Add Objectives* yellow hyperlink.
      i. Objectives = select appropriate answer from dropdown. Select "Other. See Comments" to type in your own objective.
      ii. Comments – enter if necessary or if you used "Other" for the objective.
      iii. Objective Status = In Progress
      iv. Place date in Expected Achievement Date in which you expect this objective to be completed.
      v. Click on "Save" and "Finish"

8. At the Problem/Goal Profile screen you may click on the *Add Objectives* hyperlink if you want to add in another objective to this problem. Repeat as necessary until all objectives you and client want to work toward are entered.

9. When you are finished with all the objectives for this problem click on "Finish".

10. At the Treatment Plan Problem/Goal screen if there are more problem/goals for this treatment plan repeat Step 7 thru 9 for each ASAM Category that is appropriate.

11. When finished click on "Next"

12. Planned Services screen – you may skip this screen.

13. At the Plan Outline screen review the items you entered for the client's problems, goals and objectives. If changes need to be made go back to the Treatment Plan Problem/Goal screen and make them now before signing off on the treatment plan.

14. Once you are sure everything is complete, click on "Finish".

You are back at the Treatment Plan Profile Screen. Plan Status field (which is located underneath the Plan Name field,) shows plan as "Active-Not Signed Off."

1. Click on the <u>Sign Off</u> hyperlink to access the Sign Off Confirmation screen.

2. At this screen it says "Click Yes only if ….." Click on Yes to confirm the treatment plan approval.

3. This takes you back to the Treatment Plan Profile Screen. Notice that this screen is now grayed out and that the Plan Status field says "Active-Signed Off."

4. Click on Finish.

5. You are now at the Activity List screen and you will see your newly created Tx Plan in the list.

You will need to print something for the client to sign. We are only printing the Plan Outline screen of the Treatment Plan.

1. At the client's Treatment Plan go to the Plan Outline screen.

2. Click on Print View in the upper right hand corner. This will open up another window with just the Plan Outline information in it.

3. To print, from the tool bar click on File/Print.

4. This page will need to be signed and dated by both you and the client.

5. Offer the client a copy and put the original in the client's paper file.