GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Treatment Plan	**POLICY NO:** AD-CL-07	Page **1** of **5**
RESPONSIBILITY: Personnel		
APPROVED BY: _____ DIRECTOR	**EFFECTIVE: 07/15/2015**	
	LAST REVIEWED/REVISED: NOV 16 2018	

PURPOSE:

To establish policies and procedures for the initiation, development, implementation, and review of treatment plans for each consumer at Guam Behavioral Health and Wellness Center. Treatment plans are necessary to guide the multidisciplinary treatment team as to assist the consumer in their recovery.

POLICY:

A. It is the policy of Guam Behavioral Health and Wellness Center to initiate, develop, implement, and review treatment plans in accordance with Code of Federal Regulation (CFR § 482.61) and Commission on Accreditation for Rehabilitation Facilities (CARF).

1. Each consumer will have a person-centered treatment plan. It shall be developed by the lead provider in conjunction with a multidisciplinary team if appropriate. Overall development, implementation, and revisions and documentation of the treatment plan is the responsibility of the consumer's Lead Provider.
2. It shall be developed with the active participation of the consumer and involvement of their family/legal guardian and other service providers when applicable and permitted, and shall be based upon the consumer's strengths, needs, abilities and preferences.
3. The Lead Provider shall ensure that all the components of the CARF standard treatment plan is met. The following elements should be present;
    a. Goals are expressed in the words of the consumer, and or clinical goals that are understandable to the consumer.
    b. Specific service or treatment objectives are measurable, achievable, time specific and appropriate to the service/treatment setting.
    c. Identification of specific interventions, modalities, and /or services to be used.
    d. Frequency of specific interventions, modalities, or services

B. An initial treatment plan recommendation based on the interpretive summary shall be developed by the intake worker within 3 business days of clinical intake in AWARDS Plans and Reviews Module. The initial treatment plan shall then be reviewed, updated and signed by the assigned Lead Provider within 30 days of admission to the Outpatient Program.

C. Treatment plan shall be reviewed and updated regularly based on the need such as, if new concerns or significant change would arise as well as mandated by CARF regulatory requirement. The following review frequency shall be adopted by GBHWC;
    1. Within 3 days and as needed – for Crisis Stabilization Unit
    2. Monthly Review - for Residential Recovery Program and D&A Intensive Outpatient Program
    3. Quarterly - for all other programs

DEFINITIONS:

Treatment Plan: a written direction that describes the consumer's individualized diagnosis, strengths, disabilities, problem behaviors, needs, long-range goals, short-term goals, treatment interventions, and treatment providers.

Interpretive summary: a written clinical formulation that consolidates and summarizes the available information about a consumer based on the assessment data, identifies strengths, any co-occurring disabilities, treatment recommendations and prognosis. It identifies needs and addresses how they are considered when developing the treatment plan.

RESPONSIBILITY:

Intake Worker: Conducts intake assessment, completes the assessment tools, writes the interpretive summary and completes an initial treatment plan.

Lead Provider (LP): Ensures the treatment plan is accurate, up-to-date, and reviewed regularly and documented. LP is also responsible for ensuring that other service providers are active in the development, updates, and review of the treatment plan and that the plan includes goals, objectives, and interventions from all other services.

PROCEDURE:

Outpatient Programs Treatment Plan

A. Initiation and Development of Treatment Plan/Wrap Plan:
    1. Intake worker shall conduct a comprehensive intake assessment that includes current and historical information about the consumer/youth.
    2. From this assessment, the needs and strengths of the consumer/youth are identified, and it is this information that assists the worker establish goals and objectives that will be focused on in treatment.
    3. Formulate the interpretive summary, which is an integration and interpretation of the history and assessment information collected during intake.
    4. A preliminary or initial treatment plan recommendation shall be formulated and recorded by the intake worker in the Plans and Reviews module of the electronic health record (AWARDS).
    5. Intake worker will present case to the treatment team for identification of Lead Provider (LP) and other services.
    6. The initial treatment plan in AWARDS shall be reviewed, updated by the LP and signed after 3 encounters with the consumer, youth & family within 30 days of admission to the program whichever comes first.
    7. A done date in AWARDS must be selected once a treatment plan is reviewed, updated or completed.
    8. The LP shall coordinate with the other treatment team providers when updating the initial treatment plan and have the other providers sign the treatment plan as well.
    9. The treatment plan should include specific interventions to address the safety of the consumer, including chronic and acute medical needs that require direct intervention or monitoring.

10. The LP and/or the multidisciplinary treatment team will present the treatment plan to the consumer/youth, family or guardian, offer explanation, answer questions, and provide a copy. The consumer or guardian will have an opportunity to express her/his opinions about the information on the treatment plan and sign the plan.

B. Review of Treatment Plan/Wrap Plan
    1. Treatment plan shall be reviewed within 30 days of admission and every three (3) months thereafter.
    2. The Lead Provider shall schedule a treatment plan meeting with the other treating staff, (if other Behavioral Health Discipline is also providing service to the consumer), the consumer and legal guardian if appropriate.
    3. All staff providing intervention shall complete an assessment prior to the scheduled meeting to assess the consumer's current status and prepare for the review meeting.
    4. During the review, progress of the consumer or no progress towards the goal should be documented, as well as identification of a new goal if appropriate.
    5. The lead provider should update the treatment plan to reflect consumer's progress, the current needs identified from the assessment, modify goals, objectives, and interventions.
    6. The consumer should sign the treatment plan as well as all the other treating providers (treatment team).
    7. The Lead Provider is responsible for providing a copy of the treatment to the consumer.

<u>Inpatient Unit Treatment Plan</u>

A. Initiation and Development of Treatment Plan
    1. The staff nurse/Intake worker shall conduct a crisis intake assessment that includes current and historical information about the consumer and nursing assessment.
    2. The multidisciplinary treatment team (social worker, counselors) will provide supplemental assessments of the patient if necessary and the results will be incorporated into the treatment plan.
    3. A psychiatric examination will be conducted within 24 hours, to include an interpretive summary of the assessment and result will be incorporated into the treatment plan.
    4. From this assessments, the immediate needs and strengths of the consumer are identified, and it is this information that assists the staff nurse in collaboration with the Attending Psychiatrist and other service provider to establish crisis stabilization goals and objectives that will be focused on in treatment.
    5. The admitting Registered Nurse (RN) who conducted the crisis assessment shall write the initial treatment plan with the collaboration of the attending psychiatrist in AWARDS within 24 hours of admission to the unit.
    6. The consumer, staff nurse, attending psychiatrist and other multidisciplinary team members (social worker and counselor in the unit) will sign the treatment plan once completed.

B. Updates and Review of Treatment Plan
    1. Treatment plan shall be reviewed and updated within three (3) days in the Crisis Unit and as needed whenever there is a significant change in the consumer's condition.

2. After each Psychiatrist rounds, treatment plans shall be reviewed and updated if necessary.
3. The RN shall update the treatment plan to reflect consumer's progress, the current needs identified during the rounds, modify goals, objectives, and interventions if necessary in collaboration with the attending Psychiatrist.

4. The treatment team will present the treatment plan to the consumer or guardian, offer explanation, answer questions, and provide a copy. The consumer or guardian will have an opportunity to express her/his opinions about the information on the treatment plan and sign the plan.

Residential Recovery Program

A. Initiation and Development of Treatment Plan
    1. Information for the intake assessment should be gathered during case presentation of the referring Outpatient Lead Provider, with the consumer present if possible.
    2. During the case presentation, the needs and strengths of the consumer are identified, and it is this information that assists the RRP clinical team establish goals and objectives that will be focused on in treatment.
    3. The assigned intake worker in RRP shall complete the intake assessment of the consumer in the electronic health record (AWARDS) that includes current and historical information about the consumer after the case has been presented to the RRP clinical team.
    4. The intake worker shall formulate the interpretive summary, which is an integration and interpretation of the history and assessment information collected during intake.
    5. Once the goals and objectives are jointly decided, a preliminary or initial treatment plan shall be formulated and recorded in the Plans and Review module in AWARDS within three (3) days of intake or case presentation.
    6. RRP Intake worker will discuss the case with the RRP clinical treatment team for identification of Lead Provider (LP) and other services.
    7. Upon further assessment of the consumer, initial treatment plan shall be reviewed and updated to a comprehensive treatment plan by the clinical team within 30 days of admission.
    8. The treatment plan should include specific interventions to address the safety of the consumer, including chronic and acute medical needs that require direct intervention or monitoring.
    9. The Lead Provider will document the review and updates to the initial plan with the input of other clinical team members, dated and signed.
    10. The multidisciplinary treatment team (RRP Clinical team) will present the treatment plan to the patient or guardian, offer explanation, answer questions, and provide a copy. The patient or guardian will have an opportunity to express her/his opinions about the information on the treatment plan and sign the plan every quarter during a quarterly review and/or in the annual Multi-Disciplinary Treatment Planning (MDTP).

B. Updates and Review of Treatment Plan
    1. Treatment plan shall be reviewed by the Lead Provider monthly.
    2. The Lead Provider shall schedule a treatment plan meeting with the other treating staff (multidisciplinary treatment team meeting) the consumer and legal guardian if appropriate every 3 months.

3. The clinical staff providing service/intervention shall complete an assessment prior to the scheduled meeting to assess the consumer's current status and prepare for the quarterly review meeting.
4. During the review, progress of the consumer or no progress towards the goal should be documented, as well as identification of a new goal if appropriate.
5. The lead provider should update the treatment plan to reflect consumer's progress, the current needs identified from the assessment, modify goals, objectives, and interventions.
6. The consumer and /or legal representative as well as all the other treating providers (treatment team) shall sign the treatment plan annually.
7. The Lead Provider is responsible for providing a copy of the treatment to the consumer.

REFERENCE(S):
ATTACHMENT(S):

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER DOH 101618-015
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

[x] Policy and Procedure **Submitted by: Cydsel Toledo**

[ ] Protocol/Form **Policy No: AD-CL-07**

[ ] Bylaws **Title:** Treatment Planning

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