POLICY MANUAL

Subject: Treatment Plan Review **Effective Date**: 10/91

Initiated By: Mike Todd
Clinical Director

Approved By: James B. Moore
Chief Executive Officer

Review Dates: 2/94, 2/95 CSF, 2/15/97 CSF
02/09 DF, 05/09 BLA, 01/10 Committee
02/11 Committee, 02/14 Committee

Revision Dates: 12/10/98 CSF
12/02 CSF, 11/08 LH, 03/12 DK
4/12 DNF, 05/13 WRPC, 2/14 CH

POLICY:

The multidisciplinary treatment teams of the Residential Adult, Residential Youth, and Intensive Outpatient Services conduct a treatment plan review session in which each patient's progress is reviewed. Reassessment is also conducted when major clinical changes occur, including family, social, or life events. This may also occur at daily staff meetings, as well as at the formal review sessions.

PROCEDURE:

1. The assigned counselor is responsible for presenting the patient and his/her progress to the treatment team by the seventh day of residential treatment and the seventh outpatient session.

2. The counselor presents a brief synopsis of the patient's presenting problems and history to date with comments about his/her perceptions of the patient's progress toward identified goals and objectives. The treatment team then reviews the patient's progress.

3. The Treatment Plan Review is structured as followes:

Admission Date:
Estimated Discharge Date:

TRANSITION AND RECOVERY PLAN:

Living Arrangements: [Remove any unused elements or numbering below so there are no blank items.]
Psychiatrist: [Essential if patient is on psychotropic medications]
Primary Care Physician: [Essential for patients with serious medical conditions, such as diabetes or liver problems]
IOP/PHP/Individual therapy: [Central clinical recommendation developed in collaboration with the patient]
Recovery Support: [Includes patient-specific activities. e.g. daily 12-step meetings for 90 days, step-work with a sponsor, weekly aftercare meetings, regular communication with a particular supportive relative and/or friend, etc...]
CH IOP covers: Need for SRA follow up, update on current medications to the patient is taking, UDS, and action plan.

PROGRESS ON CURRENT OBJECTIVES:

Problem 1:
Objective Progress: [e.g. Progress on treatment work, identification of relapse risks and coping skills, etc.][CH IOP – Substance Use Disorder]

Problem 2:
Objective Progress: [e.g. Changes in mood/affect, cravings, demonstrated insights, group/peer interaction, etc.][CH IOP – Sober support system]

Problem 3:
Objective Progress: [e.g. Lack of insight or commitment, difficulty completing treatment tasks, etc.] [Spirituality]

FAMILY ISSUES AND FAMILY PARTICIPATION IN TREATMENT:

1) [If this is documented in the section above, you may write, "See Problem 3" or whichever problem covers it.]
2) [Focuses on issues regarding relationships in the patient's home recovery environment]

SAFETY CONCERNS AND RISKS OF CONTINUED USE:

1) [e.g. driving, caring for children, or working in a safety sensitive environment while impaired]
2) [e.g. overdose, IV use, medical risk, recent SI/SA/HI, at risk of contracting STD, reckless/impulsive behaviors]
3) [e.g. marriage or job in jeopardy, illegal activities/incarceration, selling drugs, educational career in jeopardy]

RELAPSE RISK FACTORS:

1) [Comes from the BPS section "Obstacles to Recovery" but more info is added as it is discovered]
2) [e.g. poor impulse control, cravings, prevalent use in social circle or at job site, spouse or roommate uses]
3) [e.g. anxiety/depression, stress from job, marriage and/or children, active trauma feelings, isolation, etc.]

CURRENT BARRIERS TO TRANSITION:

1) [Answers the question, "Why does this patient continue to need 24 hour residential care instead of IOP?"]
2) [These are often relapse risk factors that the patient has not yet developed adequate coping skills for]
3) [These are not to be charted as uncompleted treatment objectives, but as problems the objectives are addressing.]

OBJECTIVES/PLAN FOR THE WEEK:

1) [Answers the question, "What still needs to be worked on before the patient is ready for transition to IOP?"]
2) [These are often current uncompleted treatment plan objectives that address the transition barriers listed above.]

CH IOP – UPDATES TO TREATMENT PLAN:

[Counselor Name, Credentials]

TREATMENT TEAM REVIEW AND UPDATES TO TREATMENT PLAN:

The treatment team met on this date to review treatment plan progress and emerging patient needs.

1) [e.g. newly discovered relapse triggers that need addressing and coping skills identified that need development]
2) [e.g. triggers could be emotions, situations, thoughts, relationships, low self-confidence, unresolved trauma, etc.]

[Meeting Facilitator/Coordinator, Credentials]

4. In addition to those disciplines mentioned, a variety of other team members may contribute as appropriate. These include, but are not limited to, the Referral Relations Liaison, the Recreation Therapist, Art Therapist, etc.

5. Suggestions for revision of treatment plans are made by a variety of team members. The counselor is then responsible for discussing these with the patient and incorporating them as appropriate.

6. The Treatment Plan Review also includes discussion of continuing care planning. Subsequent reviews refine and update both of these elements.

7. Treatment Plan Review also documents the names of the multi-disciplinary team members in attendance.

8. All of the above is documented in the EMR and is labeled Treatment Plan Review.

9. Outpatient Treatment Plan Review is conducted once per week and led by the Outpatient Services Director.