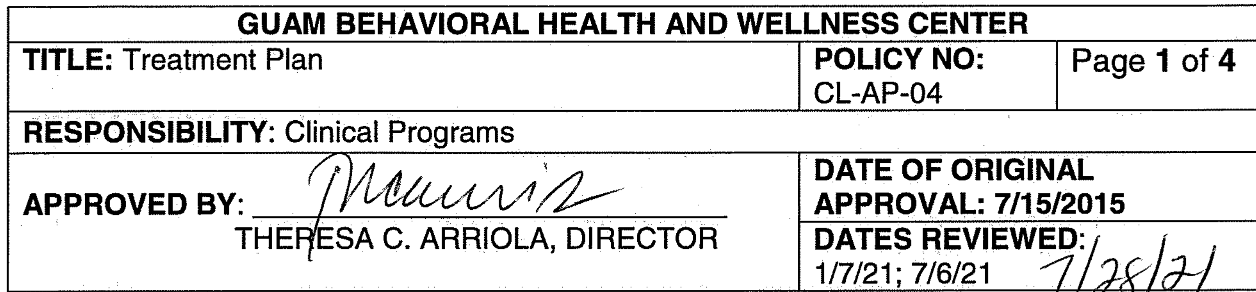

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER		
TITLE: Treatment Plan	**POLICY NO:** CL-AP-04	Page **1** of **4**
RESPONSIBILITY: Clinical Programs		
APPROVED BY: [signature] THERESA C. ARRIOLA, DIRECTOR	**DATE OF ORIGINAL APPROVAL: 7/15/2015**	
	DATES REVIEWED: 1/7/21; 7/6/21 7/28/21	

PURPOSE:

To establish a policy and procedure for the initiation, development, implementation, and review of consumer's treatment plan. Treatment planning is necessary to guide the treatment team and the consumer in their recovery. This policy is in compliance with Commission on Accreditation for Rehabilitation Facilities (CARF) standard 2.c.1-4, and Certified Community Behavioral Health Clinic (CCBHC) 4.E 1-8.

POLICY:

A. It is the policy of GBHWC to initiate, develop, implement, and review treatment plans in accordance with 42 CFR § 482.61, CARF and CCBHC standards.
   1. Each consumer shall have a person-centered treatment plan, integrating prevention, medical and behavioral health needs and service delivery which includes a safety plan, if applicable.
   2. It shall be developed by the Lead Provider (LP) in conjunction with a treatment team or wrap team, if appropriate. Overall development, implementation, revision and documentation of the treatment plan is the responsibility of the consumer's LP.
   3. It shall be developed with the active participation of the consumer and involvement of their family/legal guardian and other service providers and shall be based upon the consumer's strengths, needs, abilities, and preferences.
   4. The Lead Provider shall ensure that all the components of the CARF standards and CCBHC for treatment planning is met. The following elements should be present:
      a. Treatment planning includes needs, strengths, abilities and preferences
      b. Goals are expressed in the words of the consumer and/or clinical goals that are understandable to the consumer.
      c. Specific service or treatment objectives are measurable, achievable, time specific, and appropriate to the service/treatment setting.
      d. Identification of specific interventions, modalities, and /or services to be used.
      e. Frequency of specific interventions, modalities, or services

B. An initial treatment plan is developed by the intake worker based on the interpretive summary within 3 business days of intake for routine needs, and within 24 hours for urgent needs.

C. Crisis Stabilization unit and other programs with short lengths of stay will have a shorter treatment plan of care and must be completed with 24 hours upon admission and reviewed every 3 days.

D. A **review and update of the initial treatment plan** to an **integrated comprehensive plan addressing the medical and behavioral health needs** will be completed within

60 business days by the multidisciplinary treatment team for all outpatient mental health, drug and alcohol program and residential program.

E. Treatment plan shall be reviewed and updated regularly based on the consumer's needs such as, if new concerns or significant change would arise as well as mandated by CARF regulatory requirements. The following review frequency shall be adopted by GBHWC:
    1. Mental Health Outpatient Programs and Healing Hearts Crisis Center: quarterly
    2. Drug & Alcohol Program: monthly for intensive outpatient.
    3. Crisis Stabilization Unit: within 3 days of admission and as needed
    4. Residential Recovery Program and SERENITY: monthly

DEFINITIONS:

Done Date: The date data entry on the treatment plan was completed. The done date does not lock the treatment plan from further edits, nor does it speak to any other areas in AWARDS.

Due Date: The date when the treatment plan is due to be completed.

Effective Date: The date the treatment plan goes into effect and services can be entered/associated with the treatment plan (such as Service Plan Linked progress notes). Entering an effective date finalizes and locks the treatment plan from further edits.

Integrated Comprehensive 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. An individualized plan integrating prevention, medical and behavioral health needs and service delivery.

Interpretive Summary: Shall be used for writing a narrative of the clinical intake assessment from a bio-psycho-social perspective to include prior diagnosis and behavioral health history. Summary will identify strengths and barriers to successful clinical care and treatment to include clinical recommendations for the level of care, and referrals for types and frequency of services. It shall include co-occurring disabilities, co-morbidities and/or disorders, clinical judgments regarding both positive and negative factors likely to affect the course of treatment, treatment recommendations (level of care, focus, intensity and length of treatment), outcomes, and discharges. It shall be used to drive the development of the initial treatment plan.

RESPONSIBILITY:

Lead Provider (LP): Ensures the initial treatment plan is created, 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:

A. Development of the Initial Treatment Plan/Wrap Plan:
    1. General Guidelines
        a. The intake worker shall conduct a clinical intake which includes use of evidence-based assessment tools that can aid in gathering current and historical information as well as establish symptomatology baseline

measures about the consumer's health status. Assessment tools used are but not limited to the following.
   i. PHQ
   ii. C-SSRS (if applicable) if initial screening is positive for suicide

b. The Intake worker shall formulate an initial treatment plan in the Plans and Review module in the electronic behavioral health record (EBHR) in collaboration with the consumer based on the written interpretive summary addressing the immediate need.
c. Once all fields in the treatment plan have been completed, the done date and effective date should be entered, For instances in which a signature cannot be obtained to validate the consumer/team participation in the plan, a signature sheet of the treatment/wrap team meeting is sufficient to indicate acknowledgement of the updated treatment plan. Note: Once the effective date is entered, the treatment plan is locked for edits.
d. The intake worker will present the case to the treatment team for identification of a Lead Provider (LP).

2. RRP/SERENITY Protocol
   a. Information for the intake assessment should be gathered during the case presentation by the referring Outpatient Lead Provider with the consumer present, if possible.
   b. Once the case is presented, the team discusses eligibility for admission to RRP or SERENITY. If the consumer is eligible for admission, a staffing meeting is scheduled to include the consumer.
   c. During the case presentation, the needs and strengths of the consumer are identified. This information assists the RRP/SERENITY clinical team to establish goals and objectives that will be focused on in treatment.
   d. The intake worker shall formulate the interpretive summary, based on the case presentation, identified needs and strengths of the consumer.
   e. Once the goals and objectives are decided upon with the consumer, an initial treatment plan shall be formulated and recorded in the Plans and Review module in EBHR within 24 hour of admission date.
   f. Upon further assessment of the consumer, initial treatment plan shall be reviewed and updated to a comprehensive treatment plan by the clinical team within 60 days of admission.
   g. The multidisciplinary treatment team (RRP Clinical team) will present and explain the treatment plan to the consumer or guardian, for collaboration. A copy is then provided to the legal guardian and consumer for signature.

3. Crisis Stabilization Unit
   a. The intake worker shall conduct a clinical assessment which will include use of evidence-based assessment tools from which to formulate an interpretive summary regarding consumer's health status and needs
   b. The admitting nurse shall write the initial treatment plan based on the clinical intake and interpretive summary within 24 hours of admission to the unit.
      ~~i.~~ The immediate needs and strengths of the consumer are identified and used to guide the Crisis Stabilization Unit (CSU) staff in establishing crisis stabilization treatment goals and objectives. It shall include orders from the admitting psychiatrist.

c. Consumer agreement with the treatment plan will be indicated by either an electronic signature, wet signature on hard copy or notation of verbal consent on CSU staff notes.

d. Once all fields in the treatment plan have been completed, the done date and effective date should be entered. Note: Once the effective date is entered, the treatment plan is locked. If treatment plan needs to be modified, staff shall conduct a plan review in AWARDS and make the updates.

B. Review of the Initial Treatment Plan/Wrap Plan

1. The initial treatment plan shall be reviewed and updated by the LP, to modify or identify any new goals, objectives or interventions and come up with a more integrated comprehensive plan to include medical needs (if appropriate) within 60 business days.
2. All subsequent treatment plan reviews should follow the specified time frames for the different programs (*see Policy E above*) or sooner based on the consumer's needs and document any progress or no progress of the consumer.
3. 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.
4. The Lead Provider shall schedule a treatment plan meeting with the treatment team, the consumer, and legal guardian, for each review, and update of the treatment plan if appropriate.
5. The consumer will be asked to sign the treatment plan if possible, as well as the treatment team whenever updates or changes are made. For instances in which a signature cannot be obtained to validate the consumer/team participation in the plan, a signature sheet of the treatment/wrap team meeting is sufficient to indicate acknowledgement of the updated treatment plan.
6. The Lead Provider is responsible for providing a copy of the treatment plan to the consumer.
7. The effective date and done date in AWARDS must be entered once the treatment plan is reviewed, updated, or completed.

REFERENCE(S):

CARF International. (2019). General program standards: Person-centered plan. In CARF. International, *Behavioral Health Standards Manual* (pp. 132-133). Tucson: Commission on Accreditation of Rehabilitation Facilities.

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