Treatment Plan - blank, examples, and guides

Treatment Plan

The Treatment Plan is your road map through the first phase of treatment with your client. If you think of treatment as a book that you and your client will write together, the treatment plan is the table of contents. If it's not in the table of contents, it's not in the book. Every service provided to the client must be tied back to the objectives within the treatment plan.

Video Instructions for Treatment Plan on Avatar: Treatment Plan Avatar

Treatment Plan Timeline

1. **Talk to your client about their goals for treatment.** There are many ways to do this and chances are you have already been doing it throughout your first few sessions! Often goals comes up naturally as part of the assessment. Sometimes we get more specific goals from the client by doing the PCOMS together and discussing what a 10 out of 10 would look like in various categories. For some clients it works well to do concrete goal-writing activities where you actually write down goals for treatment together or do a worksheet related to setting goals.
2. Write a draft of the treatment plan and review it with your supervisor
    - It is recommended to write the treatment plan draft in Word on OneDrive because treatment plans are particularly confusing format-wise on Avatar.
    - You can review the treatment plan in supervision or you can write the plan on Avatar and submit it to your supervisor for review the same way you submit a progress note. Your supervisor can review it and return it to you for corrections.
3. Go over the treatment plan with the client.
4. Finalize the treatment plan. Change the "Plan Start Date" to reflect the date you reviewed the plan with the client.

5. Write a progress note documenting time spent on the treatment plan (this time is not billable). The note will be for Plan Development (6) and only documentation time is added (the amount of time you spent writing the plan).

Treatment Plan Components

The treatment plan should generally include 2+ broad, general goals for the client's treatment. Each of these two goals is accompanied by 2-3 specific, measurable objectives or smaller goals that will support the client's progress toward the general goal. The basic format of a treatment plan is:

Client's Identified Problem

Goal #1: Client's broad goal for treatment

- **Goal #1 Objective #1:** Small measureable objective/SMART goal
- **Goal #1 Objective #2:** Small measureable objective/SMART goal

Goal #2: Client's second broad goal for treatment

- **Goal #2 Objective #1:** Small measureable objective/SMART goal
- **Goal #2 Objective #2:** Small measureable objective/SMART goal

Plan Type

Initial: The plan will be "Initial" if it is the first treatment plan to be written in the current episode (likely the one you opened). If a client was open with another DCYHC clinician in the past but it was a different episode (i.e. they were closed and then reopened) this is still the "Initial" treatment plan.

Annual: Select this for any treatment plan written 1 year after the last treatment plan in the ***same*** episode.

Update: Select this for any treatment plan written between an Initial and an Annual (You might write an "Update" treatment plan if you need to add a goal, objective, or intervention to the client's treatment that was not stated in the initial plan).

Plan Start Date

This is the date that you submit the Treatment Plan to your Supervisor for approval. It is okay that the client hasn't given their final approval yet.

Plan End Date

Plan Start Date - 1 year and 1 day = Plan End Date

- Plan Start Date = 10/10/2023
- Plan End Date = 10/9/2024

Client's Overall Goal/Desired Outcome

In this section, put a quote from the client and/or the caregiver about their goal for treatment. A quote is the best thing to put here even if the client says their goal is something like "I want to get off of probation" or "I want my mom to leave me alone."

Signature/Client Approval

Did Client sign the Treatment Plan?

- ☐ Signed Electronically
- ☐ **Verbal Approval** - You will most often select verbal approval and you MUST state this explicitly in a Plan Development note
- ☐ Did Not Sign
- ☐ Signed Paper Copy
- ☐ Will Sign Printed Version of this Plan

Plan Name

Was Client offered a copy of the Treatment Plan?

- ☐ Yes-Accepted
- ☐ Yes-Declined
- ☐ No - You will never select no

  * Always offer the client/parent a copy of the treatment plan.

Comments (Document the reason for the client not signing or not being offered a copy of the plan):

This answer is required if the client verbally approves the plan. Write: " The DCYHC clinic does not have the capability to capture electronic signatures."

Treatment Plan Items

Medical Necessity Goal?

- ☐ Yes / No

  * Always select "YES"

Diagnosis/Problems/Impairments

Use formula: "Client meets criteria for DSM DISORDER due to LIST DSM CRITERIA CLIENT MEETS"

(ie Client meets criteria for major depressive disorder, moderate due to symptoms of depressed mood, feelings of hopelessness, difficulty sleeping, fatigue, feelings of worthlessness, and difficulty concentrating.)

Goal #1

This should be a very general goal that addresses the client's symptoms.

> Client will demonstrate reduced symptoms of depression to improve mood and well-being.

Objectives for Goal #1

Objectives should be small, specific, and measureable. Objectives should be more tailored to the specific client. Think about what kinds of things you plan to do with the client in sessions and then come up with objectives that match the tasks you will need to write progress notes for.

For example, if I am planning to talk to the client about his sleep and work on his sleep hygiene, I need an objective relating to that: Client will improve sleep hygiene and daily independent living skills by demonstrating ability to implement 2-3 daily living tasks (i.e.

going to bed at a similar time each night, eating regular and healthy meals) into his daily routine. Up from a baseline of one consistent independent living skill task per day.

Another example; A lot of our sessions involve something along the lines of allowing the client to process emotions, practicing coping skills with them, and validating or problem solving with them. To cover these interventions you will want goals like this:

- Client will learn and practice coping skills to manage difficult emotions (i.e. talking through feelings with trusted others, physical activity, drawing) in 3 out of 5 opportunities per month up from 1 out of 5 as reported by client and observed by clinician.
- Client will demonstrate ability to communicate about and process difficult emotions and traumatic memories (i.e. with clinician and family) 3x per week, up from 1x per week.

Interventions

- Reminder: trainees can only do the following interventions:
    - Assessment
    - Plan Development
    - Case Management
    - Rehab/Rehab Group
    - Crisis

There are only 2 of these interventions that can be included in a treatment plan:

- Rehab/Rehab/Group
- Case Management.

Check off both of these interventions. Next, Avatar will ask you to describe how you will use each intervention to promote the client's progress toward the treatment goal. This section should clearly connect the intervention to the goal. For example:

Case Management: DCYHC staff will work with client to connect him to community-based services and activities, and provide support with school placement, engagement, and services

- This connects directly to the client's goal of increasing engagement in the community and with peers.
- Note that here I said "DCYHC Staff" instead of "Clinician" this is so that both the clinician AND the DCYHC case manager could bill case management under the same treatment plan.

Rehab: DCYHC clinician will utilize techniques from motivational interviewing and distress tolerence to meet with the client weekly to support her in developing skills for healthy communication, coping with difficult emotions, and increasing her independence.

9. **Client Participation in & Agreement with Client Treatment Plan:** The client's participation in and agreement with the Treatment plan is documented by one of the following: (1) reference to the client's participation in/agreement written within the body of the Treatment Plan (2) the client's signature* on the Treatment plan or (3) a description of the client's participation in/agreement documented in the medical record.

   The client's signature* (or client's legal representative's signature) must appear on the Client Treatment Plan if both of the following are true: (1) the client is expected to be in long-term treatment (defined by County Mental Health Plan) and (2) the Treatment plan includes more than 1 type of specialty mental health service (for example, the client is receiving both "therapy" and "targeted case management")

   *If the client refuses or is unavailable to sign the Treatment Plan, then the Treatment Plan must include a written explanation of the refusal/unavailability of the signature.

10. **Evidence of Offering Copy of Client Treatment Plan to client**: The Treatment Plan will include documentation that the agency offered a copy of the Treatment plan to the beneficiary. *this is on the page of the document above the client signature, indicated by two checkboxes. You MUST check these two boxes for it to be audit-proof.

11. **Dates & Staff Degree/Title on the Treatment plan:** The Treatment Plan must include all of the following (1) the date of service; (2) the staff's signature, professional degree, and title of job/licensure; and (3) the date the documentation was entered into the medical record.

Note: The TP must be updated any time there is a significant development or change in the focus of treatment.

NOTE: All planned services must be covered by a current and valid TP. In order to bill planned services, complete with client signature indicating client participation in the formulation of the plan must be in place. If there is a lapse between TP expiration and renewal dates, then services occurring during the lapse cannot be billed, and will be disallowed. Therefore, it is important to be timely with the renewal of TPs. Annual or "updates" for authorization periods are due within 30 days of the annual or update calendar date. For example, if you opened a client on July 31, 2021, the annual assessment and treatment plan would be due in draft to your supervisor by June 30, 2022 and must be finalized prior to July 30, 2022.