TITLE: **Treatment Plan**	PAGE: Page 1 of 2
DEPT./SECTION Behavioral Health/Records & Operations	NUMBER: YCHC-BHS-9.05
AFFECTS: Clients and Staff/PROVIDERS	DATE CREATED: 3/1/2016 DATE APPROVED: **05/01/17** DATE REVISED:

Policy:
It is the policy of the YCHC that all clients receiving BHS will have a plan of care individualized to meet their unique needs and is a collaboration between the client, their case manager, and their providers.

Purpose:
To ensure the Treatment Plan for the client receiving services is an individualized, personalized plan and is developed collaboratively to meet their identified needs.

Procedure:

1. The plan is created with the assistance of the client's Case Manager under advisement of the BH Provider. The plan is not meant as a "to-do" list for the case manager but an action oriented document that incorporates information gained from the clinical visit, the case management assessment, and the client's concerns. The plan identifies the following:
   A. Issues and goals stated by the client.
   B. Strategy (supports) the client has chosen to use.
   C. Their intention or the desired outcomes of their strategy.
   D. The person responsible for the supports.
   E. When it will be reviewed for progress.

2. A Treatment Plan must be completed for all active clients receiving services that extend beyond one visit.

3. The client, their legal guardian, caregiver, or family member, develops the plan with the case manager in collaboration with service providers.

4. The Treatment Plan must be formulated within seven days of the assessment and should be regularly discussed by the person receiving the support, the case manager, and the BH provider. The plan should be updated as needs change, goals are achieved, and as follows:
   A. Plans should be clear, concise and easily understood by the person receiving services and the person(s) providing services.
   B. The plan must be agreed upon by provider and client, as well as signed and dated within two business days. Both parties will receive a copy; the clinic copy becomes part of the EHR.
      1) If a client does not wish to include a concern that arises during the assessment process, then it should be noted on the plan.
      2) If a client does not wish to sign a plan, it should also be noted.
      3) A refusal to any one part of the plan does not preclude the client's right to receive other services sought.

5. Treatment Plan Outline includes:
   A. **Issues and Goals:** Goals should be what the person receiving services hopes to accomplish with the support of services. Be sure that issues and goals reflect the words and sentiment of the client.
   B. **Plans/Strategies:** Is an outline of activities that will be used to pursue each listed goal.
      1) There may be multiple strategies for a goal.
      2) Planned progress should be regularly monitored and documented in progress notes.
   C. **Responsible Person:** The client is responsible as far as is appropriate for implementation and progress on goals but the listed person could also be anyone who can help facilitate the support being provided.
   D. **Target Date:** Should be as specific as possible.

1) If goal and strategy will be continuous, it is suitable to use either the date of next assessment or list as "Ongoing".

6. Plan Review: Plans are reviewed:
   A. At each visit regardless of provider type.
   B. At any time circumstance may change goals.
   C. In accordance with guidelines from third party payers.

APPROVED BY:	
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