Treatment Plan Review

For more information regarding the Treatment Plan Review see the Treatment Plan Review Procedure.

Treatment Review Section

- **Review Period From** – this is the date the Treatment Plan was done or the "To" date of the most recent review
- **Review Period To** – this is the date the treatment plan review expires, this will differ based on level of care
    - Residential – 7 days
    - Halfway House – 30 days
    - Intensive Outpatient – 7 days
    - Extended Outpatient – 30 days
    - Aftercare/Continuing Care – 90 days
- **Date of Review** – this is automatically completed with today's date

Updated Info Section

- **Documents Reviewed (include dates of documents)** – the treatment plan and date, review dates, or individual and group notes for the period
- **Assessments Conducted During This Review Period** – complete with none unless one has been completed, if one was completed enter the name of the assessment and the date it was completed

Treatment Team Section

If there have been changes to the Treatment Team update them here, for more information regarding the Treatment Team see Appendix B Treatment Team Screen.

ASAM Section

This section consists of updating the ASAM, for more information regarding the ASAM please see the ASAM Procedure.

Recommendations and Changes Section

- **Was the client involved in the review process** – select yes or no from the drop-down box
- **New Problems identified to be added to treatment plan -** select yes or no from the drop-down box

- **Discharge Criteria** – complete with the steps the patient must take to successfully complete treatment
- **Strengths/Resources/Abilities/Interests/Barriers to Success** – complete this with the patient's current strengths and barriers to treatment
- **Progress Towards Goals/Accomplishments** – complete this with the progress the patient has made in completing their goals, this may include any assignments that they have completed
- **Family/Recipient Written Comments Regarding Their Satisfaction With Treatment, Planning, Services, and Progress** – this does not have to be a quote, give a brief statement of how the patient feels they are progressing
- **Changes to Client's Diagnosis (Reference the documents the change is based on)** – if there are changes to the patient diagnosis make note of them here
- **Need for Further Treatment** – explain why the patient remains appropriate for this level of care or intentions of transferring or discharging and the reasons
- **Was plan reviewed for least restrictive setting** - select yes or no from the drop-down box
- **Was plan reviewed to make sure that services recommended are appropriate to client's strengths and need** - select yes or no from the drop-down box

Treatment Team Section

You may skip this section, if you wish to update the Treatment Team please see the Appendix B Treatment Team Screen.

Plan Outline Section

If you have changes to make to the Plan Outline complete the following steps, if not click Finish.

- Click the Comment/Modify Plan hyperlink in the Outline Actions box
- Answer Yes
- Click the Comments hyperlink in either the goal or objective to add new comments about that area
- Click the Modify hyperlink to modify the Treatment Plan or the Problem/Goal & Objective. Use Modify when the patient has completed a goal or objective
    - Click the Modify hyperlink
    - In the Objective Status dropdown box choose "Complete"
    - Enter the Resolution Date as the date the patient completed this goal or objective
    - Click Save
    - Click Finish
- Click the Delete hyperlink in the Problem/Goal & Objectives to remove an entry
- Click the Add Objective hyperlink in the Problem/Goal & Objectives to add in more objectives