



## Division of Public and Behavioral Health Policy

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### 1.0 Policy

It is the Policy of the Division of Public and Behavioral Health (DPBH), Substance Abuse, Prevention, and Treatment Agency (SAPTA) that all providers, in accordance with 505 (a) of the Public Health Service Act (42 US code 290aa-4) which directs the Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), to collect items including admission and discharge data.

Residential treatment plans need to be reviewed and updated at least every 2 weeks.

Outpatient treatment plans (including IOP) need to be reviewed and updated at least every 30 days or whenever the condition of the client changes over the course of the treatment (per NAC 458.246).

### 2.0 Procedure

1. In the Client widget on the home screen, enter the client ID or last name in the Client Name/ID field, click Select Client Name/ID Search. Click Ok.
2. In the search forms screen, enter Treatment Plan.

The screenshot shows a software interface with a search bar at the top. The search bar contains the text "treatment plan" and a magnifying glass icon. Below the search bar is a list of search results. The first result is "Treatment Plan" with the menu path "Avatar CWS / Treatment Planning". This result is highlighted with a red box. Other results include "Treatment Plans Entered", "Treatment Plan Input (Workflow)", "Treatment Plan Report", "Treatment Plan Dictionary Maintenance", "Treatment Plan Library Definition", "Copy Treatment Plan Problem", "Treatment Plan Input (MH) - (Workflow)", "Treatment Plan Report (MH)", "Print Treatment Plan", "Treatment Plan Default Setup", "Treatment Plan Definition", "Mental Health Treatment Plan Default Setup", "MH/MR Treatment Plan Status Override", "Create New Treatment Plan", and "Treatment Plan Status Override".

3. Double-click the Treatment Plan.
4. If the client has multiple episodes, the select client episode window will appear. Double-click the correct



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episode and click Ok.

**Treatment Plan**

Name: STEPHANIE ROBBINS  
ID: 2  
Sex: Female  
Date of Birth: 08/01/1995

Episode	Program
3	Residential
2	S1 Level 1 OP Adults-Indv~INACT
1	S1 Assessment Adult Pre-Admit~II

- In the Plan Date field, enter the treatment plan date.
  - Click “T” for today
  - Click “Y” for yesterday or
  - Type in Date
- In the Plan Name field, type the treatment plan name. (Ex: Treatment Plan)
- In the Plan Type field, select the plan type. This will be a dropdown to choose the type of treatment plan.
  - Initial

**Treatment Plan**

Plan Date: 08/31/2015 [T] [Y] [Calendar]

Plan Name: Treatment Plan

Plan Type: Initial

Submit

- If a Plan End Date is appropriate, enter the date. This is not a mandatory field.
- Enter the Next Review Date. If a date is entered into this field, it will send the practitioner a notification in their “to-dos” seven days prior to the review date.

Plan End Date: [ ] [T] [Y] [Calendar]

Next Review Date: [ ] [T] [Y] [Calendar]

- The Treatment Plan Status will be Draft until the plan has been finalized. Once the initial plan is



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complete, with all elements added, choose the Final status. Once deemed Final, the plan cannot be edited.

Treatment Plan Status

Draft
  Pending Approval

Final

11. Enter the Team Member to Notify field, select which supervisor will approve or reject the plan.
12. Problems can be entered into the plan from this Problems box. Simply click “include in this plan” if the problem listed should be on the treatment plan.

Problems

Include in this plan?	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Res
<input type="checkbox"/>	Drug abuse (S...				06/01/2015		Active (A)			
<input type="checkbox"/>	Accidental can...				07/01/2015		Active (A)			

13. To add other staff members as participants in the plan,
  - enter the role – double click to see options
  - staff ID – search by last name
  - Participant Name – will auto-populate
  - Plan Author – Y for yes, or N for no
  - Notification – to send a notification to the other user(s) – Y for yes, or N for no
  - Add “New Rows” as needed.
  - “Delete Rows” as needed.

Plan Participants

Role	Staff ID	Participant Name	Plan Author	Notification
Case Manager (1)	ROBBINS,STEPH...	ROBBINS,STEPH...	Yes (Y)	Yes (Y)



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14. Document Strengths, Weaknesses, and Discharge Planning.

Strengths

Weaknesses

Discharge Planning

15. When completed with the first page, scroll up and click “Launch Plan”.

Chart Treatment Plan

Submit

Online Documentation

Plan Date: 08/31/2015

Plan Name: Treatment Plan

Plan Type: Initial

Plan End Date: [ ]

Next Review Date: 11/30/2015

Last Updated: [ ]

Last Updated By: [ ]

Treatment Plan Status:  Draft  Pending Approval  Final

Team Member To Notify: ADMIN,SAPTA

Launch Plan

16. The Treatment Plan will display as follows:



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**STEPHANIE ROBBINS (000000002)**  
F, 20, 08/01/1995

Ep: 3 : Residential  
Problem P: -  
DX P: T40.7X1A Poisoning by cannabis (derivati...

Location: Quest House / Room D / 7  
Attn. Pract.: HALLMAN, BRENDA  
Adm. Pract.: furlong, kendra

Chart Treatment Plan

Treatment Plan: STEPHANIE ROBBINS

- Problem: Drug abuse
- Problem: Accidental cannabis overdose

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

**Problem Code**

**Other**

**Date of Onset**

**Status (Problem List)**

**Problem**

**Status**

**Date Opened**

**Staff Responsible**

**Staff Assigning**

**Date Due**

**Date Closed**

**Staff Responsible**

17. The problems that were checked in the previous screen will carry over to the launched treatment plan.
18. The Problem Code will auto-populate from the previous screen.

**Problem Code**

19. Date of Onset will auto-populate from the previous screen.
20. Status (Problem List) will auto-populate from the Problem List on the previous screen.

**Date of Onset**

**Status (Problem List)**

21. Date Opened auto-populates the current date.
22. Staff Assigning auto-populates the staff member.
23. Status is a mandatory field. You must choose an option from the dropdown.



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- Discontinued
- Monitor
- Resolved
- Treat

The screenshot shows a form with several fields:
 

- Date of Onset:** 05/01/2015
- Problem:** Drug abuse
- Date Opened:** 08/31/2015
- Staff Assigning:** ADMIN,SAPTA (000042)
- Date Closed:** (empty)
- Predefined:** No
- Status (Problem List):** Active
- Status:** (highlighted with a red box)
- Staff Responsible:** (empty)
- Date Due:** (empty)

24. Staff Responsible is a field used if the supervisor is assigning this treatment plan to a specific staff member, instead of the staff member entering in their plan on their own. This is not a mandatory field.
25. Date Closed field is only used when that problem has been resolved. That will be used in future Treatment Plan Reviews.

The image shows a close-up of the "Date Closed" field, which is an empty text box with a calendar icon and "T" and "Y" buttons for date selection.

26. If there is a due date on the Problem, enter the date in the Date Due Field.

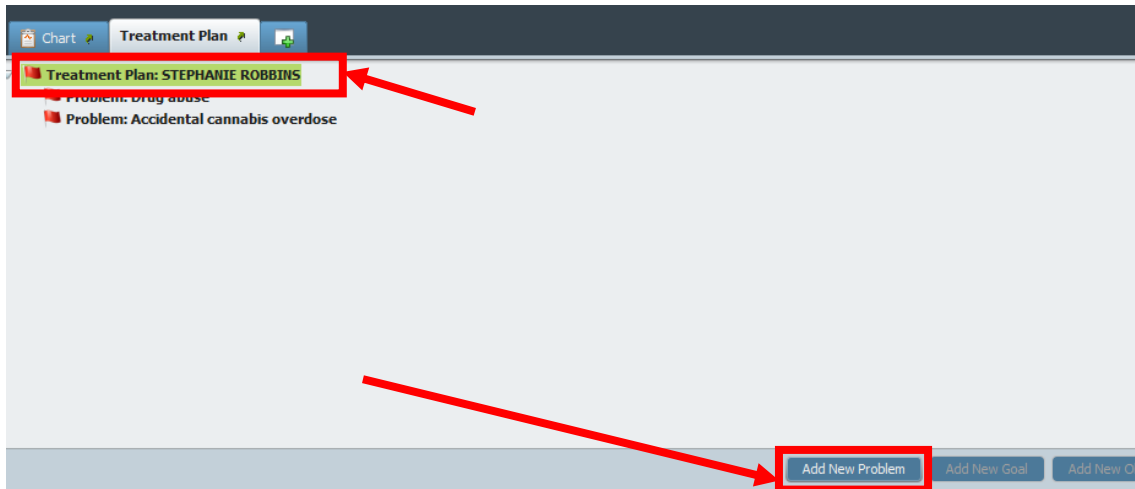
The image shows a close-up of the "Date Due" field, which is an empty text box with a calendar icon and "T" and "Y" buttons for date selection.

27. To add a new Problem, you must click on the top treatment plan title. This will open up the "Add New Problem" button for a new problem to be entered.

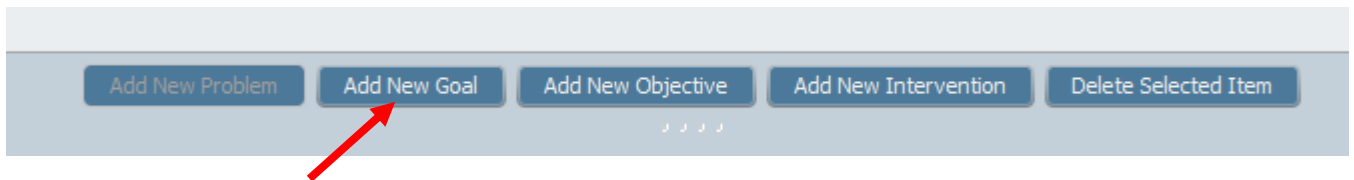


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28. After the problem is entered, click on “Add New Goal” located in the middle of the launched treatment plan.



29. Type in the Goal/Long Term in the space provided.
30. Date Opened field will auto-populate with the current date.
31. Choose the status.
- Achieved
  - Active
  - Discontinued
  - Revised
32. If applicable, choose a Date Due.
33. When the goal has been completed, the Date Closed field will be completed.
34. “Update Comments” is the field that will be used when a Treatment Plan Review is completed. Use this field if comments need to be added to the original goal that was documented.



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35. Once the goal has been entered, click on “Add New Objective” in the middle of the screen.

36. Type in the objective in the box provided.

37. The Date Opened field will auto-populate.

38. Choose the status of the objective.

- Active
- Discontinued
- Met/Achieved

39. If applicable, choose a Date Due.

40. When the objective has been met/achieved, record a date in the Date Closed field. This field will remain blank until the objective has been met. Only close the Objective in the Treatment Plan Review that it was closed in.





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41. When the Objective is complete, click “Add New Intervention”.

42. Enter the Intervention in the space provided.

43. The Date Opened and Staff Assigning with auto-populate from previous screens.

44. Select the “Status”.

- Active
- Inactive

45. Choose the “Type of Intervention.”

- Clinician – most likely will be the choice the majority of the time
- Consumer
- Family – do not document family interventions in the Treatment Plan. Always document these interventions as a chart note associated with the correct episode.

46. When the intervention has been completed, record a date in the Date Closed field. This field will remain blank until the intervention has been met. Only close the intervention in the Treatment Plan Review that it was closed in.

47. If applicable, enter the Date Due in the field provided.

48. The last tab on the Treatment Plan is “Delete Selected Items.” Use this option to delete line items on the Treatment Plan **before** the Treatment Plan is marked final.





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[Add New Problem](#) [Add New Goal](#) [Add New Objective](#) [Add New Intervention](#) [Delete Selected Item](#)

49. If any of the mandatory fields in the treatment plan are missing, the treatment plan view will display red flags. You must make these corrections.

NOTE: Always start with the red flag at the bottom of the view.

Chart Treatment Plan

▼ Treatment Plan: STEPHANIE ROBBINS

▼ Problem: Drug abuse

▼ Goals

▼ The first goal for this client is to find a job.

▼ Objectives

▼ The first objective is hfgjhfjgkfdhgfjkdhgfjghfdgvbnfmfogthjfdnglfdjg.

▼ Interventions

This intervention will work like a charm!

▼ Problem: Accidental cannabis overdose

50. When the treatment plan is complete with no errors, click on “Back to Plan Page” at the bottom right hand corner of the screen.

[Back to Plan Page](#) [Exit to Home View](#)

51. Upon returning to the screen shown below, if the treatment plan is complete, mark as final and then click “submit.”

Chart Treatment Plan

Treatment Plan

Submit

Plan Date: 08/31/2015

Plan Name: Treatment Plan

Plan Type: Initial

Plan End Date: [ ]

Next Review Date: 11/30/2015

Last Updated: 08/31/2015

Last Updated By: ADMIN, SAPTA

Treatment Plan Status:  Final

Team Member To Notify: ADMIN, SAPTA

Launch Plan



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### Treatment Plan Reviews : INTERIM PROCEDURE

In order to document a treatment plan review (in the interim while the full process is still being built), follow the steps below:

52. **Edit** the **Initial** treatment plan, use the **Update Comments** fields to document the review.
  - a. Ensure the date is documented. Add review comments for problems, goals, objectives and interventions. Ensure you are closing out items that have been resolved using the **Date Closed** field.

Problem Code  
(SNOMED-15167005) Alcohol abuse

Status (Problem List)  
Active

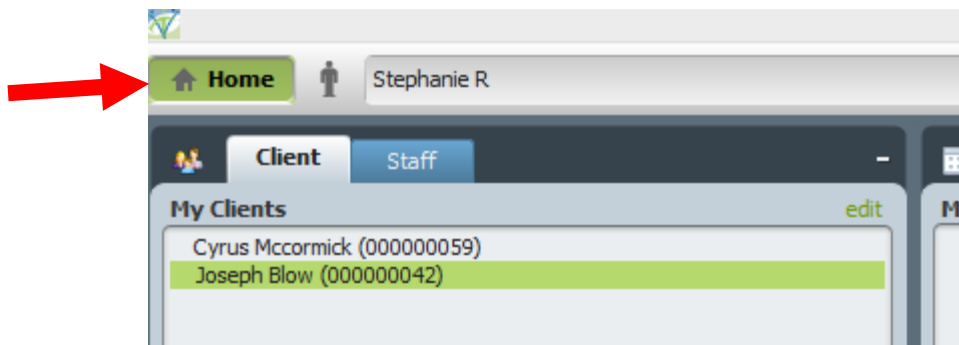
Problem  
Alcohol abuse since age 10.

Update Comment  
12-15-2015 TX PLAN REVIEW: This problem is still present. Client reports that the urge to drink is improving.  
01-15-2016 TX PLAN REVIEW: This is documentation on the next review. Problem is still active.  
02-17-2016 TX PLAN REVIEW: Just keep documenting.....

Status  
Active

### Print Treatment Plan

53. To print a treatment plan, return to the home screen by clicking on the HOME button on the top left hand corner of the Avatar screen.

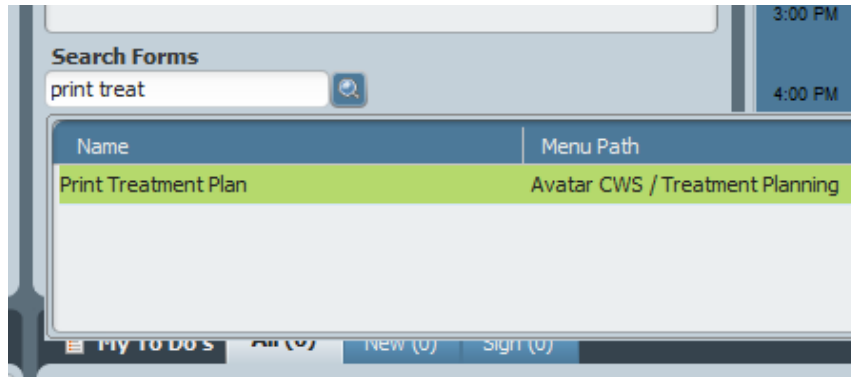


54. In the Search Forms widget, type in Print Treatment Plan. Double-click to open.



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55. In the Select Client field, search by Last Name or ID number. Double-click your selection.

56. Choose the Episode for the treatment that you'd like to print.
57. Select the Treatment Plan from the drop-down.
58. Select Client Plan from the drop-down.
59. Click "Print Treatment Plan".
60. A Crystal Report will display with the Treatment Plan, listing the Problems, Goals, Objectives, and Interventions. There will be a client signature line as well.