SMART Tip Sheets
Treatment Plan

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Treatment Review

This Tip Sheet outlines the steps to complete a client Treatment Plan and Treatment Plan Review

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Treatment Plan

1. **Entry Steps:** Login, Select Facility, Select Client List from left Menu to generate the Client Search Screen, find client, select Activity List, Admission.

2. Before you begin a Treatment Plan for your client you should develop the Treatment Team. If you haven't done so, follow the directions found on the Admission tip sheet. ***Note*:** There must be an active Program Enrollment to complete.

3. To develop a treatment plan Click **<u>Treatment</u>** on the Left Menu Toolbar and then click **<u>Tx Plan</u>**.

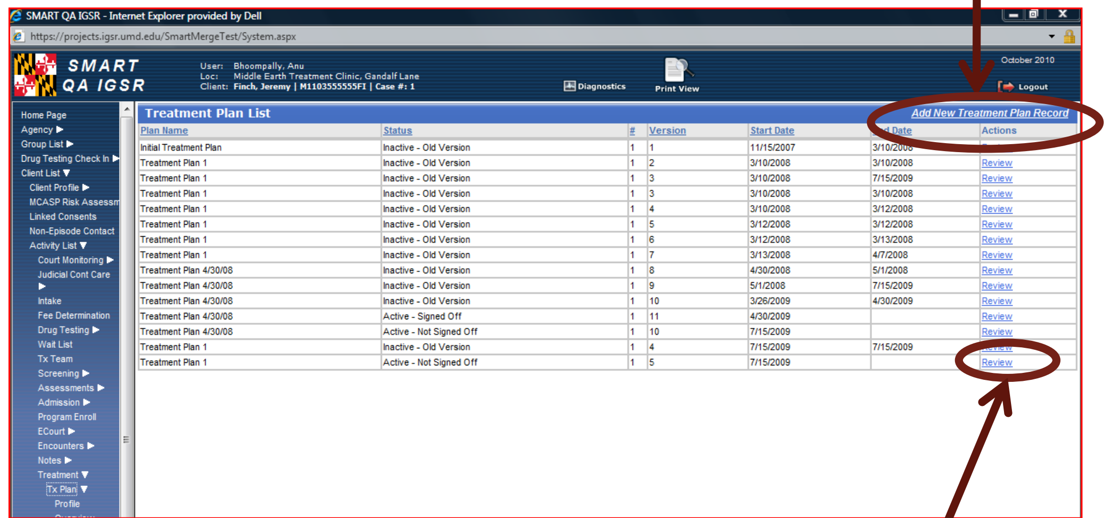
4. An existing **Treatment Plan** can be reviewed by clicking **<u>Review</u>** in the **Actions** column of the **Treatment Plan List**.

5. If no treatment plan exists, click on **<u>Add New Treatment Plan Record</u>** to create a new treatment plan. This will take you to the **Treatment Plan Profile Screen**.

6. Complete the dark yellow fields, then click ➔.

   Note*:* Please review the Treatment Team members on this screen. If there are team members who will need to perform a treatment team review, create a new version of the treatment plan or sign off since they must also be a treatment team member. Treatment Team members can be added on either the Admission screen or the Treatment Team screen.

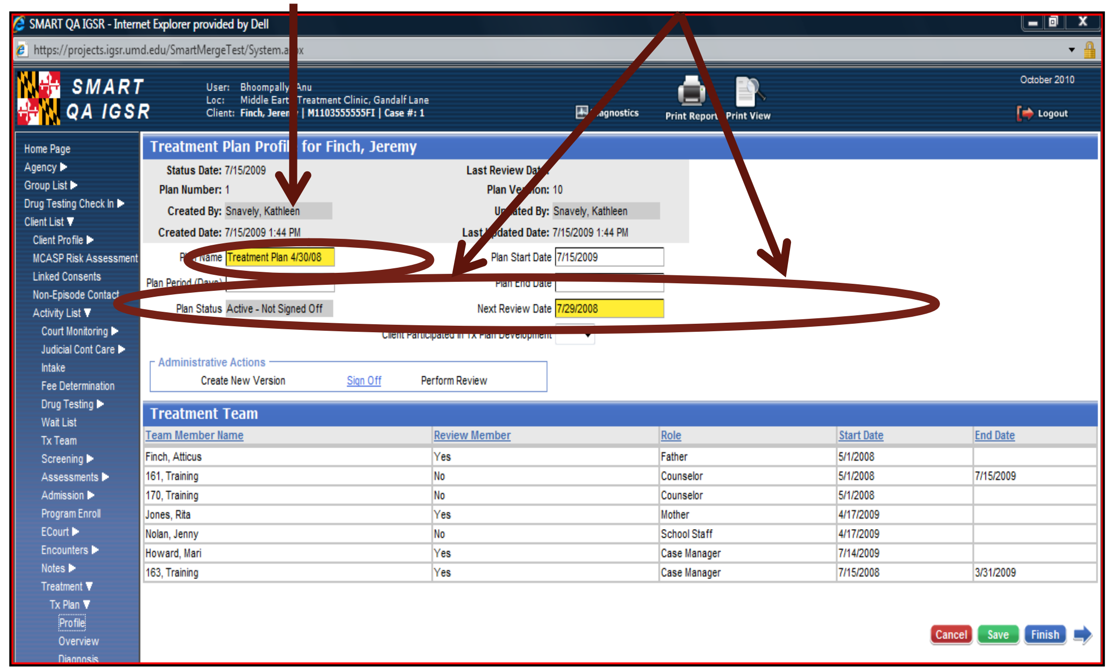
To Create a new Treatment Plan, click **<u>Add New Treatment Plan</u>** Record.



Click **<u>Review</u>** to view an existing Treatment Plan

Keep track of your Treatment Plans by naming them.

By entering the number of expected days for the Treatment Plan, the End Date is automatically calculated.



Overview & Diagnosis

1. The Overview screen allows you to document additional background information about your client in free text format.

2. **Presenting Problems** is pre-populated based on **Presenting Problems** documented at Intake and is uneditable on this screen. To edit this field, the user must return to the Intake screen.

3. All the other fields are free text boxes which allow you to type unlimited information.

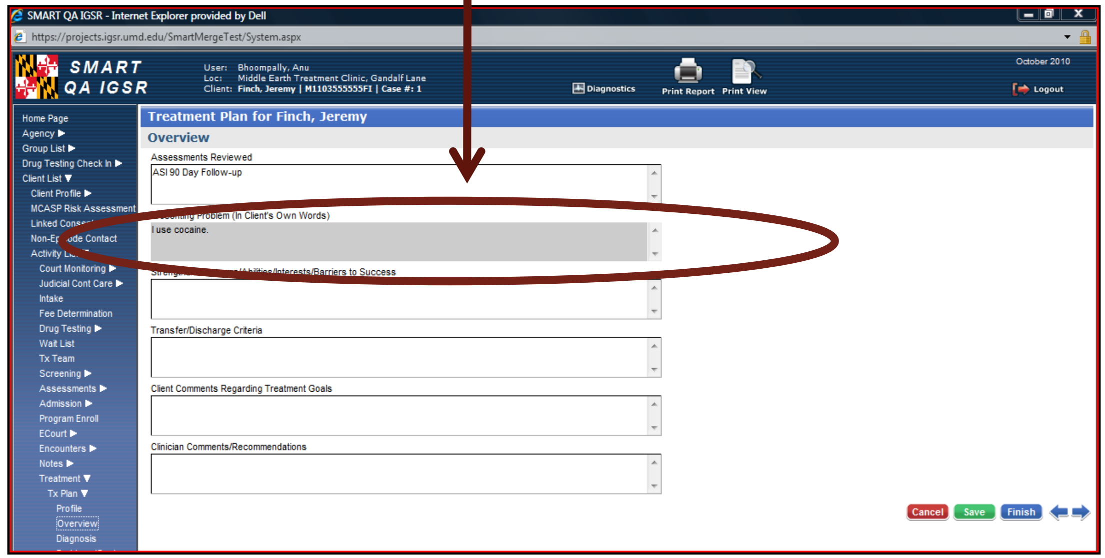
4. Click **<u>Next</u>**.

5. To add a diagnosis or diagnostic impression, select the diagnosis from the drop down box for **Primary, Secondary** or **Tertiary**. If a diagnosis is entered, you will also be required to enter whether the diagnosis is **Based on Clinical Impression** (yes/no). Any Diagnoses entered in the Admission module will prefill here.

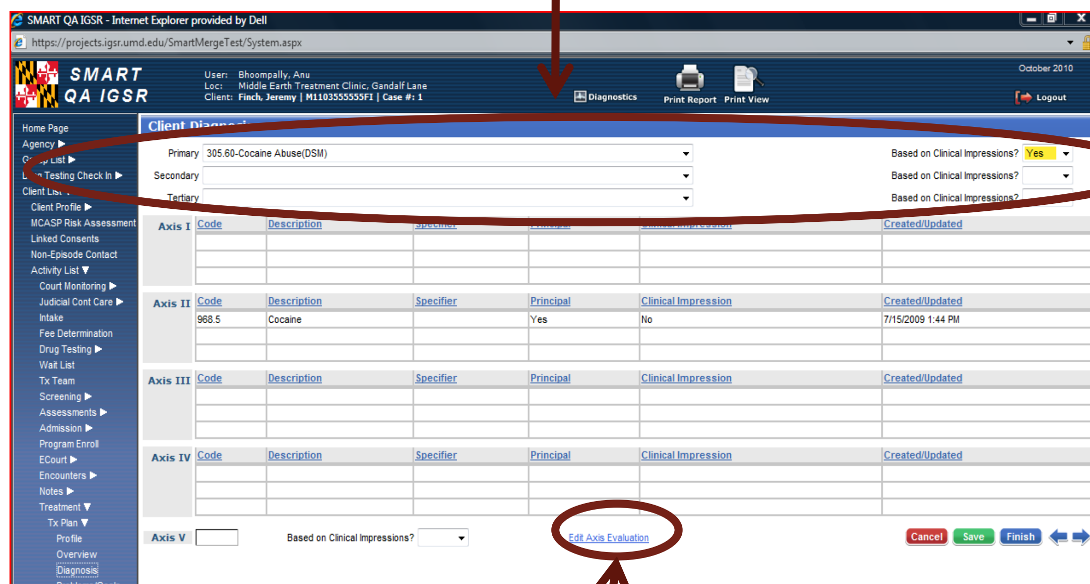
6. After completing the screen click **<u>➔</u>**.

   Note: You must select a Principal Diagnosis and determine whether the diagnosis is Based on Clinical Impression prior to clicking **<u>Add to Axis</u>** and clicking **<u>Finish</u>**.

Presenting Problem prefills from the Intake module. To update the information, go back to the Intake screen.



Primary, Secondary and Tertiary ICD-9 diagnoses will prefill from the Admission module if entered there. If not, enter them here.



To edit or enter the Axis Evaluation to add DSM diagnoses, click Edit Axis Evaluation. If entered on the Admission module, they will also prefill here.

Step 1- Adding Treatment Plan Problems

1. This is the first screen in a series of screens to document problems, goals, objectives, and interventions

2. Each category is listed here, along with the associated problem(s) and goal(s). Click **Review** if you want to review details or revise any of the existing goals.

3. Click **Add New Treatment Plan Problem Record** to add a new problem . There can be several problems as part of a treatment plan.

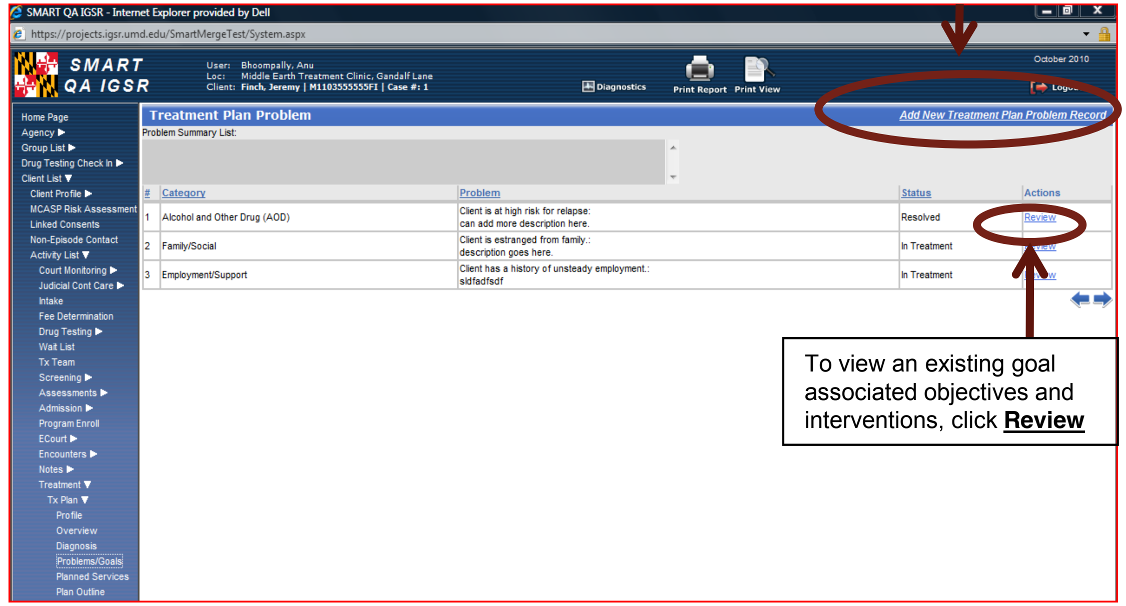
4. **Note:** SMART automatically defaults to the present date for the Problem Date, therefore enter an accurate Problem Date.

5. Complete all of the yellow fields: ***Program Name, Problem Status Problem Category***, ***Problem***, ***Description***, ***Strengths/Resources***, .

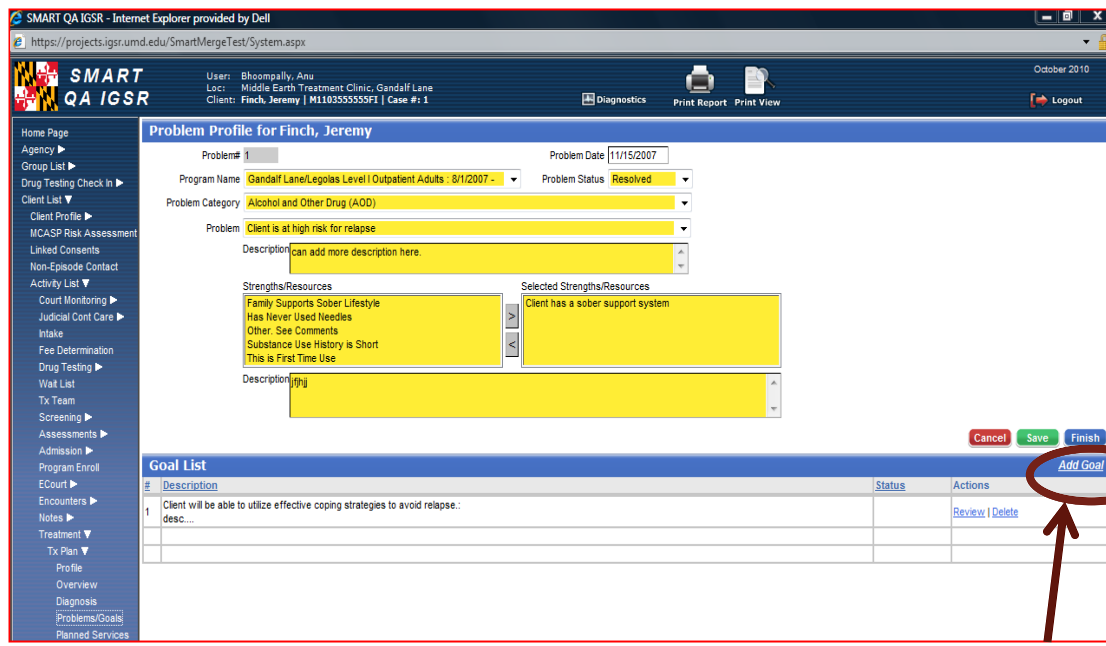
6. Click **Save** to save the data entered thus far.

7. To add a **Goal** for this Problem click **Add**
8. **Goal**. Multiple Goals can be added for each Problem.

Click Add New Treatment Plan Problem/Goal Record



To view an existing goal associated objectives and interventions, click **Review**



Multiple goals for each problem can be added by clicking **Add Goal**.

Step 2 – Adding Treatment Plan Goals

1. To add goals associated with a particular problem click **Add Goal**, found in the lower right hand section of the **Problems** screen.

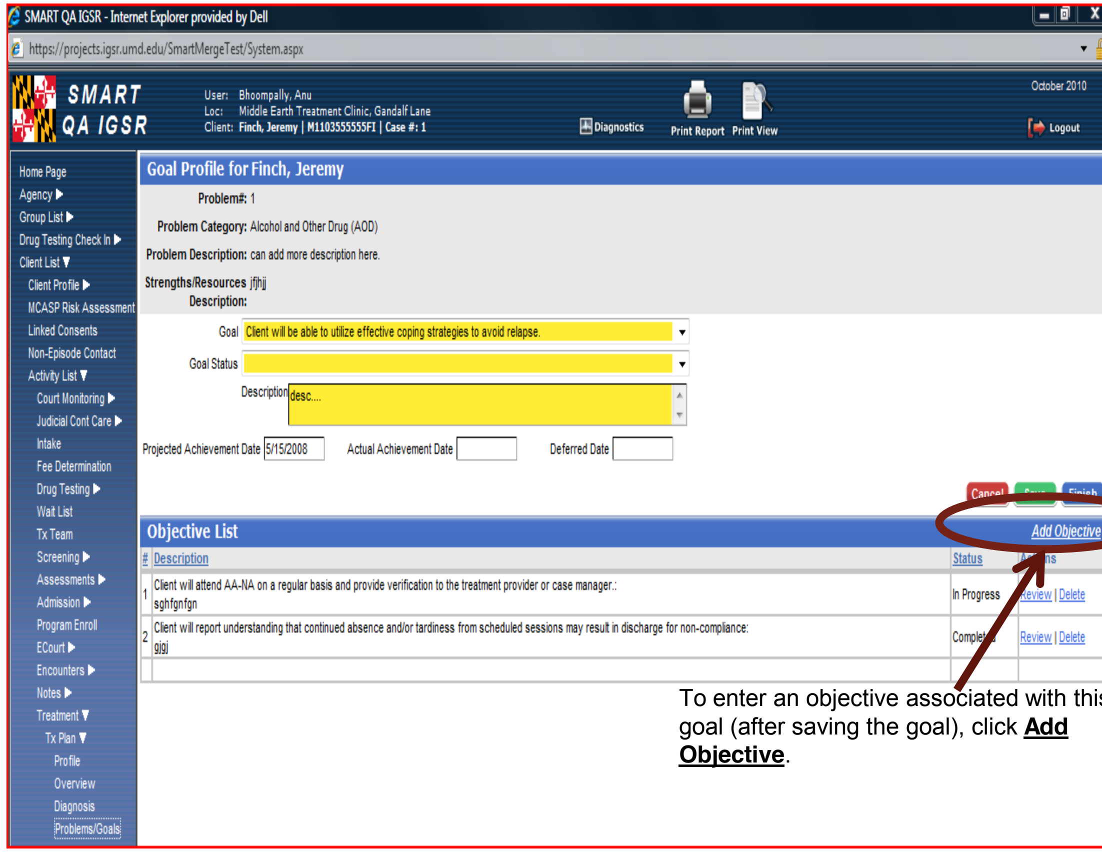
2. The top part of the Goals screen identifies the problem, strengths, and is shaded and read-only.

3. Complete all of the fields highlighted in yellow and add other details in the ***Description*** box.

4. Click **Save**.

5. To repeat the process, click **Finish**. This will take you to the previous screen where you can click **Add Goal** to document additional goals for the same problem.

6. To add an Objective for a particular goal, click **Save** and then click **Add Objective.**



To enter an objective associated with this goal (after saving the goal), click **Add Objective**.

Step 3 – Adding Treatment Plan Objectives

1. To add objectives associated with a particular problem and goal, click **Add Objective**, found in the lower right hand section of the **Problems/Goals** screen.

2. The top part of the **Objectives** screen identifies the problem, strengths, and goal and is shaded and read-only.

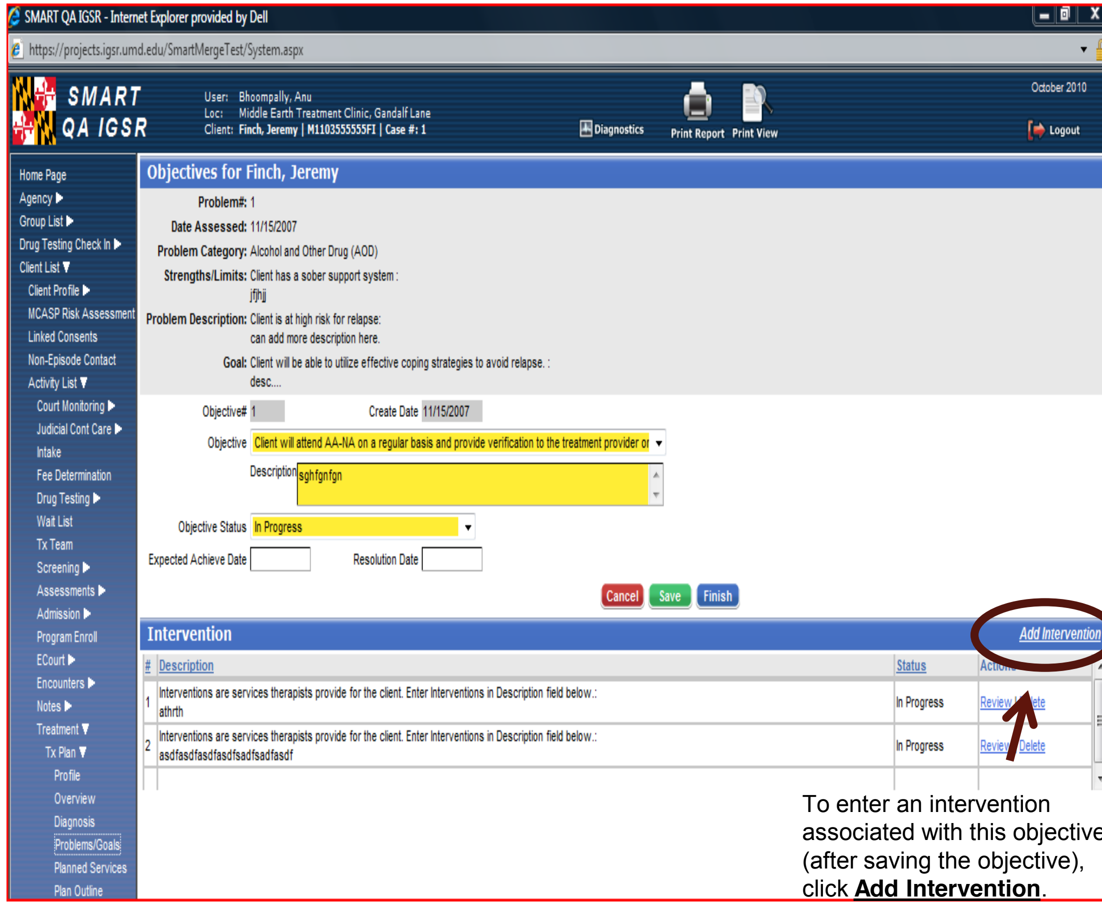
3. Complete the fields highlighted in yellow and add other details in the ***Description*** box.

4. The **Objective Status, Expected Achieve Date,** and **Resolution Date** fields allow the user to enter information about the status of the objectives.

5. Click **Save**.

6. To repeat the process, click **Finish**. This will take you to the previous screen where you can click **Add Objective** to document additional objectives for the same goal.

7. To add an Intervention for a particular objective, complete the Objective, click **Save** and then click **Add Intervention**.



Step 4 – Adding Treatment Plan Interventions

1. Click **Add Intervention**, located in the lower right hand section of the **Objectives** screen.

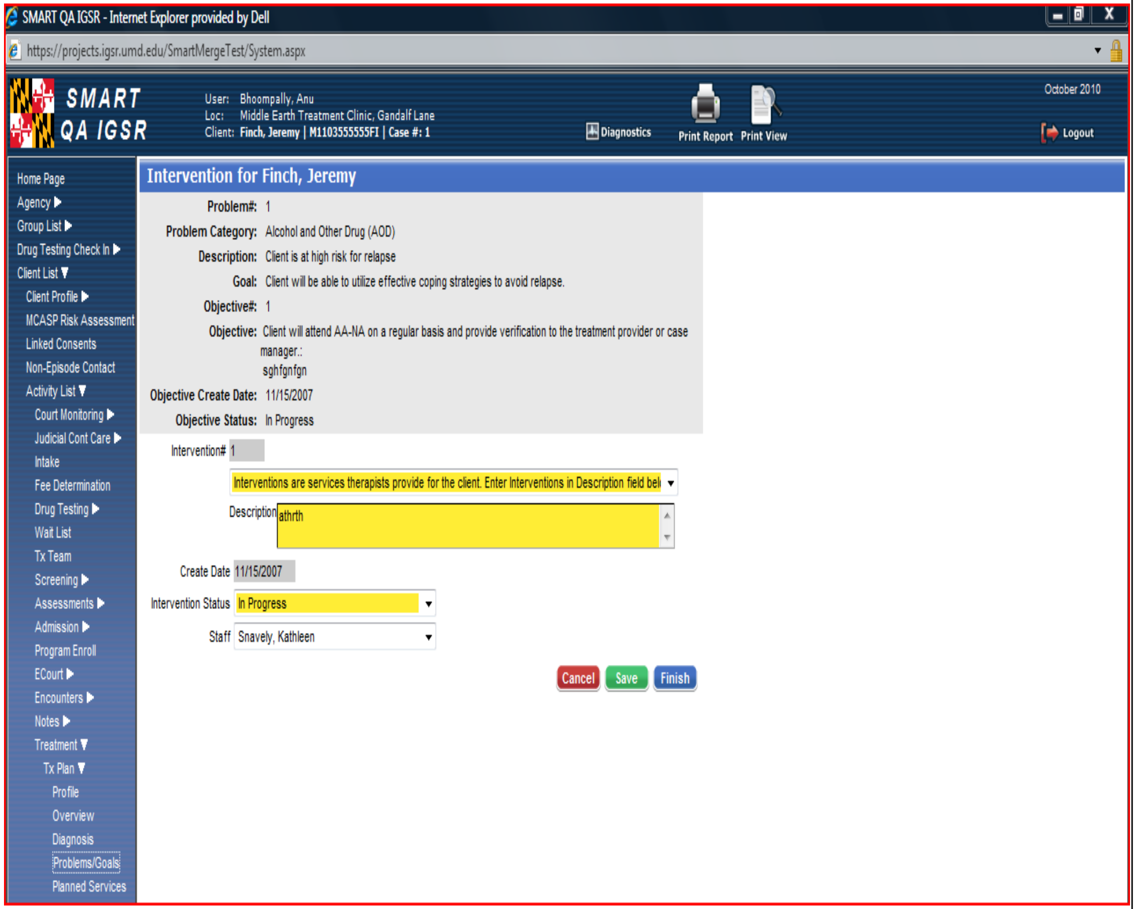
2. The top shaded part of the screen consists of read-only information carried forward from earlier parts of the treatment plan.

3. Complete all fields highlighted in yellow and add additional details in the ***Description*** box.

4. Click **Save** to save the data and stay on the same screen.

5. To repeat the process, click **Finish** to save your work and return to the previous screen where you can then click **Add Intervention** to document additional interventions associated with the same objective.

   Note*:* The **Staff** field defaults to the person who is logged in at the time and documenting the plan in the system. If the plan was written by someone other than the person logged into the system, select the name of the person who wrote the plan from the drop down.



Adding Planned Services to the Treatment Plan

Planned Services are specific services that are planned for the client as part of the treatment plan. Examples include individual counseling sessions, group therapy, etc.

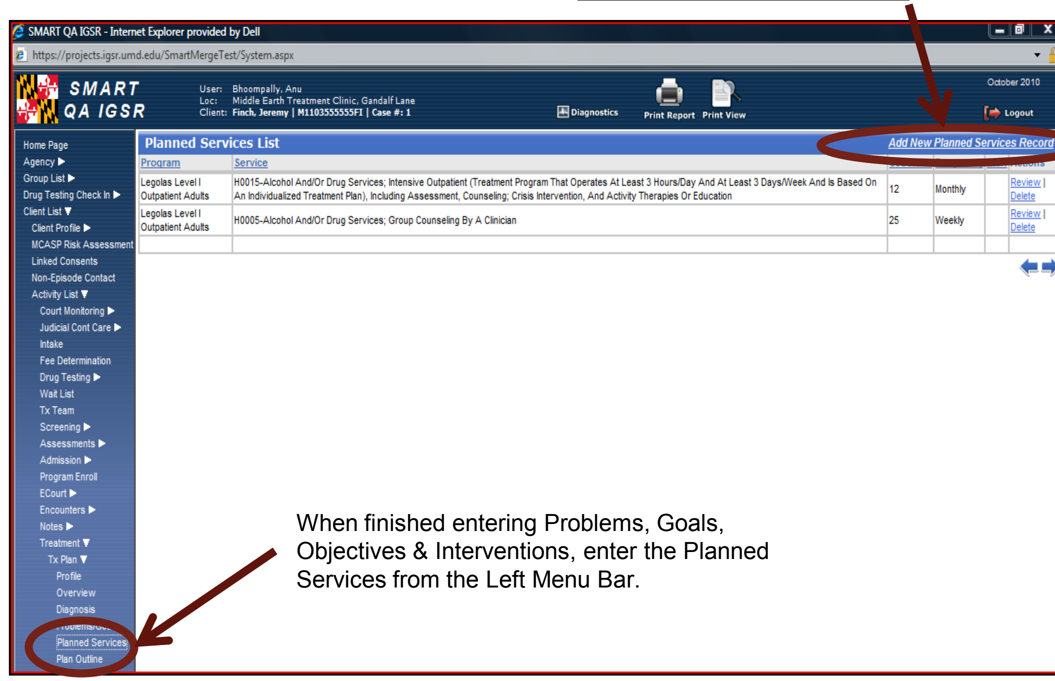
1. Each planned service should be documented individually.

2. To document a planned service, select **Planned Services** from the Left Menu Toolbar, then click **Add New Planned Service Record.**

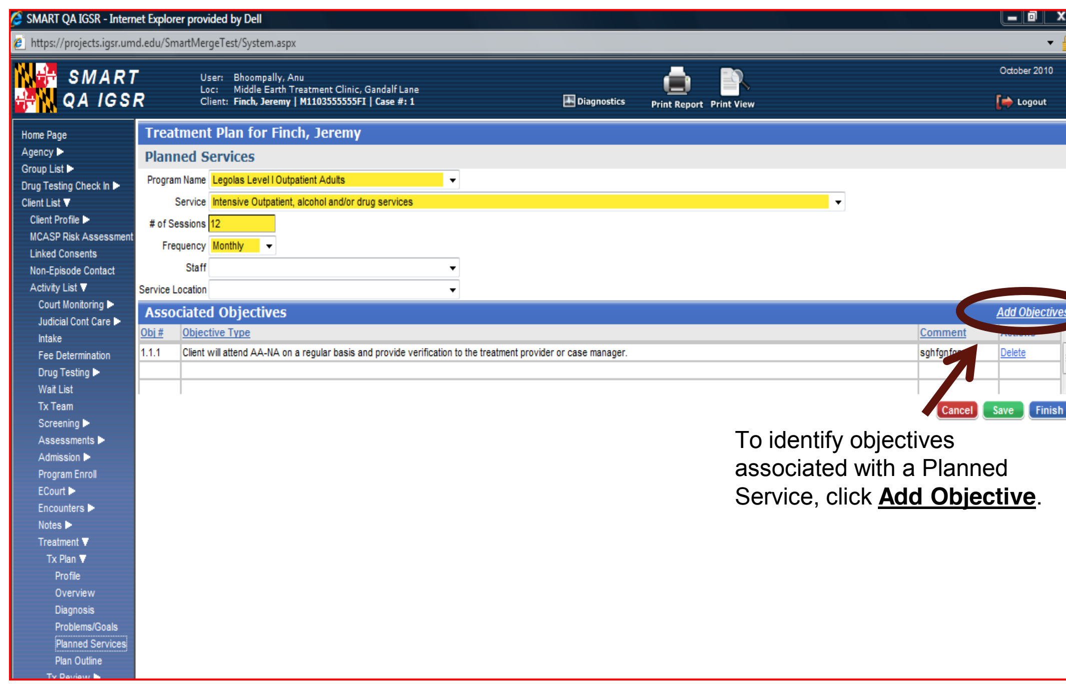
3. Complete ***all*** of the fields then click **Save**.

4. Objectives from the treatment plan may be associated with the planned service to indicate what objectives are addressed by this particular service. To add an Objective, click **Add Objective**. All of the objectives written in the treatment plan will be listed here. To select the relevant objectives, click the box on the left associated with the objective of choice, then click **Finish**.

To enter a Planned Service, click **Add New Planned Service Record.**



When finished entering Problems, Goals, Objectives & Interventions, enter the Planned Services from the Left Menu Bar.



To identify objectives associated with a Planned Service, click **Add Objective**.

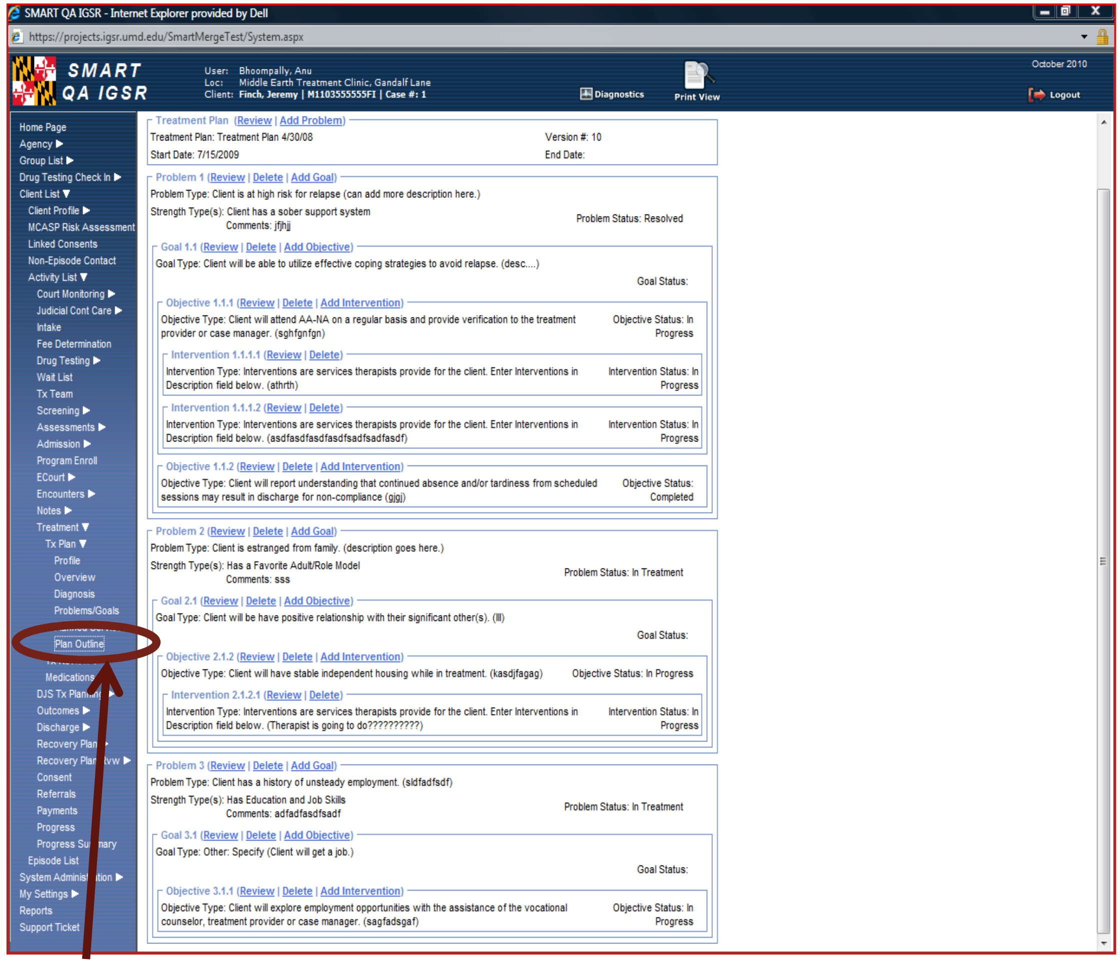
Plan Outline

1. The Plan Outline Screen shows and overview of the client treatment plan. You can **Review, Delete or Add** to the different sections of the Treatment Plan. To do so, click **Plan Outline** from the Left Menu Toolbar.

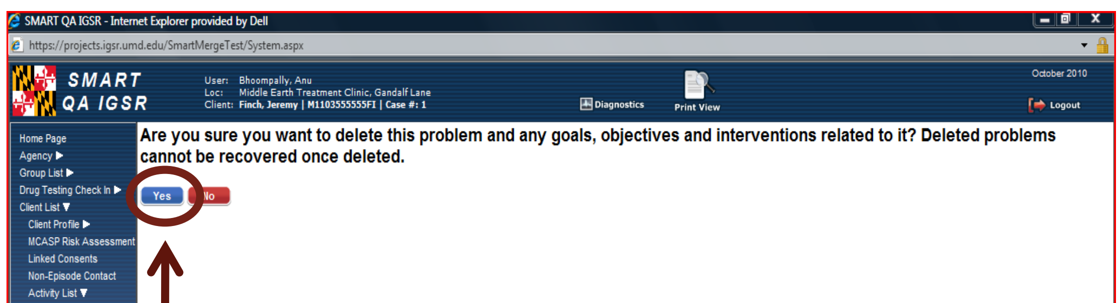
2. Once you have reviewed and/or edited a section, click **Finish** to return to the Plan Outline screen.

3. If you determine a section should be deleted click the **Delete** hyperlink. A message will appear asking if you are sure you want to delete. The message will also inform you that ***deleted sections cannot be recovered once deleted***.

4. Once the outline review is complete click **Finish.**



To view the Plan Outline, click Plan Outline from the Left Menu Bar.



If you are sure you want to delete an item in the treatment plan, click **Yes**.

Signing Off

1. Once the Treatment Plan is completed, a hard copy must be printed and signed by the client and appropriate team members. From the **Treatment Plan Profile**, click **Print Report**.

2. After the hard copy of the treatment plan has been signed, you are ready to “sign off” on the electronic plan.

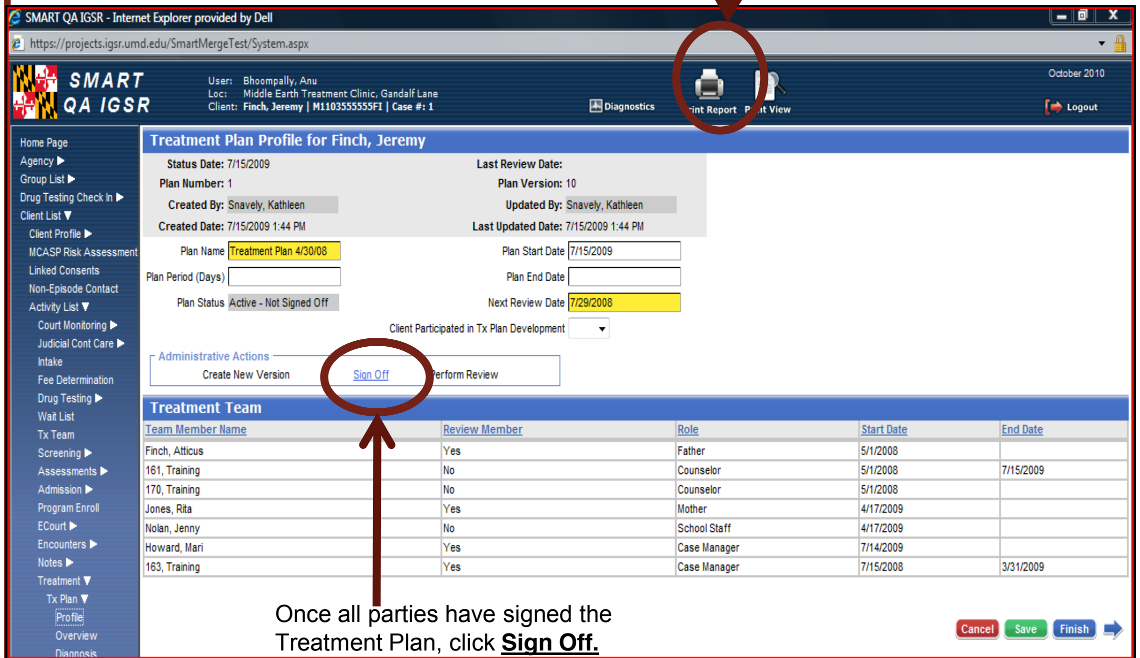
3. Go to Treatment Plan on the Menu Toolbar and click on **Profile.**

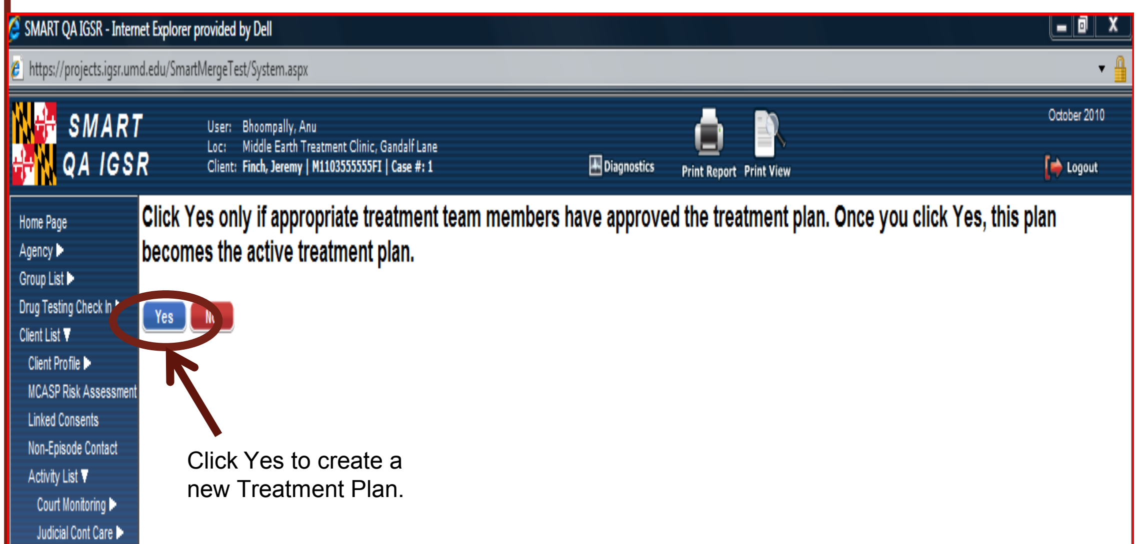
4. Click the blue **Sign Off** hyperlink found in the Administrative Action box. Once a Treatment Plan has been electronically signed off, it becomes uneditable. Thus, the Treatment Plan sign off is often a function completed by a Supervisor. Please refer to your agency’s business practices to find out who at your agency can/should sign off on a treatment plan.

5. The following message will appear: **“Click Yes only if appropriate treatment team members have approved the treatment plan.”** Once you click **Yes**, this plan becomes the active treatment plan.

   Note: Once a treatment plan is completed and signed by the treatment team, it cannot be changed. Modifications can only be made by creating a new version of the treatment plan. This new version creates a copy of the original plan only with a new version number. Additionally, this new version can be modified until it is signed by the treatment team

To print a report for signature, click Print Report.





Treatment Review

1. To perform a Treatment Plan Review, click **Treatment Review** from the Left Menu Toolbar. ***Note***: a Treatment Plan Review can only be completed once the Treatment Plan has been signed off.

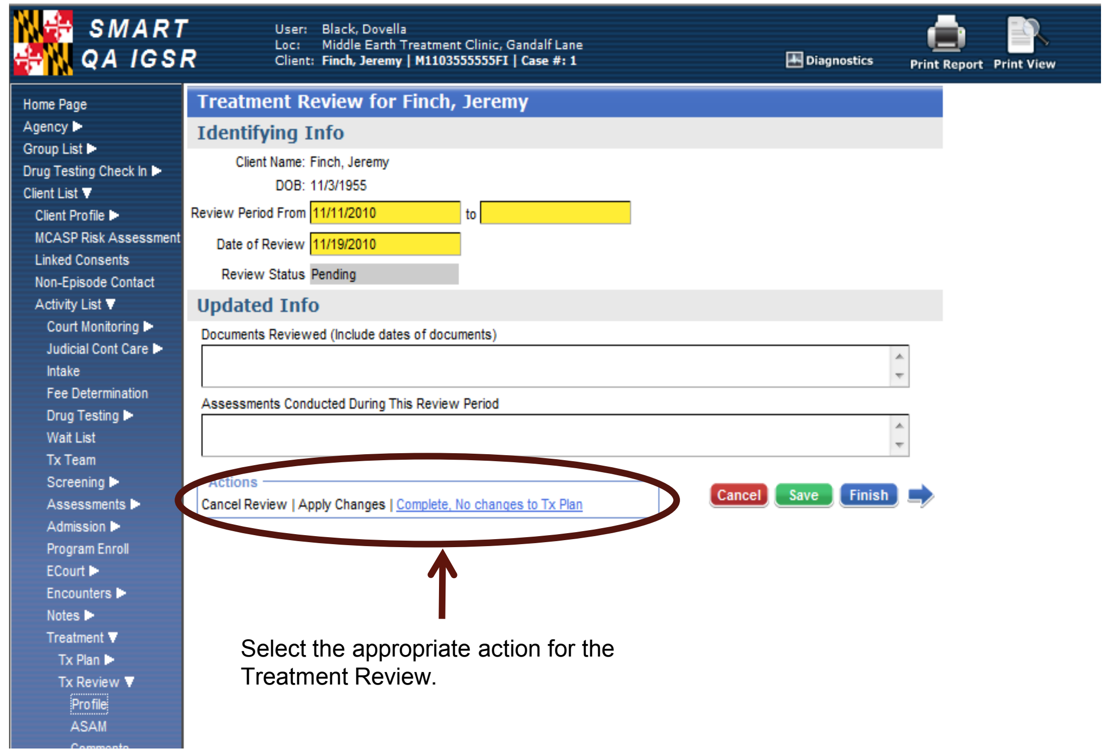
2. Click on the **Add New Treatment Review Record** hyperlink. ***Note***: it is up to each agency as to who can perform a Treatment Plan Review and it may vary from agency to agency.

3. After reviewing the Treatment Plan you have two options. You can:
   a) Return to the Profile Screen and click **Complete no changes to Treatment Plan**

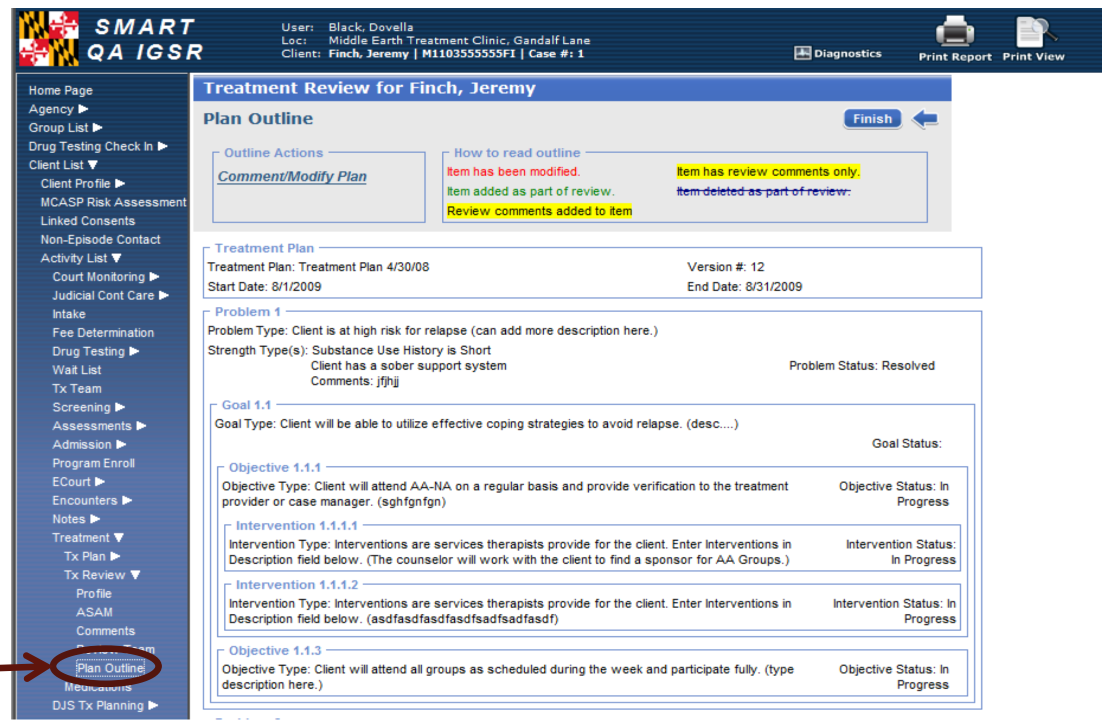
   b) Complete the screens associated with the Treatment Plan Review and click **Save**. Then go to the Plan Outline Screen from the Left Menu Toolbar and click **Comment/Modify Plan**.

4. If you choose to click **Comment/ Modify Plan,** a screen will appear asking you if you are sure. If you click **Yes**, the Outline screen will appear once more with modifying links now active. Once you have made your modifications, click **Finish**.

Note: Please remember that all fields highlighted in yellow must be completed.



Select the appropriate action for the Treatment Review.



From the Left Menu Bar, click **Plan Outline** to modify the Treatment Plan as part of the review.

Treatment Review

1. **Go back** to Treatment Plan on the menu tree

2. Click **review** next to the current treatment plan
3. **Change** the plan date to reflect the next round of treatment as well as review date.
4. **Answer** the question about client's participation in tx plan development
5. Click **Save**.
6. You must now print the new treatment plan and have the review team and client sign.
7. Click **Sign Off**
8. Click **Yes** to the prompt that says "click yes if the appropriate treatment team members have approved treatment plan.