BHRS CLIENT TREATMENT AND RECOVERY PLAN

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BHRS CLIENT TREATMENT AND RECOVERY PLAN

A. Treatment Planning

The BHRS Client Treatment and Recovery Plan:

- Is developed by and is the result of an interactive process between the client and the treatment team. The Mental Health diagnosis and the symptoms that impact the client's functioning is the primary issue that BHRS treats.

- Is effective when treatment planning involves the client's participation in developing her/his goals and objectives. The treatment team assesses the client's motivation to participate in the type(s) of services or interventions BHRS staff will provide so that the client will be successful and can achieve their desired outcomes, goals and/or objectives.

- Is effective when the family's goals are captured and a set of objectives to meet these goals are developed.

- Is a dynamic process that allows for reassessment, updates and achievement of goals.

- Is required for *each* episode of care and is usually developed by the primary therapist.

- Is completed *within* the intake period (60 days) from admission for each episode.

- Meets regulatory/compliance requirements for service authorization when completed on *time* and *signed/co-signed* by the LPHA.

- Provides accountability for the clinician and the client in achieving the expressed/desired outcomes of treatment.

The following link provides information about the Client Treatment and Recovery Plan:
http://www.smchealth.org

B. Purpose of Training

This training will introduce you to the BHRS Client Treatment and Recovery Plan and will help you:

- Understand treatment plan terminology and how you to complete all 3 tabs of the BHRS Client Treatment and Recovery Plan.

- Understand that the clinical formulation from the client's assessment is necessary to identify the Client's: Stated Goal; Barrier (s) to Recovery/Success; Goals; Objectives; and Interventions by the Treatment Team.

- Learn who can perform the treatment plan functions, and when a Co-Signature is necessary; how to Edit/Delete a Barrier, Goal, and Objective; and how to close and exit the treatment plan.

- Understand the importance of getting signatures from "Participants" involved in developing the client's Treatment Plan.

- Learn the process of Notification to a Supervisor for Approval of a Pending Plan, and how to record the Notification to a Supervisor for Annual Updates to the Plan.

C. Compliance and the Client Treatment and Recovery Plan

The client's assessment documents have been completed and you are sitting with your client and/or the parent/guardian to develop the Client Recovery and Treatment Plan.

- Every client receiving mental health services must have a completed treatment plan within 2 months of the date they entered the program where they are receiving services.
- A client needs a *separate* treatment plan for each program or episode to which they are admitted.
- Treatment plans are *required* to be renewed/updated annually and are due by the client's anniversary date; however, a client's barriers, goals and/or objectives may be added, revised or deleted as needed. ***** *Please see Appendices # 2-page 20 " Anniversary Date" for more information.*
- Clinical staff may develop the treatment plan but the primary therapist for the client is usually responsible for creating the plan and monitoring that the plan is current and accurately reflects what the client has agreed to work on.
- The treatment plan must be signed/co-signed by a Licensed Practitioner of the Healing Arts (LPHA) and it is the LPHA's signature on the plan that determines the authorization or start date of when a service can be billed.

D. How Do I Create the Client Treatment and Recovery Plan?

Path: Avatar CWS↓ Treatment Planning → Client Treatment and Recovery Plan (new)

- If the client has other open episodes, a pre-display screen will appear for you to select the episode that this plan will be entered into.

Once you have selected the episode, the treatment plan will open *or*

- If any treatment plan within the selected episode has been saved as a draft or final, a pre-display screen will open that shows previous plan.
- At the bottom of the Pre-Display screen are options for you to ADD, which is to add a new treatment plan; Edit, which is to edit a DRAFT plan, you cannot edit a plan with Final status, you will only be able to view that Final plan. If you select cancel it will cancel the plan and bring you back to the Avatar homepage.
- **Select ADD**

1. Tab 1- Plan Dates and Information:

Plan Dates and Information Tab (A): This tab is orange/active.

The Type of Plan (B): Indicate if this is the Initial, Annual, or an Update to the Treatment Plan.

The Name of the Plan (C): This name needs to identify or distinguish this plan from many other plans that may be present in this episode. Use the client's name, nickname, and date, anything specific that will help you to later find this plan.

The Client's Stated Goal (D): Overall, what does the client want from treatment. Ask the client- "What would your life be like if treatment is successful"? You can use quotes of the client.

● **ATTENTION- *ALERT!* (E):** <u>**Start Date is the Approval Date when the LPHA Approved the Plan**</u> ●
This alert is BOLD to reinforce: if the date of *signature* by a LPHA is a *different date* then *when the plan was written*, the <u>***start date will always be the date of the LPHA signature!***</u>

The Plan Start Date (F): Enter the date you are developing the plan, but remember, regardless of the date entered in the start date box, the actual start date, the date when services can begin to be billed, the date of the switch turning *"on"* for authorization of service is the *Licensed Practitioner of the Healing Arts (LPHA) signature/co-signature date* on the plan.

The Plan End Date (G): Avatar automatically establishes **the anniversary date** as the plan end date. This means **authorization ends** on the *anniversary date. *Please see Appendices #2, page 20 "Anniversary Date for information.*

● You may update a plan at any time and **must** update the plan annually **by** the anniversary date. (The annual update may occur up to 6 weeks prior to the anniversary date).

● The plan end date in Avatar is **alway**s the anniversary date and **NOT** a year from when the plan was developed and/or updated. *Please see Documentation at a Glance Report, pages 16- 17 for information about monitoring treatment plan due dates.*

Client's/Guardian's/Parent's Signature (H): You will not complete this section until you have completed Tab 2, Treatment Plan Items, and Tab 3, Participation/Notification/Signatures.
Regulation requires the client's participation in their treatment plan and this is evidenced through their signature. If Did Not sign is selected, you are required to write the reason why in the Comment Box **(J)**. Since Tab 3 is the signature page, you are bringing forward this information. If the signature pad is used, these signatures will be present on the treatment plan report when it is printed.

- If *electronically signed*, the signature(s) should match with signature(s) provided on Tab 3. This allows for multiple signatures in the signature box that will appear on the printed/final version of the plan.
- If *signed printed copy* is selected, this means a signature was obtained on a hard copy paper version of the treatment plan signature page. **The signed signature page must then be scanned into the correct Avatar episode.**
- If *verbally approved*, subsequent attempts to obtain the client's signature **must** be made and documented in a progress note or notes.
- If *did not sign* is selected, there is *no signature*, and/or the client may have refused to sign. The comment box **(J)** **must** be completed with the reason(s) the client signature is missing. You will be unable to select *final status* and *file/save* the treatment plan until there is something in the comment box. Further attempts must be made to obtain the client's signature (at least 3) and these attempts **must** be documented in progress notes.

Client's/ Guardian's/Parent's Acceptance of a Copy of the Plan (I): You will not complete this section until you have completed Tab 2, Treatment Plan Items, and Tab 3, Participation/Notification/Signatures. Regulation requires evidence that the completed Client Treatment and Recovery Plan be provided or at least offered to the client/guardian/parent. Select the appropriate answer. If Offered/Declined is answered "Yes" or Offered, "No" is selected, you **must** write the reason *why* in the comment Box **(J)**.

- If you select, *Offered a copy of the plan and "Yes" it was accepted*, print the treatment plan from the print client plan box **(M)** and give to the client/parent/guardian. Be sure to document this in the Plan Development progress note you will write for the service you provided.
- If you select, *Offered a copy of the plan and "Yes" it was declined*, you must explain why the plan was declined in the comment box **(J)**.

- If you select, *"No" or NOT offered*, you must document the reason(s) you did not offer or the reason (s) the plan was refused in the comment box **(J)**.

Comments Box (J): You *must* document reason(s) the client did not sign the treatment plan or reason(s) a copy of the treatment plan was declined/not offered. This is a free text box and you can write as much as you need. The pad/pencil icon is the text editor where you can get an expanded view of what is in the comment box and can also edit, use spell check for the text.

Plan Status (K):
- **Draft:** The status of the plan is in DRAFT form because it is not complete. Authorization for service is not valid until the treatment plan is submitted as **final**. While you are developing the treatment plan, select draft until you are sure you will not make any further changes. Always be sure to FINALIZE any plan that is a DRAFT!
- **Pending Approval:** The plan **is** complete but cannot be finalized until a LPHA co-signature is obtained. Authorization is not valid until the LPHA co-signature is provided and the plan is submitted as final.
- **Final:** The plan is submitted as FINAL, there is a LPHA signature/co-signature, and authorization is valid from that signature date.

Send to for Co-Signature (L): If the plan status is "Pending", you will select the name of the team member responsible to co-sign the plan from a dropdown box. This person will be notified of the pending plan on their "To Do" list.

File/Save (M): allows you to file/save items on this Tab. You will not be able to move to Tab 2 without filing. (If you try to move to tab 2 without filing, a pop-up window will appear with a question, "Do you want to save before continuing?" Answer "yes" and you will be back to Tab 1 and will need to just click the file/save. `File / Save`
- After you click file/save button, a pop-up box will appear and ask if "you want to default to information from a previous plan."
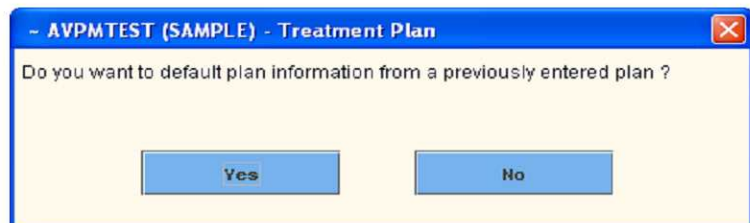
- If you click "YES", a window with all the previous plans will appear for you to select/click on the plan you want to bring forward. Then, click "return" to exit this screen. Another pop up box will appear and ask if you are "sure you want to default data from this plan", answer "Yes". Then, another pop up screen with *filing complete* appears; you can answer "ok". You will be back at Tab 1, just click on the next tab, **Treatment Plan Items** and the Tab 2 window will open. You will notice that Tab 2 has become *orange* and *active.* You will then be able to edit, add, and delete items in Tab 2.

- If you click "No", no data will be brought forward, the data entered in this tab will be filed or saved; you can now click "ok" to this pop up box.

E (LIVE) - Client Treatment Plan

Data Filed.

OK

Print Client Plan (N): The print button generates a report that displays the completed treatment plan on your computer screen which can be printed and given to the client.

Exit Treatment Plan (O): Notice the in the toolbar that is used to close other Avatar documents is *gray*; **you can not use it to close the Client Treatment and Recovery Plan.**

Exit Treatment Plan - This is the *only* way to Exit from the Treatment Plan and is present on all 3 tabs.

2. Tab 2 - Treatment Plan Items:

Treatment Plan Items Tab (A): This tab is now orange/active.

Barrier to Recovery/Success (B): allows entry of a barrier/problem that was identified by a clinician, client, parent, or guardian. Each barrier/problem includes the mental health signs/symptoms referenced by the primary diagnosis and/or other life domain challenges. These **barriers/problems meet medical necessity** and prevent recovery/success from being achieved. They are the **focus of treatment**.

- **Default Barrier**: If you answered "Yes" to default information in from a previous plan when asked from Tab 1, the barrier(s) from the plan you selected will display in box **(B)**. If you click on the black arrow **(C)**, (drop down box) you can view other barriers that have been brought forward. You click each barrier and determine if it is current. You can add or edit information to that barrier in the add/edit barrier box **(D)** If you want to delete this particular barrier you can click delete **(M).** A pop up box will ask if you are "sure you want to delete this item" If you click "Yes" then the goals objectives, interventions and duration for that barrier will also be deleted.

- **Add Barrier (D)**: is to add a new barrier
    1. If there was no default barrier then go directly to the Add/Edit Barrier to Recovery/Success box **(D)**. Enter the barrier, and then go to goals, objectives, interventions, duration and status of the barrier. Be sure to File /Save this information. You can add more barriers if indicated.
    2. To **add** a *new* barrier when there are existing barriers, start at the Barrier to Recovery/ Success box **(B)** and click on the black arrow, as you bring your cursor down click on the yellow blank space. This will clear the fields in all boxes below and allow you to enter the new barrier in the Add/Edit Barrier to Recovery/Success **(D)** text field.
    3. Once the new barrier is added, then add Goals, Objectives, Interventions, Duration, and Status related to the added barrier. File/Save each new added barrier.

click here

BARRIER TO RECOVERY / SUCCESS (displays current listing of Barrier to Recovery / Success being work on)

test has no money and he has poor time management, gets anxious with deadlines,has quit other jobs in the past ▼

test has no money and he has poor time management, gets anxious with deadlines,has quit other jobs in the past
test spends money on alcohol to avoid dealing with anxiety

yellow blank space

⚠ When you are adding a new barrier, do not backspace over a current barrier that is present in the box. **And,** don't forget to select the yellow space within the barrier box. You will overwrite (delete) the current barrier**,** as well as, the information in the goals, objectives, interventions, and duration fields.

- **Edit Barrier (D):** is to edit an existing Barrier.
    1. Click on the blue space within the Barrier to Recovery/Success box and select/click on the Barrier you want to edit.
    2. The selected Barrier will populate into the Add/Edit Barrier to Recovery/Success Box.
    3. Edit the Barrier and File/Save.
    4. If the edits you've made to the Barrier require edits of other treatment plan items (e.g., Goals, Objectives, Interventions), be sure to modify and then File/Save these changes.

Goals (D): These are statements of specific results or outcomes that the client wants to achieve. The "Stated Goal" from Tab 1 is more global and long term. Goals identified in this part of the treatment plan identify what the client can *do* to remove the problem's power, what can the client *do* to manage their issues and improve their functioning?
    1. Goals connect to and address a Barrier; many Goals may be added within the Goals box **(D).** Press enter in between each Goal that is added.
    2. *If you **right click** inside the Goals box, a pop up box appears that will allow you to select System Templates (see below). When you click on the arrow, there will be many common Goals that may be selected to address the specific barrier. Some of the template Goals are complete statements, some require the entry to be relevant and individualized for the client. The general rule is to have 1 or 2 goals that address each barrier, however, you can select as many as applicable. Whatever you select from the "Goals" System Template will populate into the Goals box of the treatment plan.* ***** *Please see Appendices #1, pages 18-19 for the System Template documents with examples for Goals and Objectives.*

3. ⚠ If there is already information in the Goals box, a pop-up box will appear and state there is already information within the text box (see below). You will make a selection if you want the template to replace the current information or append (ADD) to the current information that is in the Goals box. Select either replace or append.
4. The *pad/pencil icon* located near the upper right hand corner of the Goals box is the **Text Editor.** It expands the view of what is in the Goals box and enables editing of the Goals.

You can enter client goals by writing your own, using the system template or both

If you add a template goal when there is text already in the Goals box this pop up appears, select to either replace what's in the box or add (append) to it

Objectives (E): These are next steps the client can take to achieve their Goals. Objectives describe what the client can do to help remove a problem or increase their skills. The client can achieve success when the larger Goals are broken down into smaller steps or objectives. Objectives should be specific, observable or quantifiable and related to the assessment and diagnosis. A simple nemonic to remember when creating Objectives is *smart*- **s**imple, **m**easurable, **a**ccurate, **r**ealistic and **t**ime bound.
1. To address meeting a **Goal**, many Objectives may be added within the box.
2. Right clicking within the Objectives box opens a selection box where system templates Objectives may be selected, if applicable. When you select/click on the template 'Objective' it will populate into the Objectives box on the treatment plan (you may need to add client specific information or if the template includes a set of objectives, you may need to edit and select only the ones the client agrees to and that address the goal).
3. The *pad/pencil icon* located near the upper right hand corner of the Objectives box is the **text editor**. It allows viewing the whole Objectives box and enables editing of the Objectives.

Interventions (G): select or check the **types of services the treatment staff will provide.** Check *all* Interventions that are applicable.

* PLEASE NOTE: Medication Support (H) if provided by a BHRS clinician, must be selected separately and in addition to the other listed Interventions. If Medication Support is selected, it should be in conjunction with another service intervention.

Additional Interventions (I): allows for an intervention(s) other than those listed to be "written in". For example, cognitive behavioral therapy, solution focused therapy, art or drama therapy. This field is optional. You will see the *pad/pencil icon* or **text editor** that allows viewing the entire field and enables editing of the Additional Interventions.

Duration of Intervention (J): you will select the projected time that the Intervention(s) will be provided. This period is usually 12 months. If certain interventions will be authorized for less than 12 months, please indicate this in a progress note.

Status (K): this is a dropdown box to indicate if a Barrier is *current, closed, deferred, partially resolved* or *successfully resolved.* **NOTE: Leave the status as "current" unless you are defaulting information in.**

If you *have* defaulted information in:
1. Choose the appropriate Status type for each barrier when you are reviewing a treatment plan you brought forward. You will file/save and then move on to the next barrier and record the status, then file/save.
2. IF the status for a barrier is filed as 'Closed' or 'Successfully Resolved' then that goal will not be brought forward or defaulted in on any future plans.

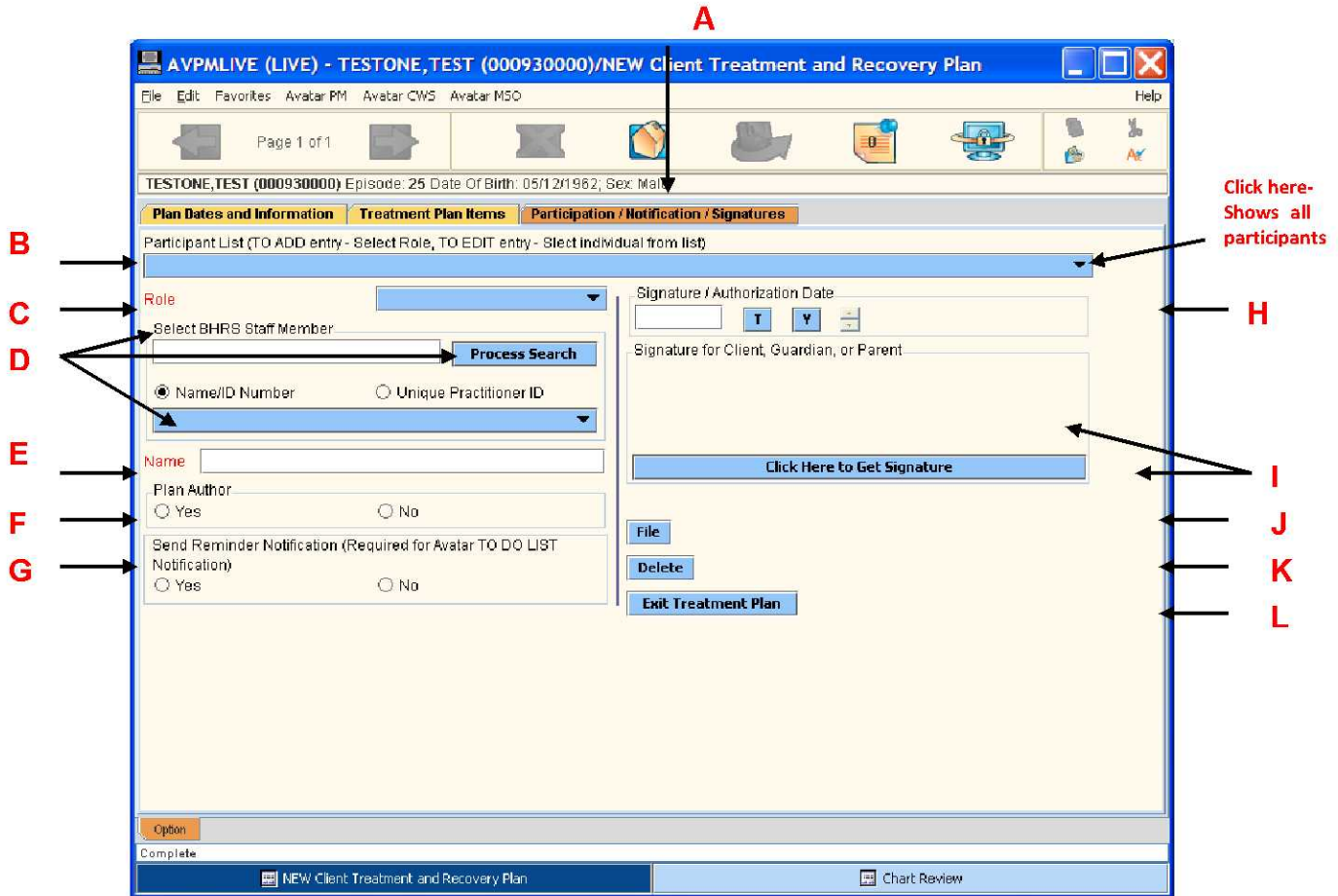**File/Save (L):** allows items on the page **and** the page to be filed.

Delete (M): allows item(s) selected to be deleted.

Exit Treatment Plan (N): This is the only way to Exit from the Treatment Plan. This is present on all 3 Tabs/Pages.

3. Tab 3 - Participation/Notification/Signatures:

Participation/Notification/Signatures Tab (A): This tab is now orange/active.

Participant List (B): you enter participants that were involved in the development of and agreement with the treatment plan. Click on the black arrow (drop down) to view participants. To ADD:

1. Go to the **"ROLE"** drop down box **(C)** and select/click on the **Role** of the participant(s).
2. Select the 'role' *primary therapist* or *psychiatrist* for yourself, as appropriate. Go to the Select BHRS Staff Member box **(D),** enter **your** last name and click on process search. Select **your** name and it will populate into blue box under the Name/ID Number button.
3. Click on File to Save. Your entry will now appear in the Participant List field, click the black arrow (drop down) to view. If you want to sign the plan, click the signature authorization date fields **(H)**, use the signature pad **(I)**, and then click File to Save.
4. Continue adding participants, as applicable. Go to "Role" and for other BHRS participants, enter the last name in the Select BHRS Staff Member box and click process search. Then click File to Save or get a signature as described above. The Roles and Names of Staff that have been entered and saved will appear in the Participant List field. You can view all participants by clicking on the black arrow (drop down).

5. When adding participants **other than BHRS staff**, go to 'role' and select as appropriate. For example, this is the field where you would *add* the *client* and the *parent/guardian*. The **Name** box **(E)** will be active (red); you enter the participant's name. You will request the signature at this time; click the signature authorization date fields **(H)**, use the signature pad **(I)**, and then click File to Save for each name added.

6. The Participant List will display all participants by role and name that you have entered. You can view all participants by clicking on the black arrow (drop down).

7. If you need to remove a participant, select/click on that participant in the Participant List box, then click the *Delete* button **(K)**. A prompt will ask if you really want to delete.

- The **Plan Author** button **(F)** select "Yes" if you are responsible for developing this treatment plan. You can make your entry when you enter your role **(C)** and **(D)** and File to Save as indicated in #2 and #3 on page 11. You may be the person who is only entering the treatment plan information, in this case, you are the you are **NOT** the plan author, so select **"No"** and go back to #2 and #3 on page 11, enter the participant who *is* the plan author, then File to Save.

- The **Send Reminder Notification** button **(G)** Avatar will send a reminder to a clinician responsible to update the treatment plan. Notification is sent to a clinician's "To Do" list up to 6 weeks before the new treatment plan is due. Always select *YES* for yourself; you *want* to be notified that the treatment plan is due for the annual update.

  1. Re: *author* and *reminder notifications* - If you are the plan author, but as a trainee will not be present next year to update the treatment plan, answer **"YES" to Author** but **"NO" to Notification**; go back to #2 and #3 on page 11, enter the participant who should receive the notification, then File to Save.

  2. If you are **NOT** the **author** or **do not want to receive the reminder notification,** go to #2 and # 3 on page 11 and enter the appropriate participant (s) who is the author and/or should receive the reminder notification for when the updated annual treatment plan is due.

- The **Signature/ Authorization Date** section of Tab 3 is for recording the **date (H)** that the Client, Guardian, and/or Parent **approved/authorized** the treatment plan. A signature is obtained usually when the plan is complete. The information here will be saved and then brought forward for entry on Tab 1
  1. Recording signatures through the signature pad **(I)** allows the entry to appear directly on the treatment plan once the plan is finalized and printed out.
  2. To use the signature pad, click the signature button which brings up the signature dialog box, have the participant sign the signature pad and click ok. The signature will appear in the signature field but will not be visible when actually signing on the signature pad.

- If a signature(s) is provided on a printed copy, this signature(s)/authorization **must** be scanned into the Avatar record. Give the paper copy with the signature to your program administrator. The date of signature(s) on the printed copy should match the date the clinician recorded on Tab 3 of the plan.
- If there is NO DATE or SIGNATURES captured on Tab 3, the page can be filed but the *reason(s)* for their absence *must be provided in the comment section of Tab 1*.
- **File/Save (J):** Allows items on the page **and** the page to be filed.

- **Delete (K):** Allows item(s) selected to be deleted.

- **Exit Treatment Plan (L): Is the only way to Exit from the Treatment Plan. This is present on all 3 Tabs/Pages.**

E. Documentation at a Glance Report:

The *Documentation at a Glance Report* is a helpful report for both supervisors and clinicians. This report will provide you with information about the current status of Client Treatment Plans, Assessments, Diagnosis and Last Service information for a *primary clinician's caseload* or *program*. This report will also indicate items that are overdue or coming due by wrapping a box around the item needing attention. It is the best way to get a quick look at your caseload and the status of each client's documentation and due dates!
Path: CWS Reports→ Documentation Status Reports → Documentation at a Glance.

You may select the report by:
Location: shows all clients by all clinicians for a selected program,
Staff: shows all clients assigned to a specific staff person for all programs or
Staff *and* Location: shows all clients for a selected staff person at the selected program.

To request the report, click on the Report Icon
The report may take some time and there may be one or more pop up windows that ask if it's ok to "download from the server" or if you "want to return to the option". You can answer "Yes" to these pop up windows.
Please use this report frequently!

Please see the next page for the screen shot example of the *Documentation at a Glance Report* and descriptions.

BULL,INGALL

410401 SOUTH COUNTY ADULT

Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930000 TESTONE,TEST DOB: 5/8/1982 222 W 39 STREET JYO TEST AGAIN SAN MATEO, CA 94403 (h) 650-589-1172 (c) 123-456-8888 (w) 555-1256	05/01 10/6/2011	BANKS,MICHAELA	Draft Plan Type: Initial Status: Draft Start Date: 10/19/2011 Next due date: 4/30/2012	Adult Special Assmt Status: Final Date: 12/16/2011 Completed By: JEANNINE MEALEY	307.81 (ICD9) TENSION HEADACHE	2/9/2012

416800 EAST BAYSHORE ADULT

Client	Anniv. Date Admit Date	Care Coordinator	Treatment Plan	Assessment Status	Primary Diagnosis Code / Description	Last Service
930003 TEST,TESTTWO DOB: 4/30/1989 123 MAIN STREET SAN MATEO, CA 94403	11/01 5/20/2010	ECCLESTON,SARA	Draft Plan Type: Annual Status: Draft Start Date: 1/23/2012 Next due date: 11/1/2012	Adult Annual Status: Draft Date: 5/11/2010 Completed By: DEBORAH BALLON	No Entry	9/23/2011 OVER 90 DAYS

Report Headings

Client: Includes the Client Name, Mental Health #, Date of Birth, address and phone numbers.

Anniversary Date / Admit Date - Current Anniversary date on file in Avatar and the Admit Date to the program.

Care Coordinator: Person assigned as the Care Coordinator in Avatar

Treatment Plan: Shows the Type of Treatment Plan, (Initial or Annual) and the *current* Treatment Plan Status (Final, Draft, or Pending). If this Item is *wrapped in a box*, it indicates that the **plan is** either **OVERDUE** or **COMING DUE** and these Items need to be addressed first. Items appearing with no box are in compliance. If a *client is **newly admitted**,* this section *will tell you the **date** their **first Treatment Plan is due.***

Assessment Status: Will show information regarding the *last assessment for the client.* Information included is **Type of Assessment** (Initial, Update or Annual), **Assessment Status (**Final, Draft or Pending), the **Date of Assessment**, and **who** completed the document. If an *assessment is left in draft* then it will have a *draft indicator in red. Reassessments are due* by the indicated *anniversary date* of each calendar year.

Primary Diagnosis: Displays **current Diagnosis Code and Description** for the client in the identified program. If *"No Entry"* you need to **complete a diagnosis** for this client in this program using **BHRS Diagnosis.**

Last Service: Displays the **last service date** and *indicates if that service is more than 90 days old.*

F. APPENDICIES

1. System Templates: Below are the system templates for Goals and Objectives that you can select from. Some are statements and some require a more specific individualized response by the client. When you select a system template you can edit it by using the text editor and be sure to save the modification you made.

These templates are meant to assist you. You may create your own, use a system template or use both.

GOALS

ANGER free of angry outbursts: I want to stop having angry outbursts at (specify…).
ANGER impulse stabilization: I want to learn ways to stop threatening or assaulting others.
ANXIETY free of anxiety: I want to feel less anxious when (specify…).
ANXIETY panic attacks: I want to stop having panic attacks.
AOD cut down on use: I want to cut down on how much or how often I use (specify a substance).
AOD stop using: I want to stop using (specify a substance).
ASSAULT stop physically violence: I want to keep from getting physically violent with my (specify..).
DAILY LIVING skills: I want to get better at (specify skills) so I can (specify..).
MOOD keep from feeling: I want keep from feeling so (specify..).
EATING healthy: I want to eat healthy and (specify…).
RELAPSE keep from getting worse: I want keep (describe a current problem) from getting worse.
SELF-CONTROL: I want to have better self-control about (specify..).
SELF-HARM RISK: I don't want to hurt myself by (specify..).
SLEEP: I want to sleep (specify # of hours a night)
SOCIAL be involved: I want to be more comfortable around other people.
SOCIAL more active: I want to be more active with (specify..).
Symptom Management- Improve my ability: I want to improve my ability to (specify..).
Symptom Management- Free of: I want to be free of (specify symptom).
Symptom Management- Be safe: I want to be safe when it comes to (specify..).
Symptom Management- Stop feeling so: I want to stop feeling so (specify..).
WELLNESS- Improve my health: Improve my health and feel better by doing (specify..).
WELLNESS- Improve how I feel: Improve how I feel and think about myself by (specify..).

OBJECTIVES

AOD- Not Use: I will not use (specify..).
AOD- Control Use: I will control my use of (specify..).
AOD- People/Places to Avoid: I will identify a list of places and people to avoid to help me remain free of (specify..).
AOD- Identify Reasons to Control Use: I will identify reasons to control my substance use.
Coping Technique: I will use (specify coping technique) for dealing with (specify a symptom trigger) at least (how often?) for at least (how long?).
Crisis Plan: I will develop/us my crisis plan when I (specify a symptom).

OBJECTIVES: continued

Develop Self-Care Plan to feel better: Develop self-care plan and follow plan to feel better (including mood, diet, exercise, & sleep).

Develop Self-Care Plan- first step: Identify at least one thing I can do everyday to help myself feel better.

Report increase in Symptoms: Report increase in symptoms and changes in thoughts, behaviors and feelings.

Free Be Free of Symptoms: I will be free of (specify one of your symptoms) for (# of days/weeks/months).

Log: I will keep a log of (specify a symptom).

Medication Compliance:

1. I will report increase in symptoms and changes in thoughts/behaviors/feelings.

2. I will report any side effects of psychiatric medicine.

3. I will take medication as agreed.

4. I will talk to MD before stopping medications.

Keep Living/Healthy in Community:

1. I will try to remain well and healthy in the community.

2. I will (specify) to maintain current living situation and stabilize health condition.

3. I will fully participate in daily activities.

4. I will develop at least one skill this year to help myself accomplish my goal.

2. Anniversary Date

INTAKE DATE

The Intake Date is the first date of claimed outpatient services for a "new" client. A "new" client is any individual admitted for outpatient services for which there is **not** a current outpatient treatment episode. The individual may have received previous services from BHRS and still be considered a "new" client.

INTAKE PERIOD

The Intake Period is two months following the Intake Date. During this time, a thorough assessment is completed, a CA/LOCUS is completed, and a Client Treatment & Recovery Plan is completed. The availability of community resources and social support systems to meet the individual's needs are evaluated. Generally, Assessment and Plan Development services are provided until the client care plan is completed. However, other services may be provided and should be coded based on the service provided.

ANNIVERSARY DATE

The anniversary date is the date an updated treatment plan, Annual Assessment, and CA/LOCUS is completed. These documents must be completed every year while the client continues to receive services.
The Anniversary Date is the first day of the month of intake.
The Anniversary Date follows the client throughout a continuous course of outpatient treatment anywhere in the BHRS system of care.

WINDOW PERIOD for DUE DATES

The window period for completing the Annual Assessment and all other Treatment/Recovery Plans is 6 weeks prior to the Anniversary Date. Plans and Annual Assessments completed and signed during the window period are effective for one year. Writing required annual documents earlier than 6 weeks before the anniversary date is too soon! **The requirement to update documentation annually is not met when written prior to the window period.**

SUMMARY

A chart must have all of the following items completed on time to avoid disallowance of services:

* Admission Assessment and CA/LOCUS completed within two months of the Intake Date.

* Initial Client Treatment and Recovery Plan completed within two months of the Intake Date.

* When an existing client is opened to a new team/program the new provider must complete a Client Treatment & Recovery Plan within two months of the opening.

* Annual Assessment and the CA/LOCUS updated annually during the 6 week window period prior to the anniversary date.

* The Client Treatment and Recovery Plan updated annually during the 6 week window period prior to the anniversary date.

These timelines are mandated and fixed for each client. Assessments may be amended or have additional material added at any time and Treatment & Recovery Plans may be amended at any time. These subsequent changes do not affect the **established timelines** and new dates shall not be entered into the computer.