SBHG EMR Training
Phase II
Care Plan/Treatment Plan
User's Guide

Volume IV
Release Date 2.8.09

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Welcome to the Phase II of the EMR Training Care Plan/Treatment Plan Users Guide

At the completion of training you will be able to:

1. Enter Problems/Needs
2. Enter Strengths
3. Enter a New Treatment Plan
4. Review/update a Treatment Plan

Enter the EMR

- Click the Internet Explorer icon
- Click into the training environment
- Login using the user name and password on the laminated login card
- Click on "Return to Main"

Refer to Phase I Manual for entering the EMR outside the SBHG network.

Select Your Client

1. Click on the Client Module
2. Click on Select Client
3. Enter Search criteria
    - o If you do not remember how to spell the client's name
        - Type in the percent symbol % which brings up all the names of client's you have access to
        - Type in part of the last or first name
4. Click on your client's name

ENTERING PROBLEMS / NEEDS

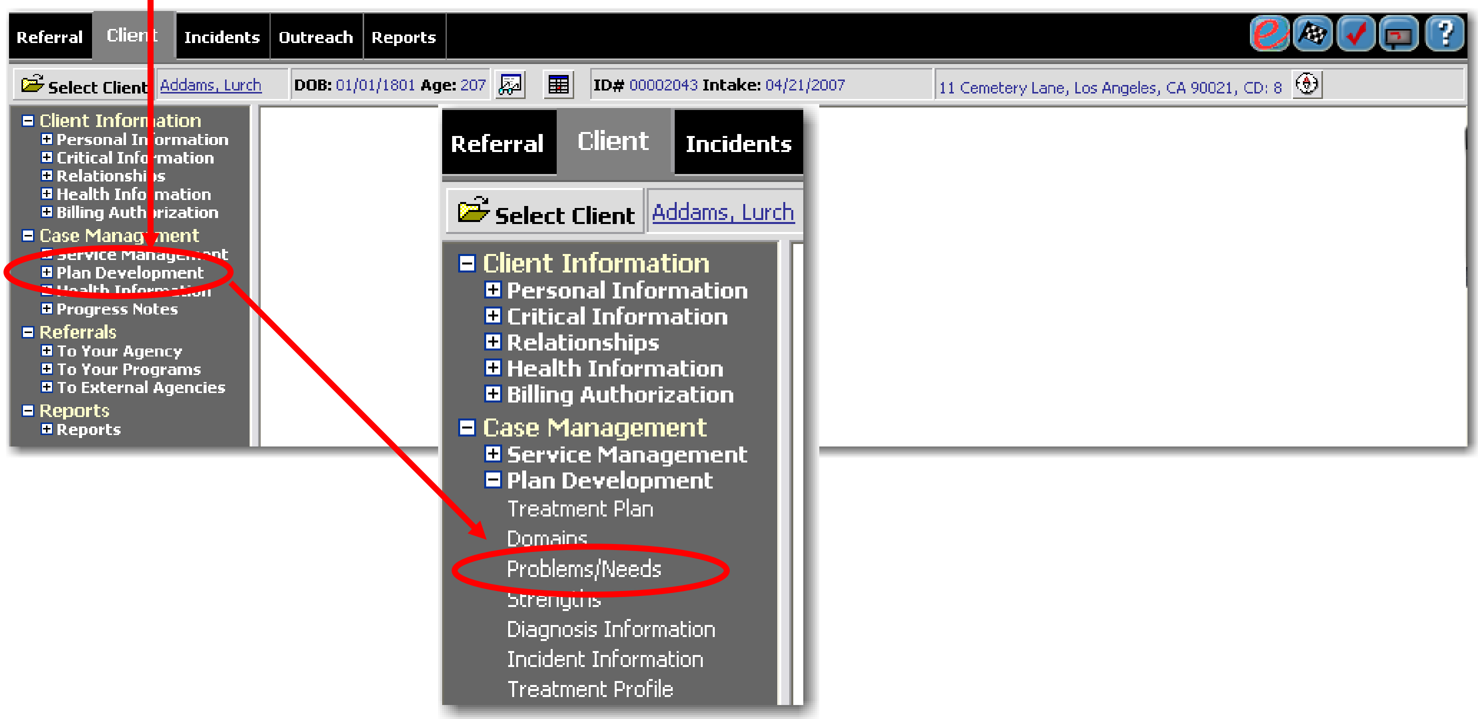
NOTE: You ***MUST*** enter Problems/Needs prior to building a Treatment Plan for your client. Without a problem/need on file you cannot build a treatment plan.

Problems/needs are the symptoms identified that lead to the diagnosis. Prior to entering in Problems/Needs an assessment must be completed with a Diagnosis. You can find the Diagnosis by clicking on Diagnosis Information under Plan Development.

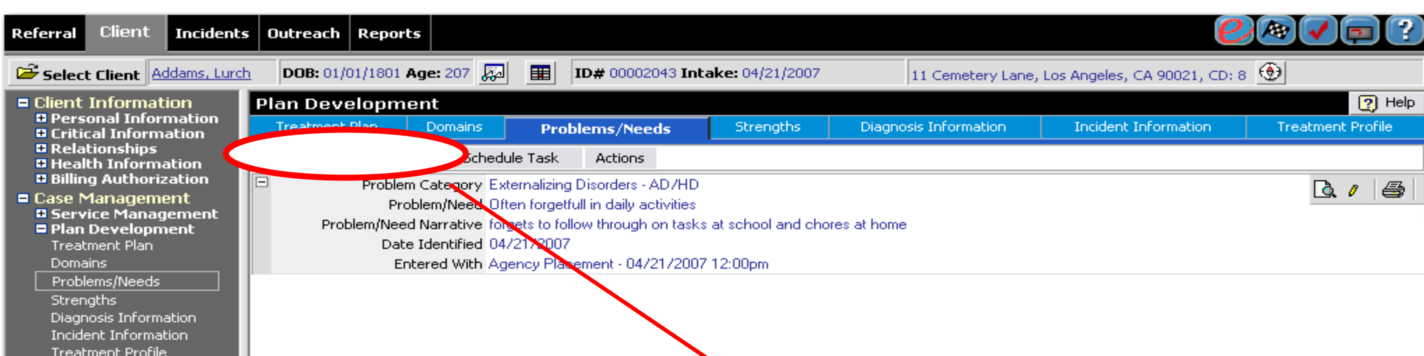
Enter a Problem/Need for your client.

Under Case Management

1. Click Plan Development
2. Click Problems/Needs



If there are Problems/Needs on file for your client they will list here. If there are no Problems/Needs you will see "None on file".



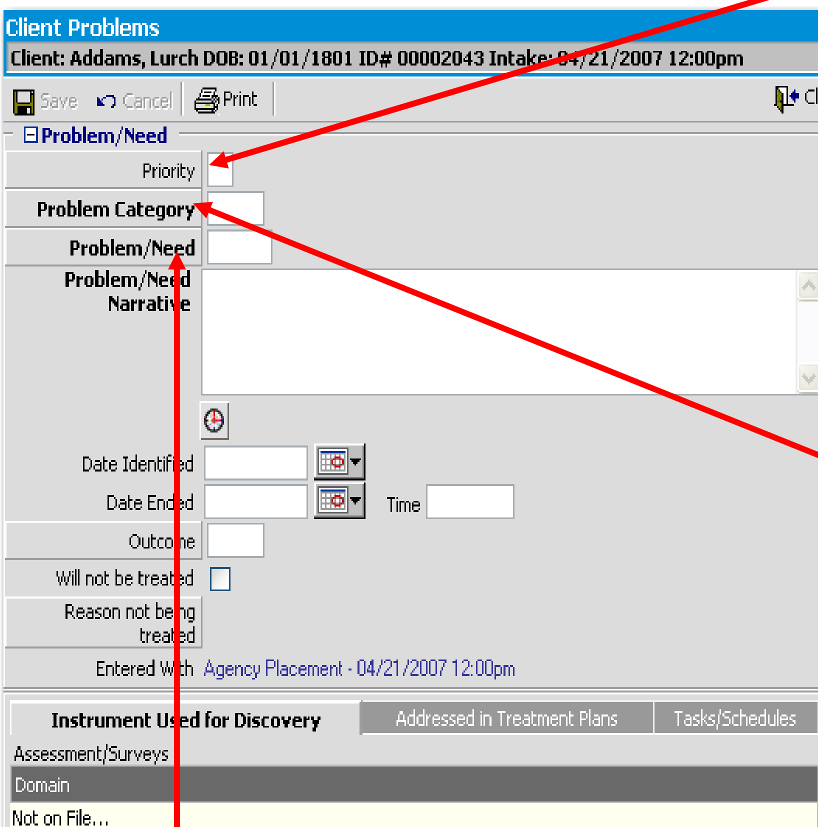
To add a new Problem/Need click New Manual Event

Click on Problems/Needs - Person [Problems/Needs - Person]

A Client Problems data entry box will open.

1. Priority: Allows you to prioritize the problem as Primary, Secondary, Tertiary or Other.

If you would like to prioritize your client's problems click on the Priority button.



2. Problem Category:
Categorizes your client's problem into the 7 Clinical Pathways listed below:

- *Internalizing Disorder
- *Externalizing Disorder
- *Severe Mental Illness
- Chemical Dependency
- Safety Concerns
- Social Service Needs
- Education

The *Clinical Pathways are linked to a DSM Diagnosis

1. Click on the Problem Category button [Problem Category]
2. A drop down list of Clinical Pathways will open
3. Click on the Clinical Pathway that corresponds to your clients Diagnosis

When entering a Problem / Need for a client receiving <u>Mental Health Services</u> DO NOT select Social Service Needs or Education.

You are able to select Social Service Needs and Education for those services provided OUTSIDE Mental Health Services (i.e. Wraparound, HRHN, FSP TAY and Child Youth).

3. Problem/Need:
Lists the functional impairments / Diagnosis criteria for the Problem Category

1. Click on the Problem/Need button

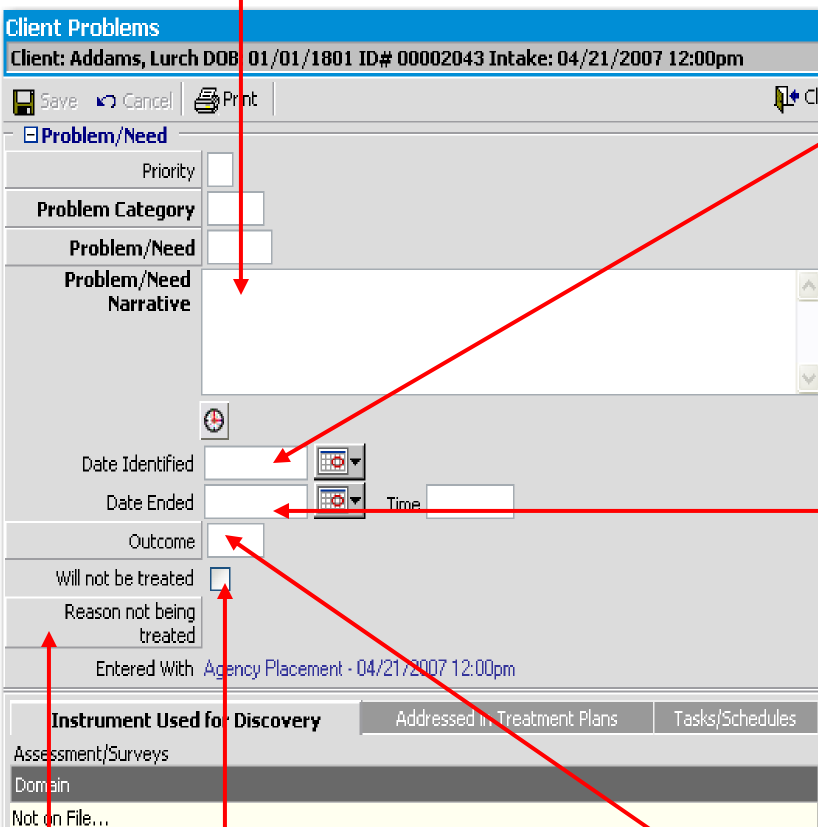
   [Problem/Need]

2. A drop down list will open with the list of criteria that coincides with the category selected
3. Select only one criteria (for additional criteria you must enter a new Problem/Need)

4. Problem Need Narrative:
A text box that allows you to type in information that qualifies the Problem/Need selected. Type in the specific behaviors noted that lead to the Diagnosis.

5. Date Identified:
Enter the date the behaviors began or were identified. If unsure of the exact date use the date the care plan was developed.

You can either type in the date or select



6. Date Ended:
The date this specific problem/need was extinguished or stopped. If unsure of the exact end date use the date the Care Plan will be reviewed/updated.

You can either type in the date or select it from the calendar.

7. Outcome: (use ONLY when ending a Problem/Need)
This allows you to indicate the outcome of the Problem/Need.

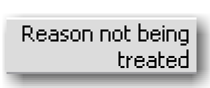
1. Click the Outcome button

2. A drop down list will open
3. Select the Outcome of this Problem/Need
   - Achieved
   - Can't be achieved
   - No longer present
   - Not achieved

8. Will not be treated:
If the Problem/Need will not be addressed you can check this box.

9. Reason not being treated:
If you checked the box "Will not be treated" you must indicate a reason.

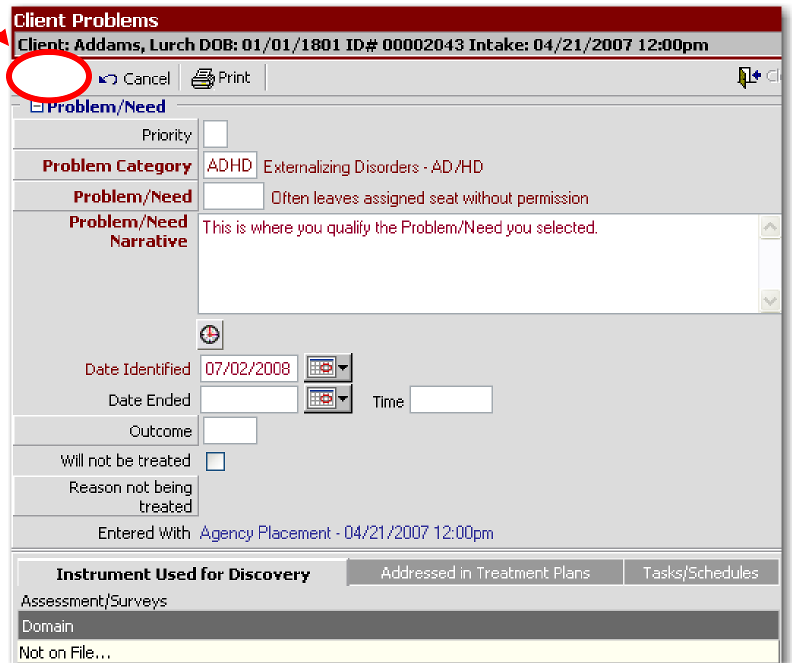
1. Click the Reason not being treated box



2. Select the reason

Your Client Problems box should look similar to the screen shot in your manual.

Click **Save** 



After clicking save, you will be brought back to the list of all Problems/Needs on file for your client.

New Manual Event | Schedule Task | Actions

			Priority	Problem Category	Problem/Need	Problem/Need Narrative	Date Identified	Date Ended	Outcome	Will not be treated	Entered With
+				Externalizing Disorders - AD/HD	Often forgetfull in daily activities	forgets to follow through on tasks at school and chores at home	04/21/2007			No	Agency Placement - 04/21/2007 12:00pm
+				Externalizing Disorders - AD/HD	Often leaves assigned seat without permission	This is where you qualify the Problem/Need you selected.	07/02/2008			No	Agency Placement - 04/21/2007 12:00pm

You **must** follow this same process for <u>each</u> symptom and Problem/Need identified. If your client meets several criteria for a particular Diagnosis you will need to have a Problem/Need selected for each of the symptom.

Only select the Problem Category that corresponds to the client's Diagnosis. If you choose to develop an objective related to a Secondary and perhaps a Tertiary Diagnosis make sure to select a corresponding Problem Category.

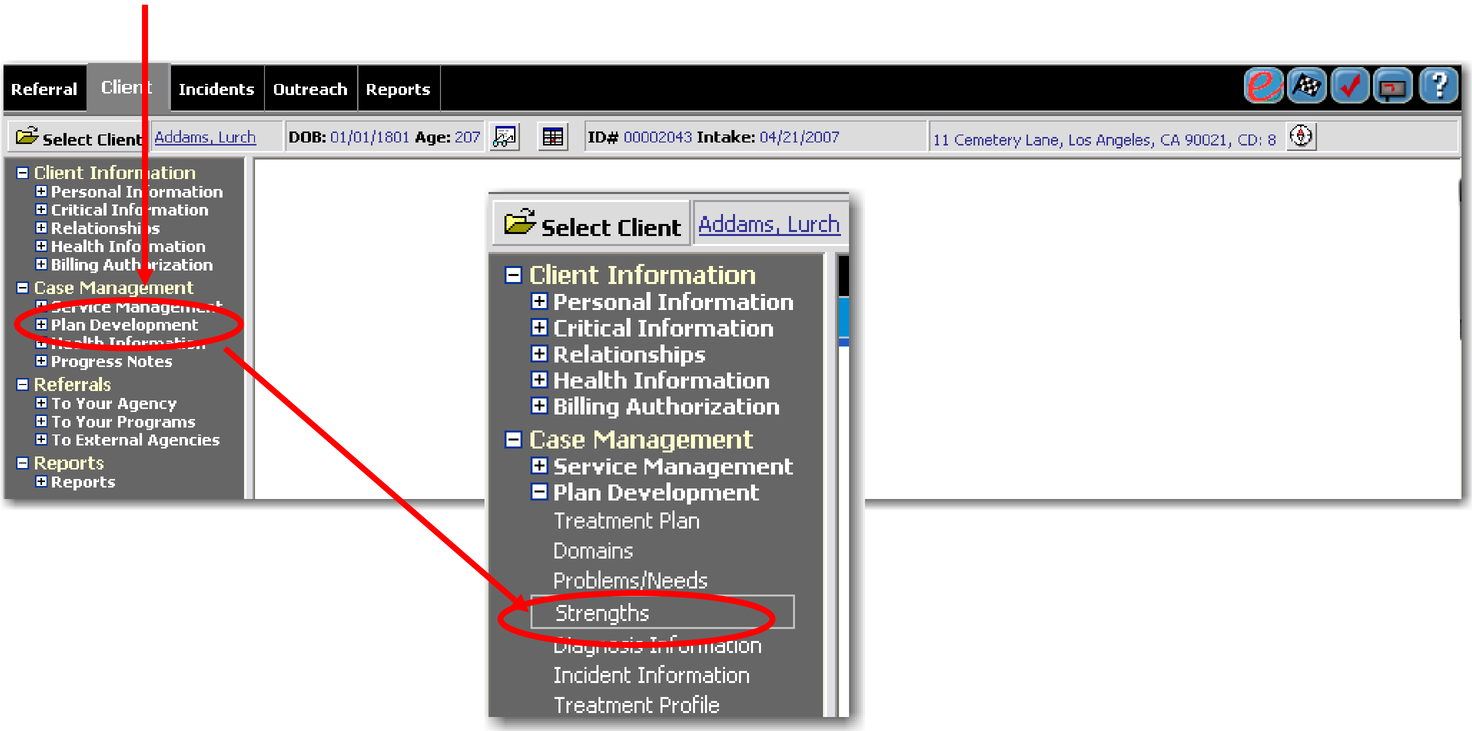
Clients typically benefit from a tight focus on only a few (2-3) problems. After initial Problems are resolved subsequent and less critical problems may be added and Tx Planned in the Review process.

ENTERING STRENGTHS

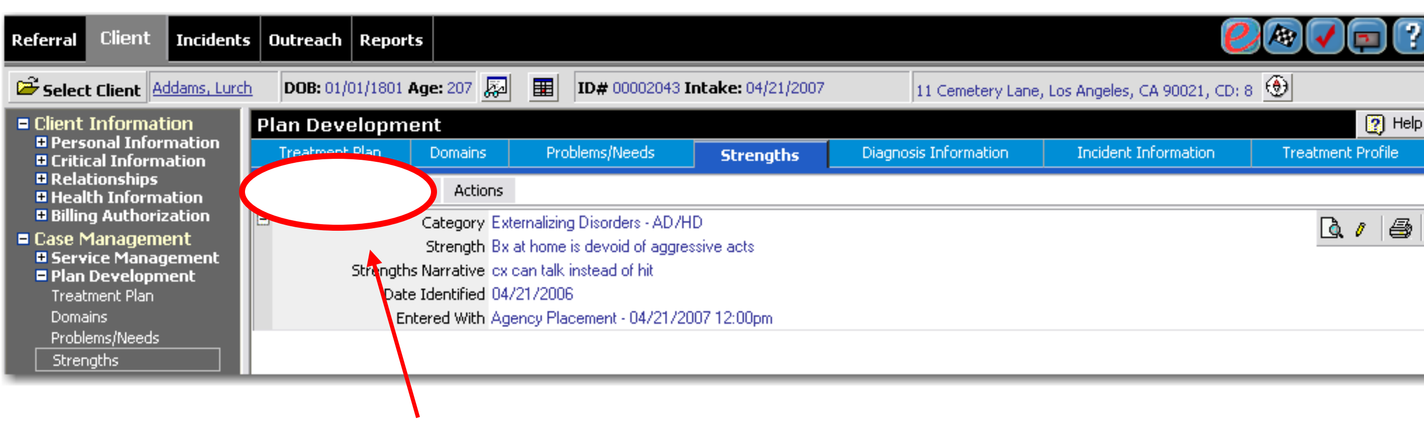
You should always identify strengths of your client.

Under Case Management

1. Click Plan Development
2. Click Strengths



If there are Strengths on file for your client they will list here. If there are no Strengths you will see "None of file".



Click New Manual Event 

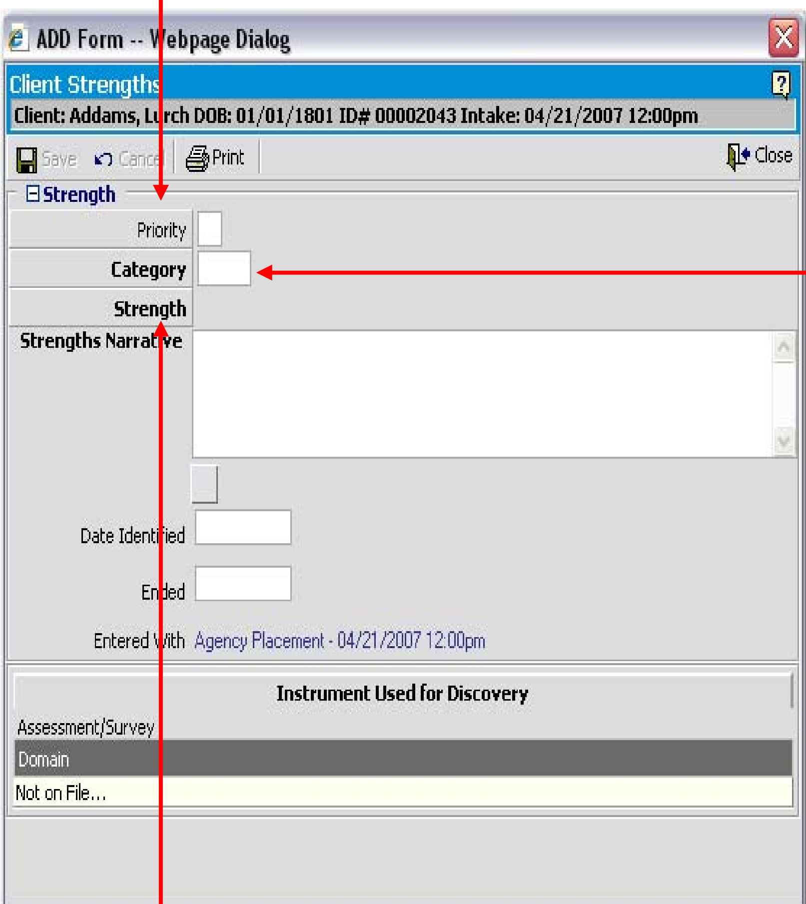
A menu will drop down with only one choice

Click of Strengths - Person 

A Client Strengths box will open

1. **Priority:** Allows you to identify the problem as Primary, Secondary, Tertiary or Other.

If you would like to prioritize your client's strengths click on the Priority button.



2. **Category:** Categorizes your client's strengths into the 4 Clinical Pathways:
   - Internalizing Disorder
   - Externalizing Disorder
   - Chemical Dependency
   - Severe Mental Illness

The 4 Clinical Pathways are linked to a DSM Diagnosis

- Click on the Category button

  Category

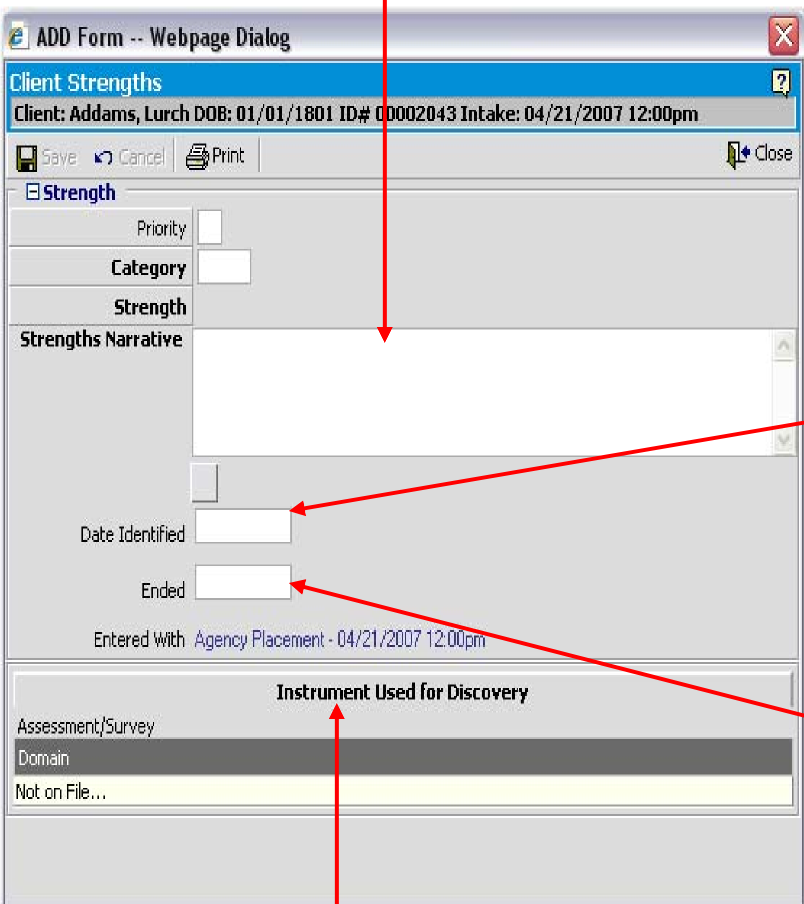
- A drop down list of Clinical Pathways will open
- Click on the Clinical Pathway that corresponds to your clients Diagnosis

3. **Strength:** The Strengths list is the same for all Categories – it is a list of 104 strengths.
   - Click on the Strength button

     Strength

   - A drop down list will open
   - Select the strength

4. **Strengths Narrative:** A text box that allows you to type in information that qualifies the Strength selected.



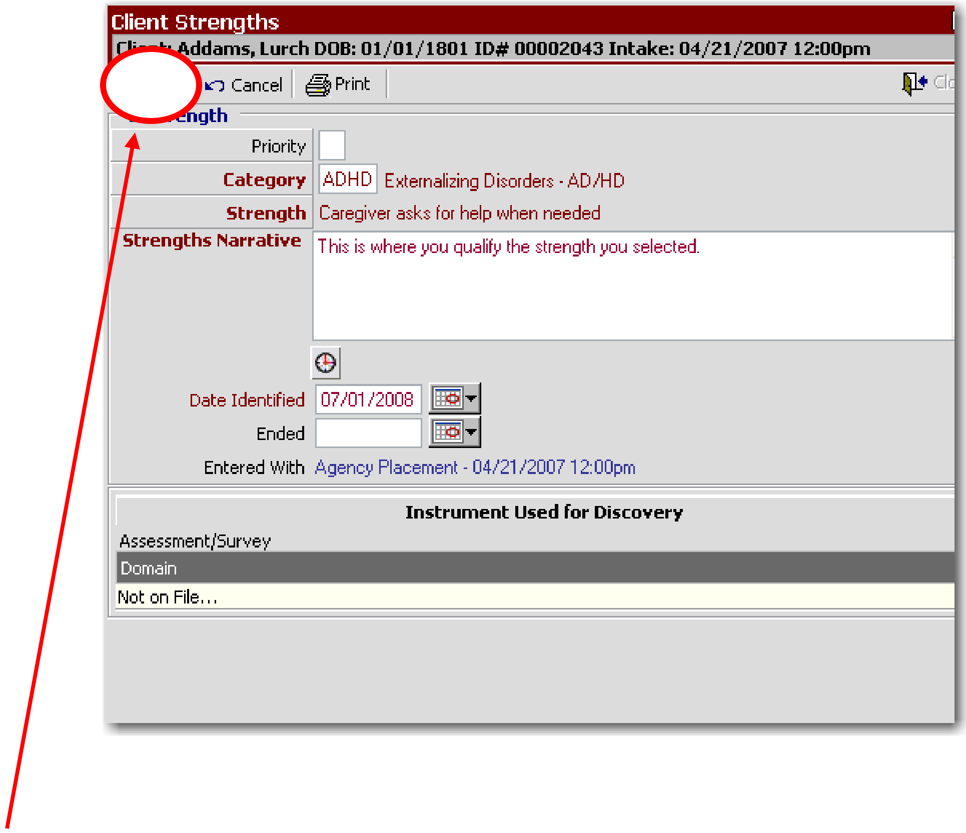
5. **Date Identified:** This is the date the strengths began or were identified. If you or the caregiver is not sure of the exact date use the date the care plan was developed.

You can either type in the date or select it from the calendar.

6. **Ended: Do not** enter an end date for strengths. This field needs to be left blank.

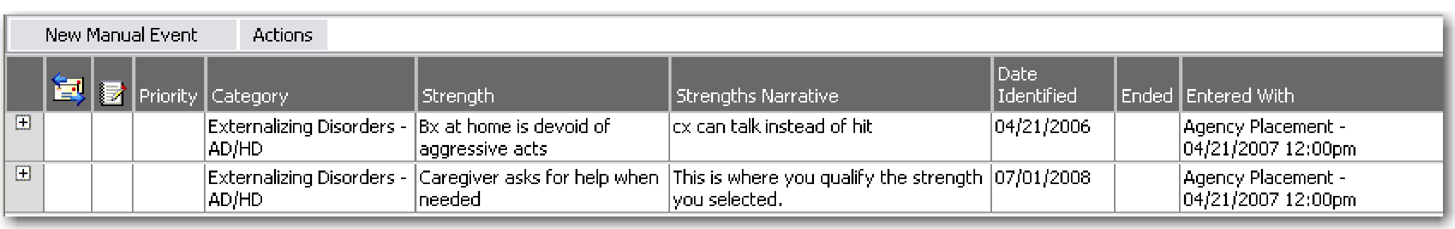
Instrument Used for Discovery is not being used at this time.

Once you have completed all the elements for a strength your Client Strengths box will look similar to the screen shot in your manual.



Click **Save** 

After clicking save, you will be brought back to the list of all Strengths on file for your client.


New Manual Event | Actions

			Priority	Category	Strength	Strengths Narrative	Date Identified	Ended	Entered With
+				Externalizing Disorders - AD/HD	Bx at home is devoid of aggressive acts	cx can talk instead of hit	04/21/2006		Agency Placement - 04/21/2007 12:00pm
+				Externalizing Disorders - AD/HD	Caregiver asks for help when needed	This is where you qualify the strength you selected.	07/01/2008		Agency Placement - 04/21/2007 12:00pm

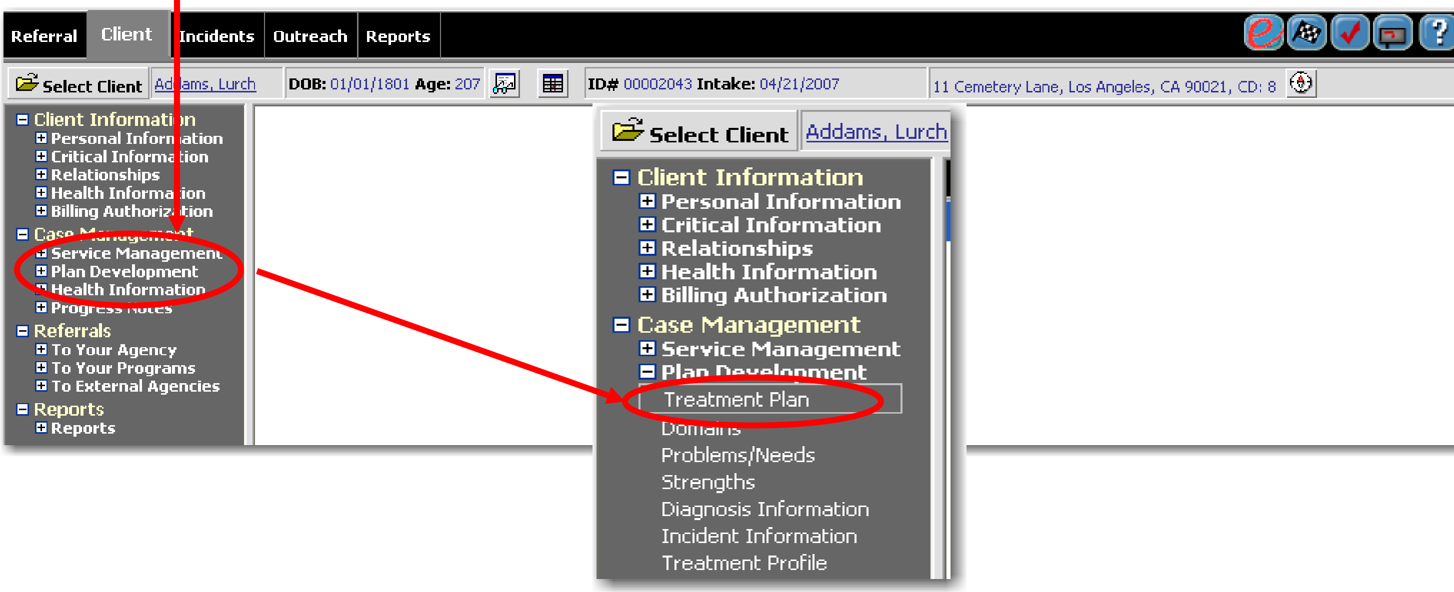
You **must** follow this same process for every Strength identified.

ENTERING THE INITIAL TREATMENT PLAN

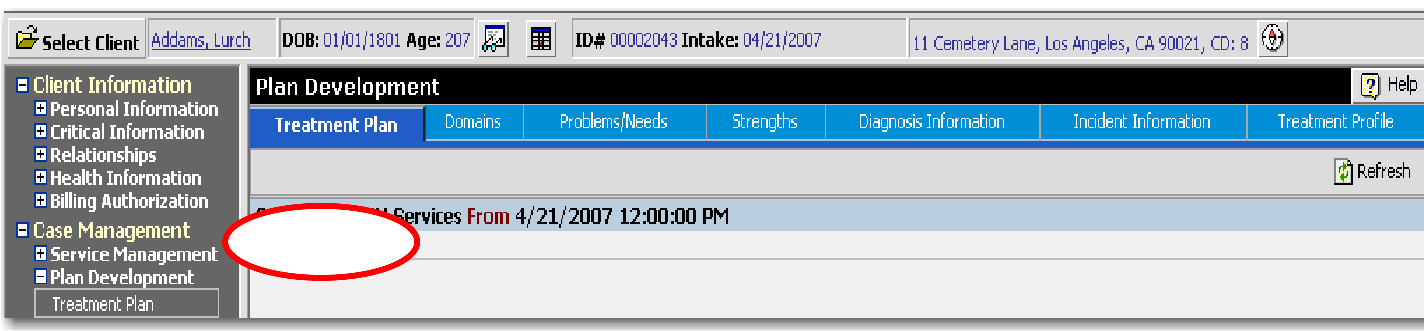
Enter a new Treatment Plan for your client.

Under Case Management

1. Click Plan Development
2. Click Treatment Plan



The following screen will appear. This is where all Treatment Plans for this client will be stored. **The Treatment Plan will not appear on the Service Entry Screen.**



Under Community MH Services click on the <Start New Plan> hyperlink.

Your client may have multiple Program Enrollments (i.e. TBS, Medication Support, etc.) and each one must have their own Treatment Plan. Make sure you are selecting the Treatment Plan under the appropriate program.

A Treatment Plan will open and will look like the screen shot on the next page.

ADD Form [Treatment Plan] -- Webpage Dialog

CMHS

Client: Addams, Cousin Itt DOB: 01/01/1901 ID# 00003362 Intake: 12/04/2003 12:00am

Save | Cancel | Print | Close

Information

County ID	
Status	Draft
Program	CMHS Community MH Services
Facility	
Type	CMHS - Initial Plan

Completed Information

Date Started	**Time**
Face-to-Face Time	
Other Time (Service + Documentation + Travel)	
Total Time	00:00
Number of Family Collaterals	
Number of Non-Family Collaterals	
Evidence Based Practice	
Completed By	Boyd, Angela
Submit To	

Client Care Plan

Problems Currently on file

Category	Problem	Statement	Date Identified	End Date
Externalizing Disorders - Adjust Dr w/ Conduct	Easily frustrated, loses temper easily	when cl gets angry he punshes teacher	12/17/2008	

Strengths Currently on file

Category	Strength	Statement	Date Identified	End Date
Externalizing Disorders - Adjust Dr w/ Conduct	Accepts direction from caregiver	cl is deeply	12/17/2008	

Planning

Problems [Category:] New Delete

Category	

Objective [Category:] [Goal:] New Delete

Problem Addressed	
Goal	
Goal Statement	
Target Date	
Staff Who Established	
Status	Established
Status Date	

Interventions [Category:] [Goal:] [Method:] New Delete

Method	
Method Statement	
Target Date	
Program	
Service	
# of Times Per Interval	0
Interval/Frequency	
Staff Responsible	
Other Person Responsible	
Status	Established
Status Date	

Current Diagnosis

Current Diagnosis

Axis	Date	Priority	Priority Description	Diagnosis	DSMIV	ICD9	GAF Score
Not on File...							

Signatures

*Client Signature and Date

*** Document reason for lack of Signature in note. Signature must be obtained at next visit.**

Caregiver Signature and Date

LPHA Signature and Date

* Psychiatrist/MD Signature and Date

*** N/A if client is not being treated by the Psychiatrist**

Cx received copy of Care Plan (Cx initials / date)

Progress Note

Progress Note

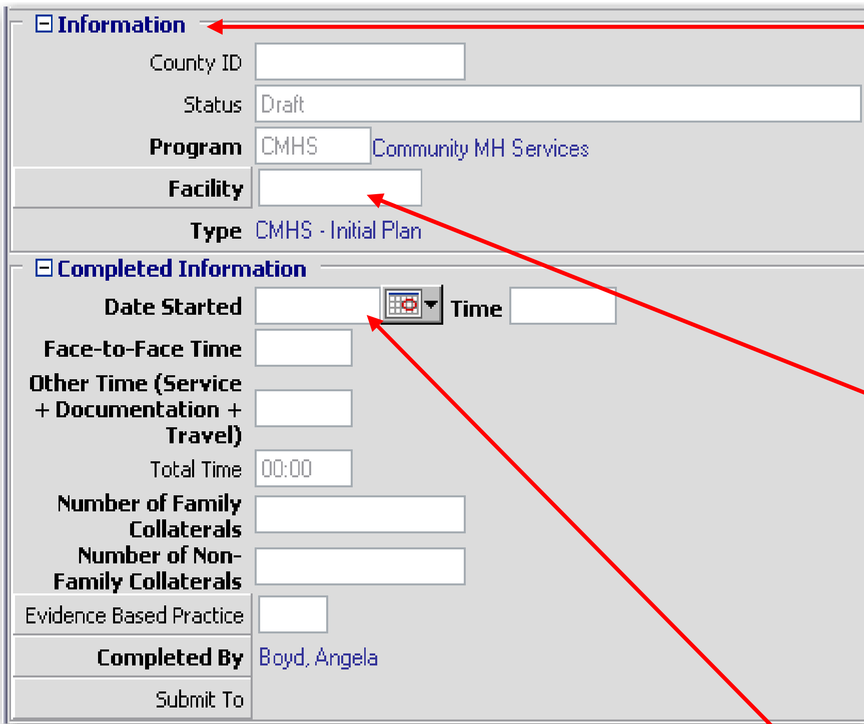
Paragraph | Font | Size

Confidentiality Statement | Participants | Tasks/Schedules

Confidentiality Statement: This confidential inform

INFORMATION AND COMPLETED INFORMATION SECTIONS

To complete a Treatment Plan start with the Information section and Completed Information sections. You will notice there are similarities between these sections and other Service Entry forms. You will need to complete the required fields. Let's review some fields that require additional explanation.



In the Information section County ID, Status and Program auto populate.
Status indicates the stage of the completion/approval process.

Facility: Is equivalent to facility providing service box in the Service Entry.
Follow the same procedure as located in the Phase 1 Users Guide on page 26.

Date Started: Actual date you started writing the Treatment Plan.

Time: Actual time of day you began to write the Treatment Plan.

The remaining fields are identical to the Service Entry fields explained in detail in Phase 1 manual.

Client Care Plan Section

This is where all problems, needs and strengths information shows including the problems/needs and strengths you entered earlier.

Client Care Plan

Problems Currently on file

Category	Problem	Statement	Date Identified	End Date
Externalizing Disorders - Adjust Dr w/ Conduct	Easily frustrated, loses temper easily	when cl gets angry he punshes teacher	12/17/2008	

Strengths Currently on file

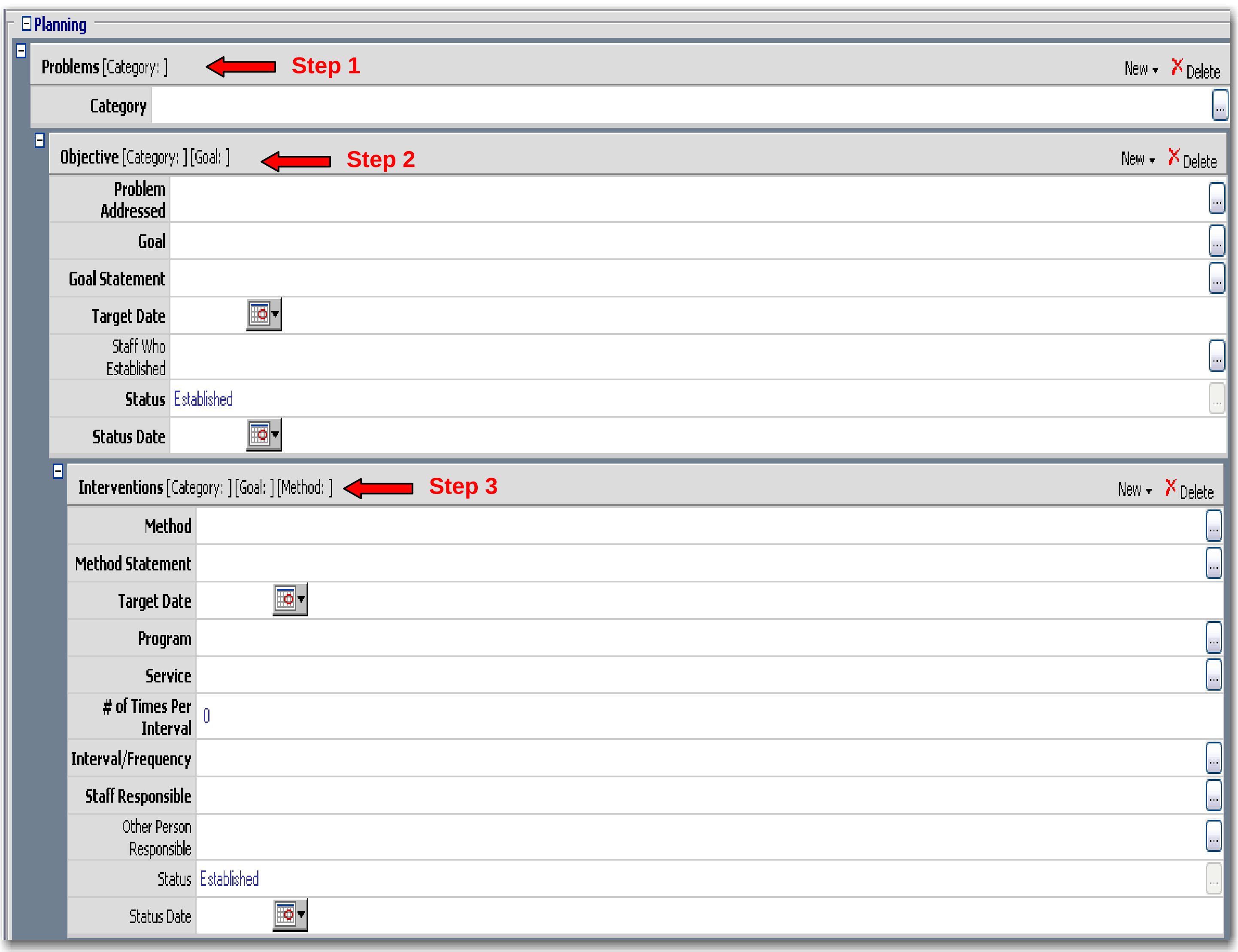
Category	Strength	Statement	Date Identified	End Date
Externalizing Disorders - Adjust Dr w/ Conduct	Accepts direction from caregiver	cl is deeply	12/17/2008	

Planning Section – Problems / Objectives (Goals) / Interventions

We have now reached the beginning of the Treatment Plan. To begin building the Treatment Plan start in the Problems Category.

It is necessary to work top down from Problems/Categories through the Goal in sequence.

You must follow the steps 1 through 3 in order or you will lose information already selected. Also, if you go out of order, the system will not narrow the search for information in each section.

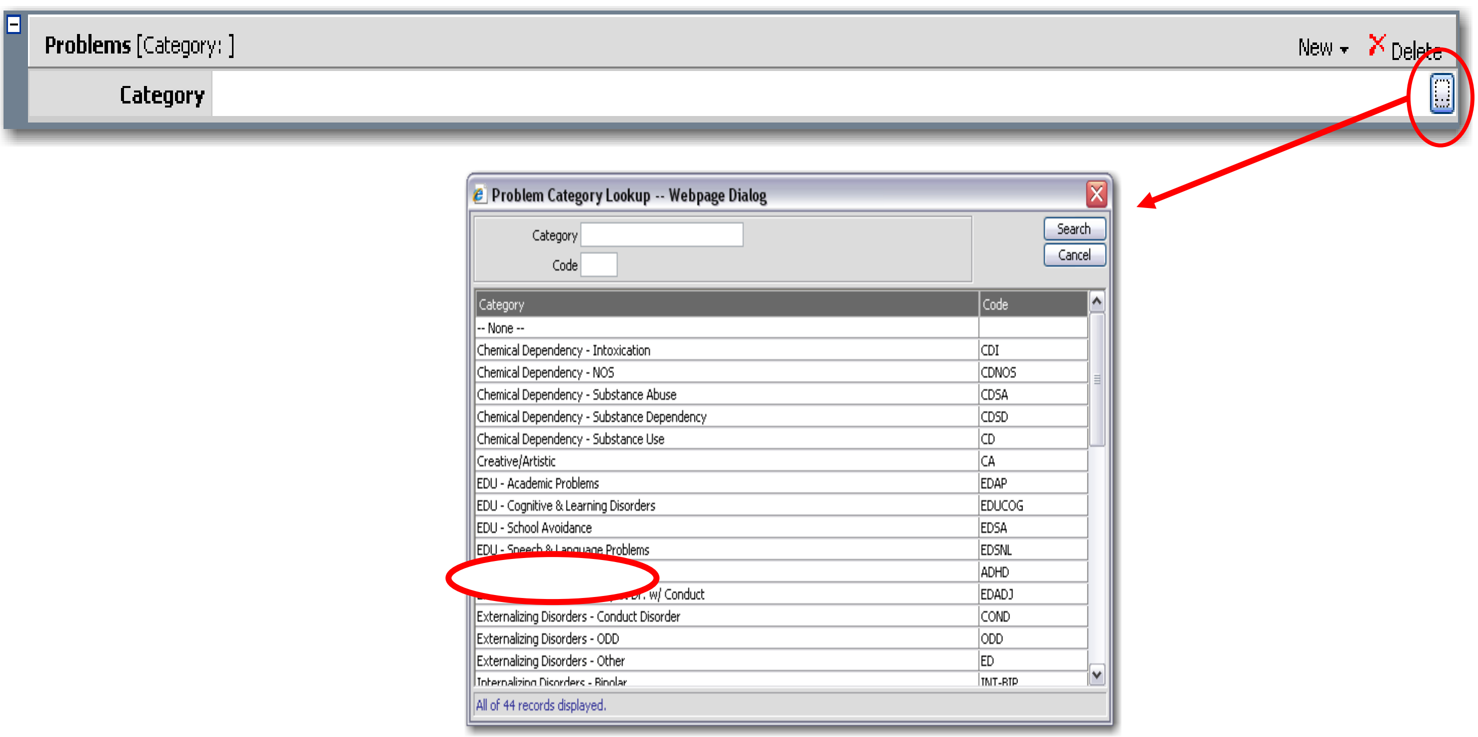


Now, let's take a closer look at **each section needed for** completing the Treatment Plan.

Step 1: CATEGORY

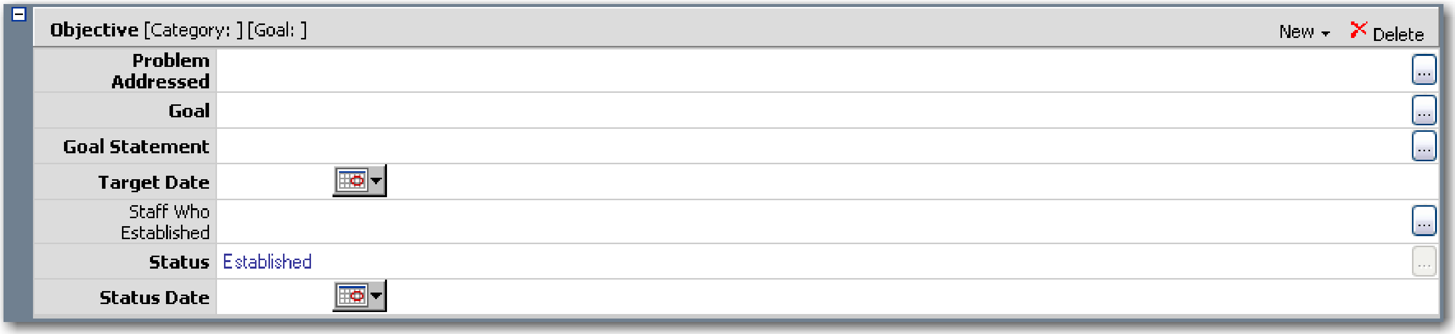
This is the overarching category from the Treatment Library that is a direct link back to the client's diagnosis. This category choice also dictates what objectives and interventions will be available via the Treatment Library.

- First click on the category ellipse at the far right
- A drop down box will open with a list of all problem categories
- Select the correct problem category by clicking on it
- The field will then populate with the chosen problem category



Select the Category that relates to the Diagnosis of the client. For example, if your client is diagnosed with Oppositional Defiant Disorder you will select Externalizing Disorders – ODD.

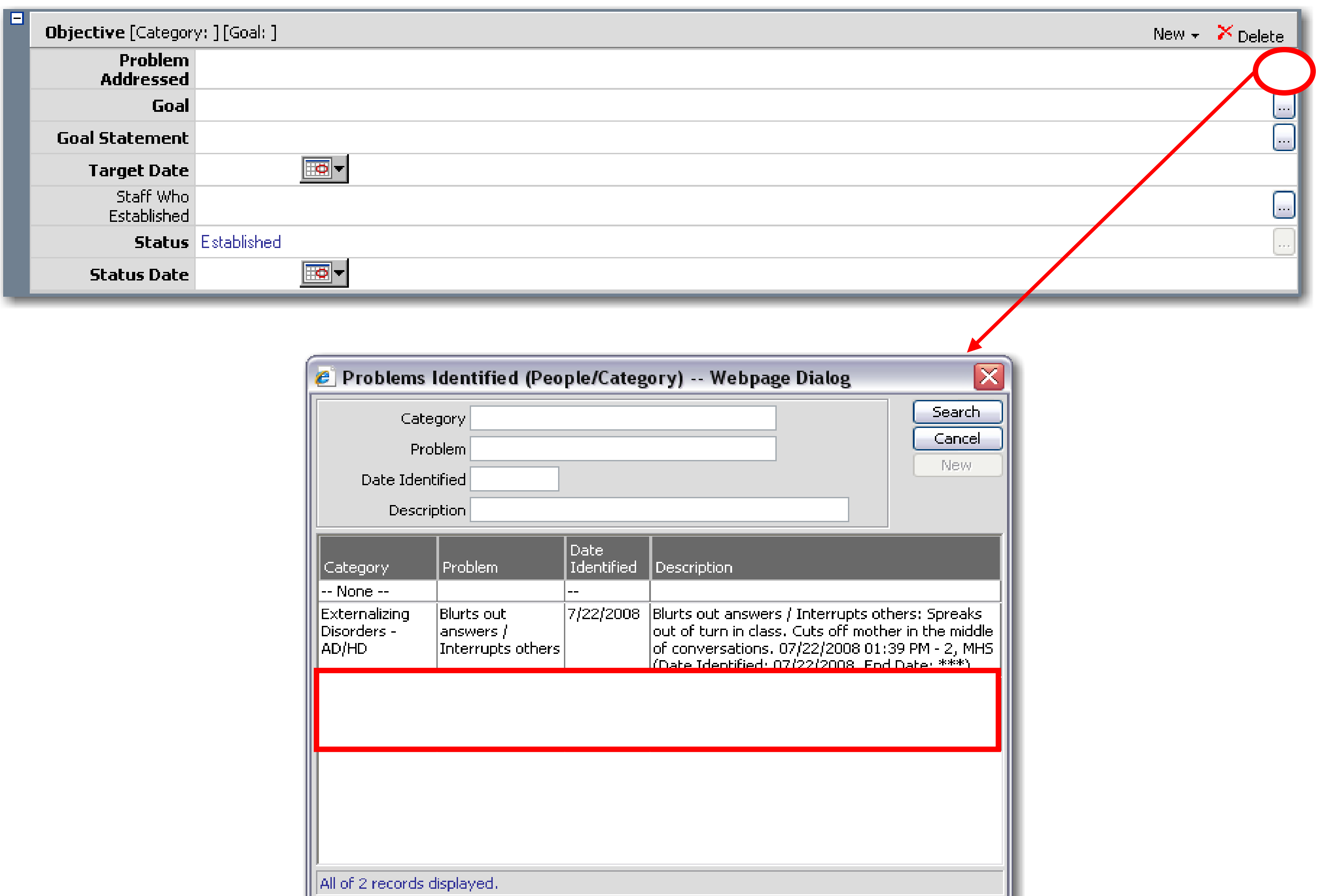
Step 2: Objective Section [Category] [Goal]



Problem Addressed

You will now utilize the Problems/Needs you developed earlier. For each problem you identify, you'll build out the Objective and then the Intervention for this specific problem.

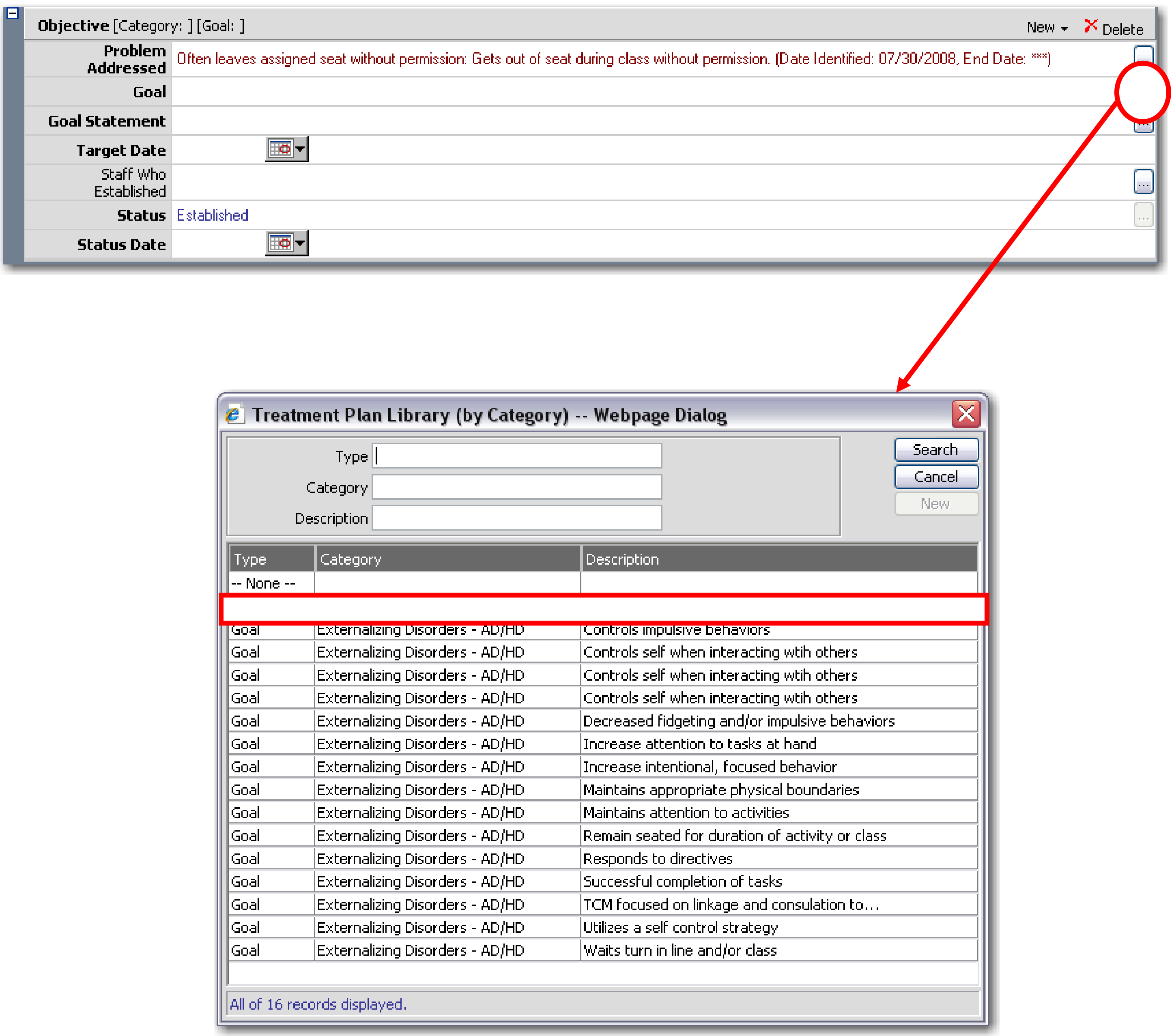
- First click on the Problem Addressed ellipse at the far right
- A drop down box will open with a list of all problems identified on file
- Select the identified problem that you want to write an objective for by clicking on it
- The field will then populate with the chosen identified problem



GOAL

The Goal is directly linked to the problem category chosen at step 1.

- First click on the Goal ellipse at the far right
- A drop down box will open with a list of all goals linked to the problem category
- Select the identified problem that you want to write an objective for by clicking on it
- The field will then populate with the chosen goal

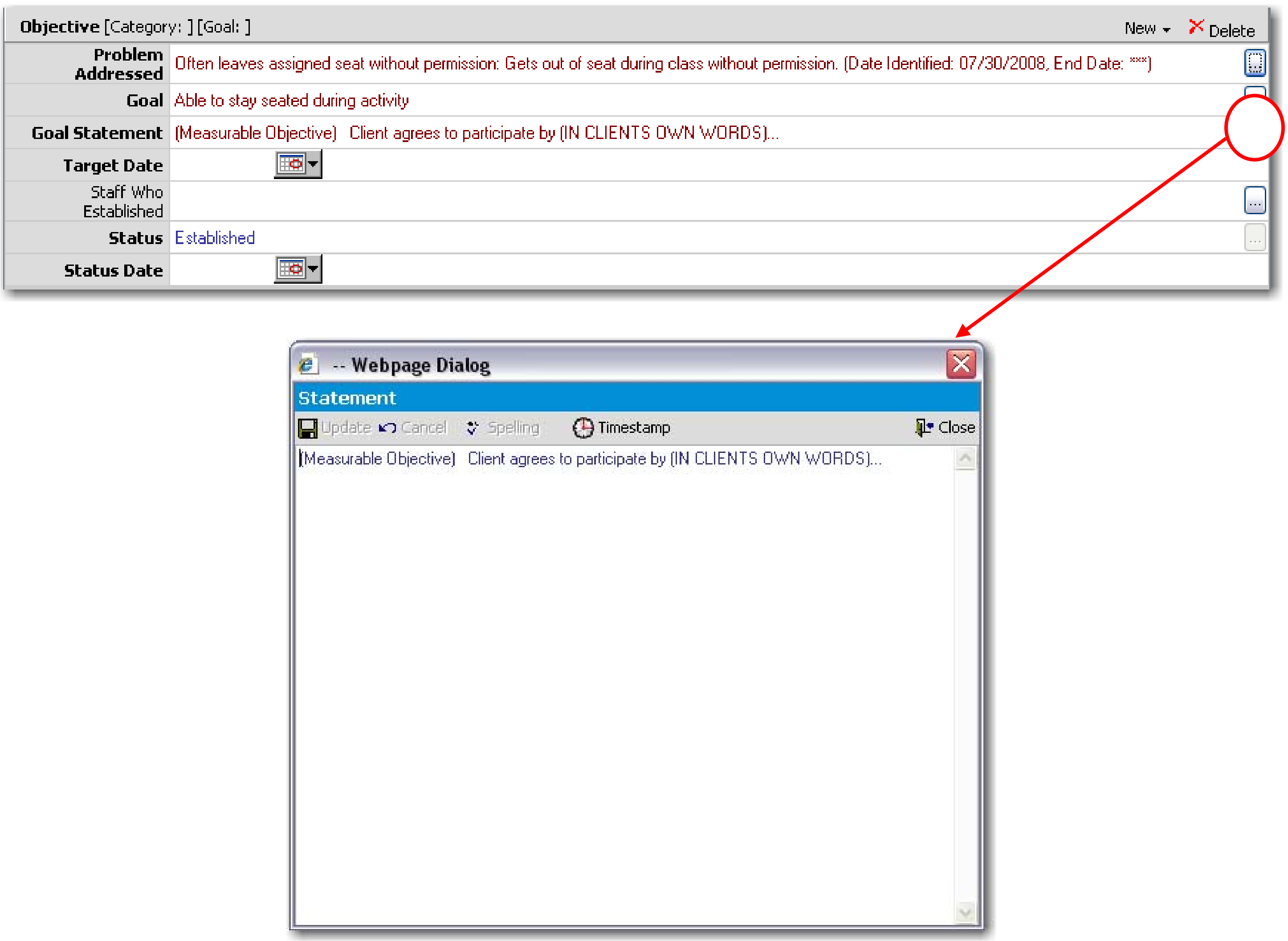


Goal Statement

This is the specific, observable and quantifiable objective required by DMH. This is a statement specific to the client. Once you click the goal, a default statement populates the goal statement field.

You will see (Measurable Objective) and **Client agrees to participate by (IN CLIENT'S OWN WORDS)…**.

- First click on the Goal ellipse at the far right
- A text box will open

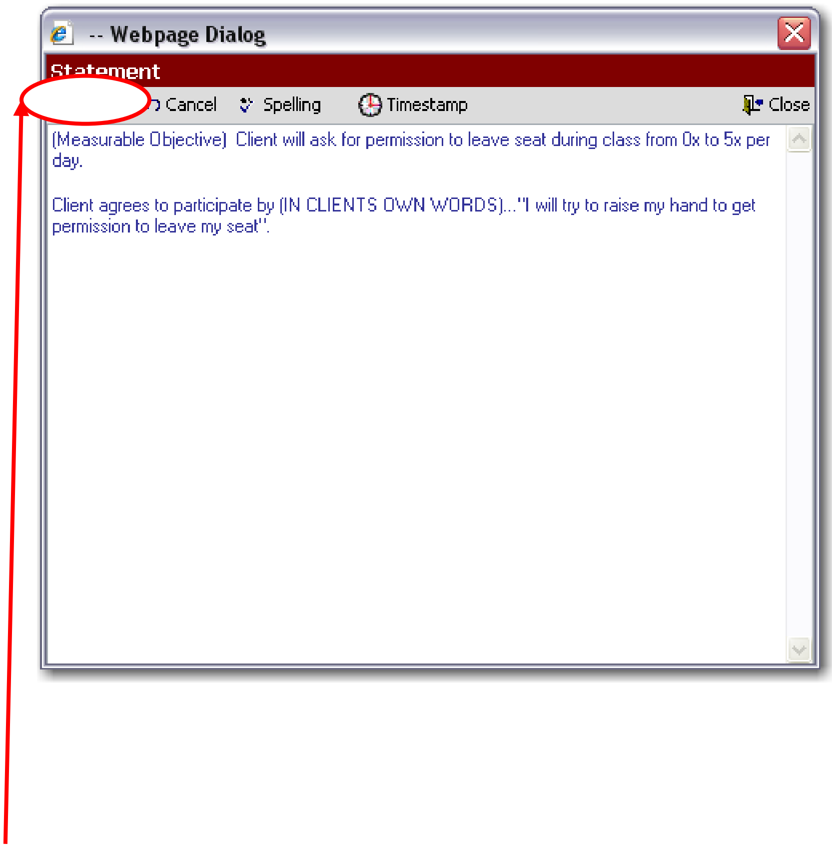


Type in the objective. Notice that prior to typing the Statement bar is blue. Once you start typing the Statement bar changes to red. This indicates there is new information in the box that needs to be saved.

Set the curser in front of "Client agrees to participate by" and click on enter twice. This ensures that there will be space between the (measurable objective) and "Client agrees to participate by".

1. Type in the client's specific objective after the words (Measurable Objective)

2. Then following "client agrees to participate by (IN CLIENT'S OWN WORDS)" type what the client says regarding how they will participate in meeting the objective. Enter the client statement using quotes if necessary.

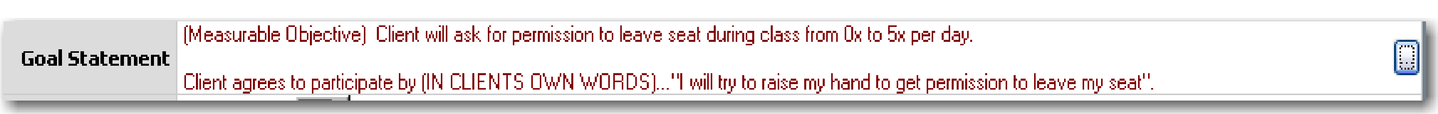


3. Once you have finished entering the objective and "client agrees to participate by" **click Update**.

4. **If you don't click Update prior to closing the box you will loose the information entered.**

5. Click Close

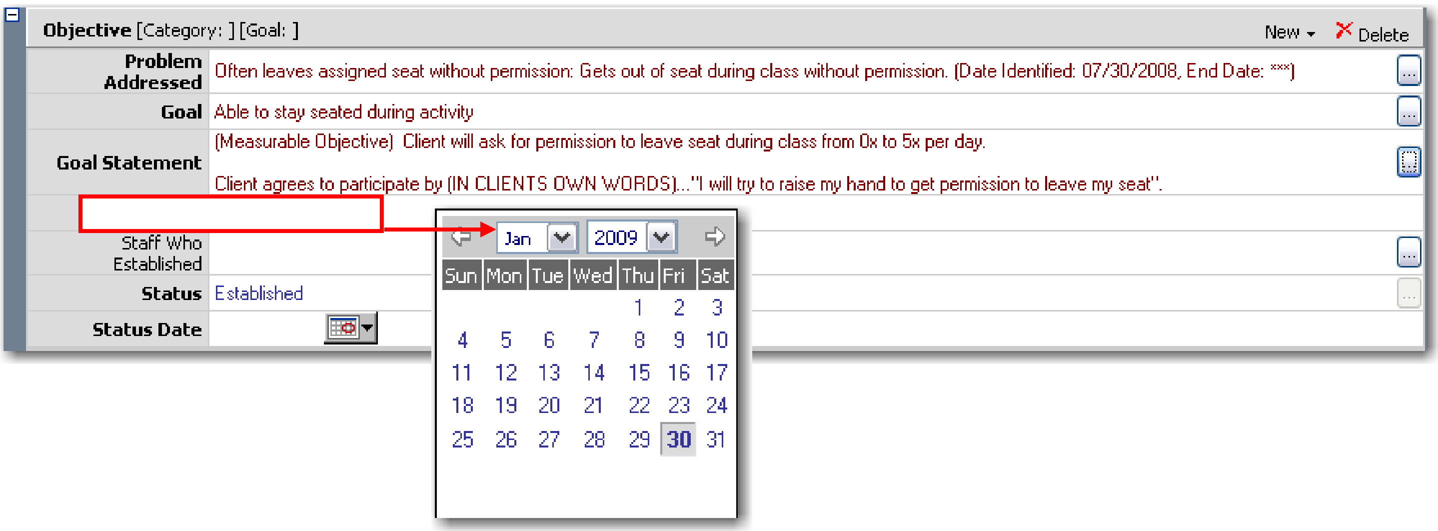
Once you close the text box the written measurable objective and client statement will now appear.



Target Date

This date reflects a future date when this objective will be revisited for updates or completion. Typically this is the end of your six month cycle date although you are able to update objectives at any time.

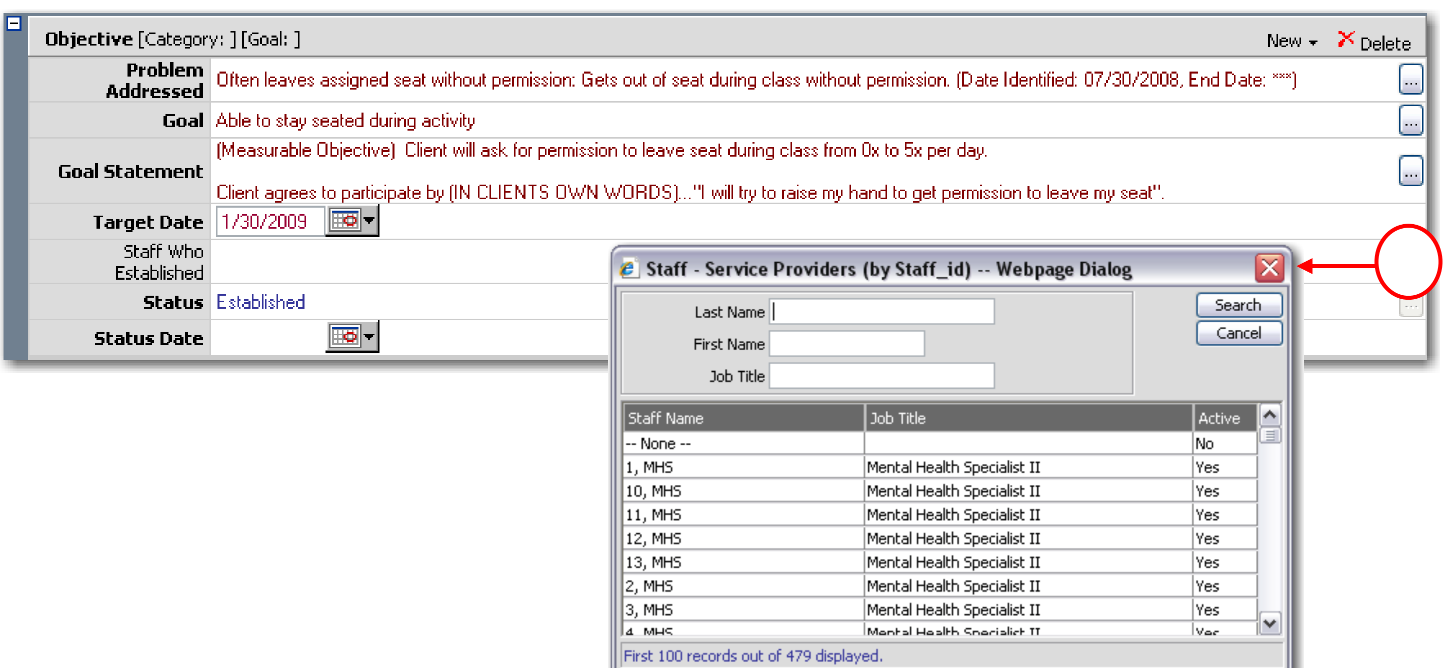
- Either type in date or click on the calendar and select the date



Staff Who Established

This is the name of the staff who establishes the objective

- First click on the Staff Who Established ellipse at the far right
- A search box containing staff names will open
- Search for either the last name or first name of the identified staff member
- Then click on the name



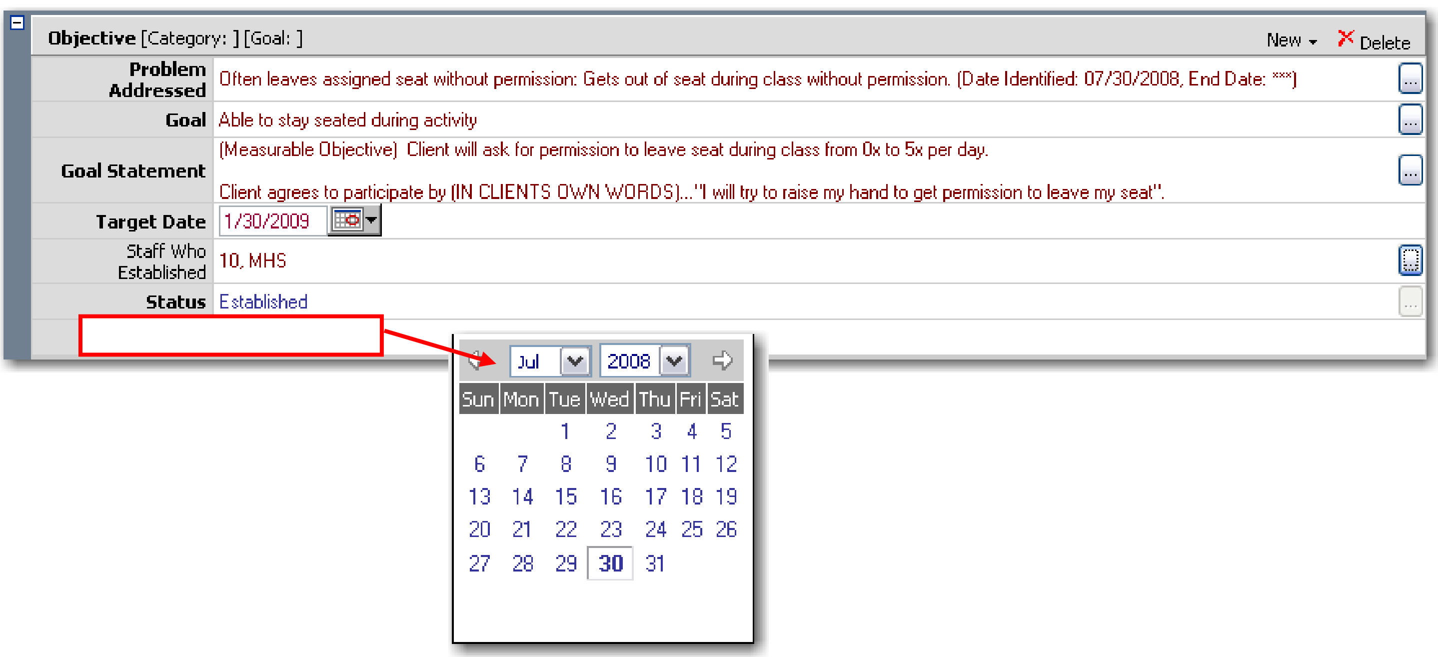
Status

This will always default to Established for the Initial Plan. Any future updates of the treatment plan will indicate revised.

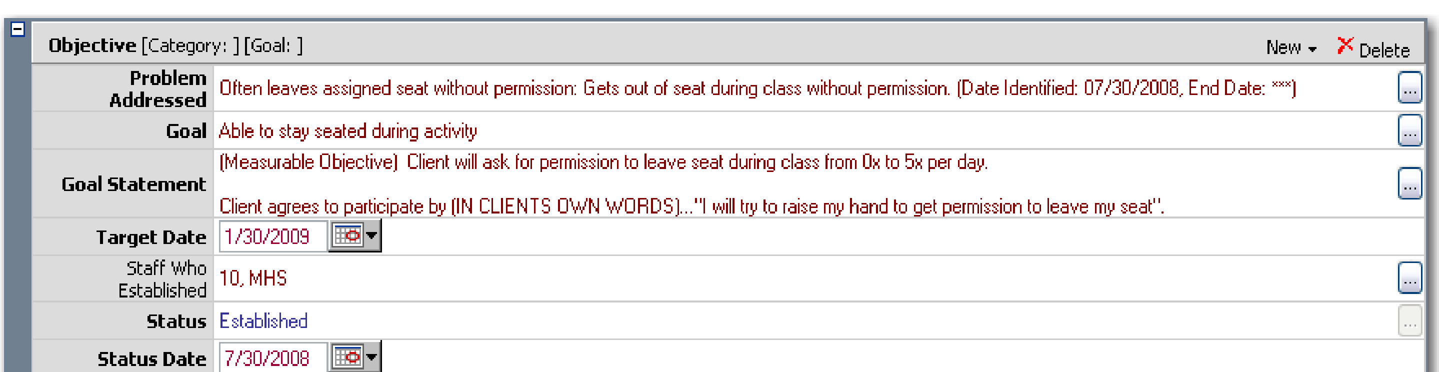
Status Date

This is the date the goal was established.

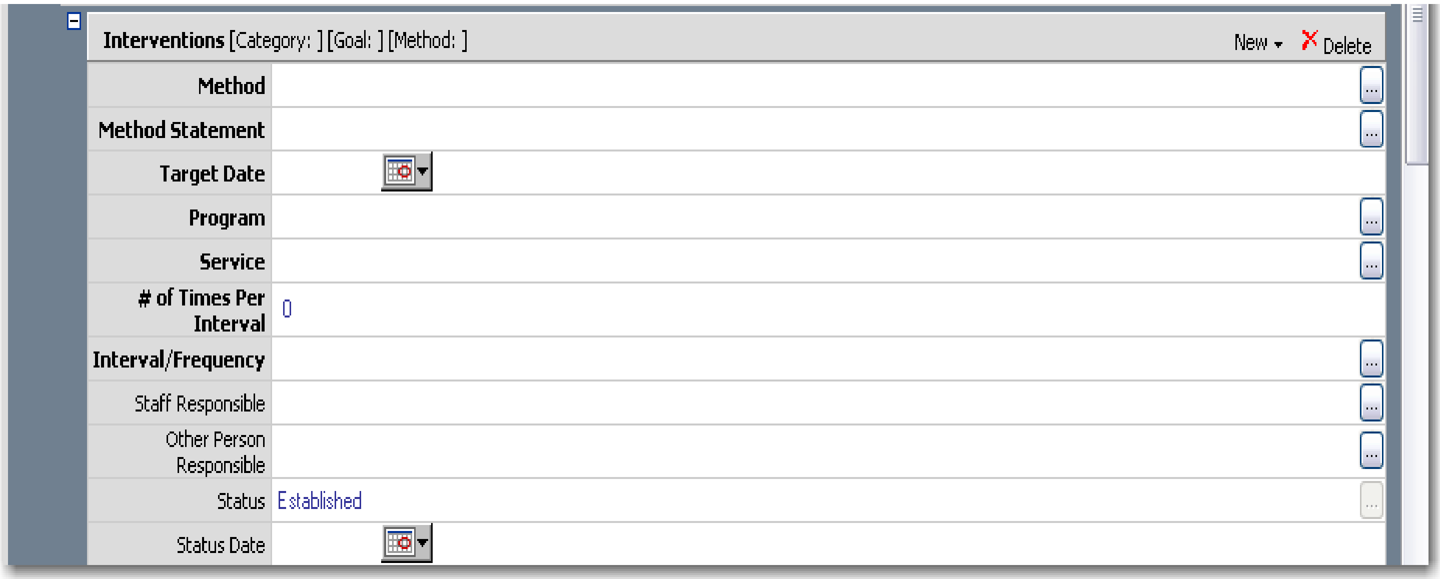
- Either type in date or click on the calendar and select the date
- Have the participants select today's date
- The date will populate the filed



Completed Objective should resemble screen shot below.



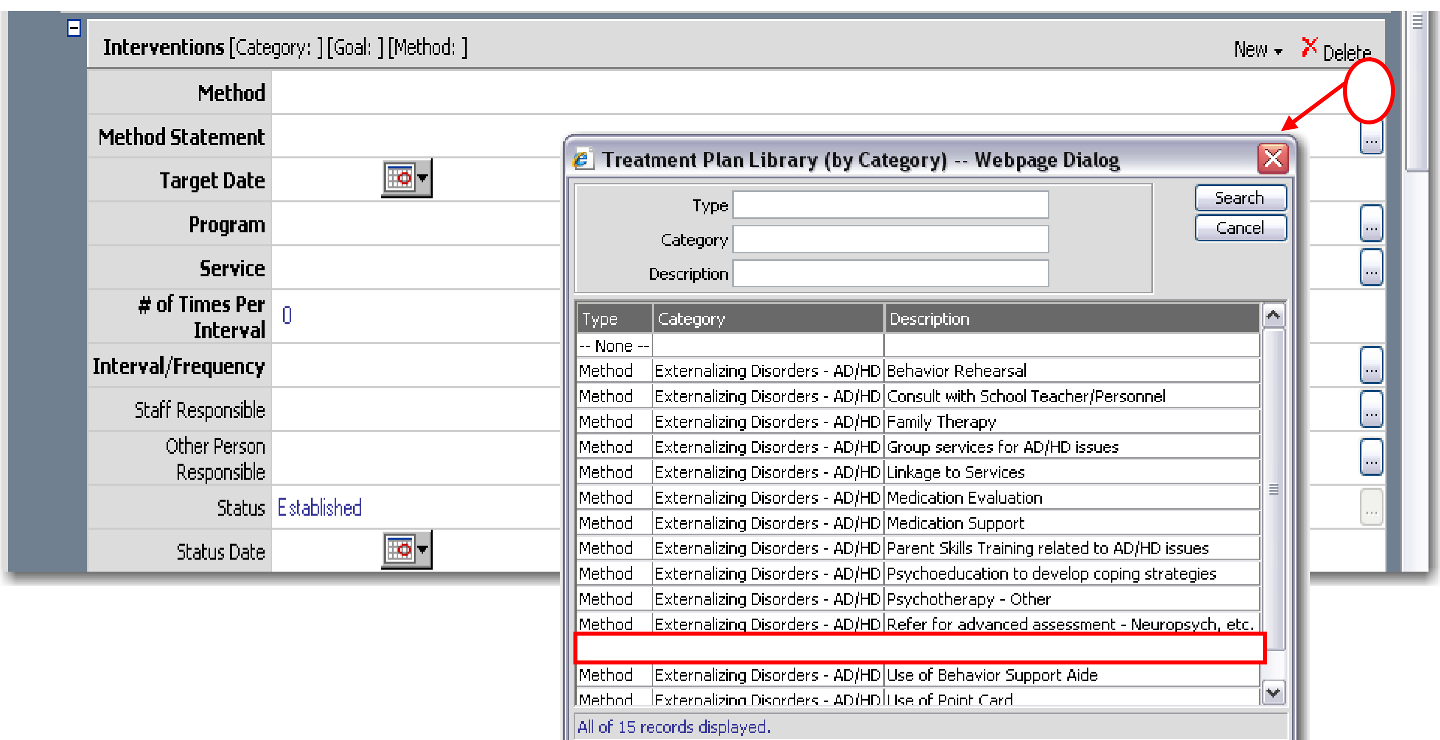
Step 3: INTERVENTIONS SECTION



METHOD

This is directly linked to the category chosen at the beginning of this plan. This is the category of intervention, **NOT** the specific intervention.

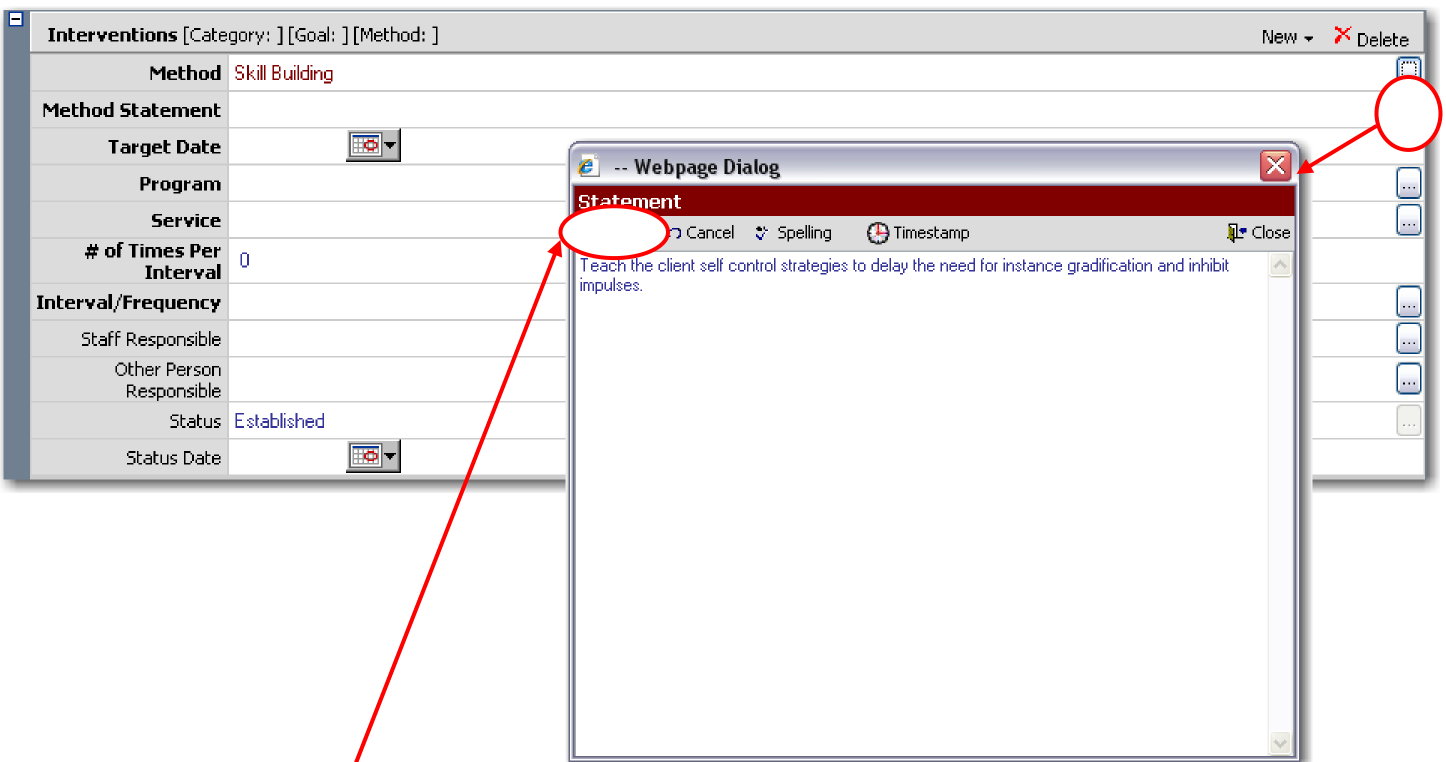
- First click on the Method ellipse at the far right
- A drop down box will open with a list of all interventions linked to the problem category
- Select the category description that you want to write an intervention for by clicking on it
- The field will then populate with the chosen category description



METHOD STATEMENT

This is a statement that qualifies the category description (method) selected specific to the client.

- First click on the Method Statement ellipse at the far right
- A text box will open
- Compose and type in an intervention to meet the objective for the client

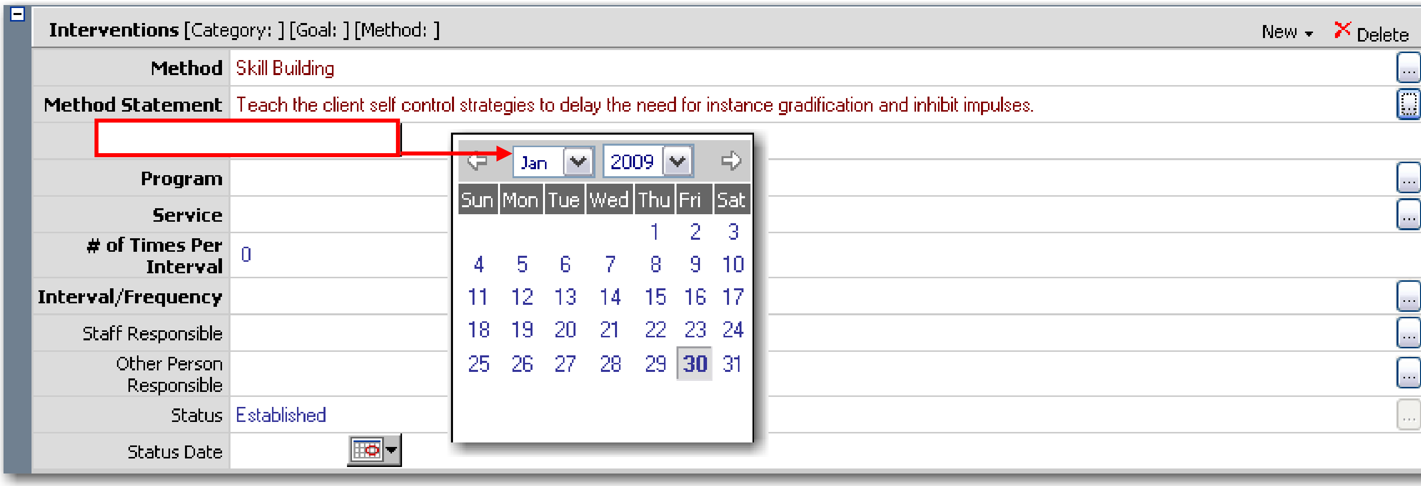


- Once you have finished entering the method statement **click Update**
- **You must click Update prior to closing the box or you will loose the information you entered**
- Click Close

TARGET DATE

This date reflects a future date when this intervention will be revisited for updates. Typically this is the end of your six month cycle date although you are able to update interventions at any time.

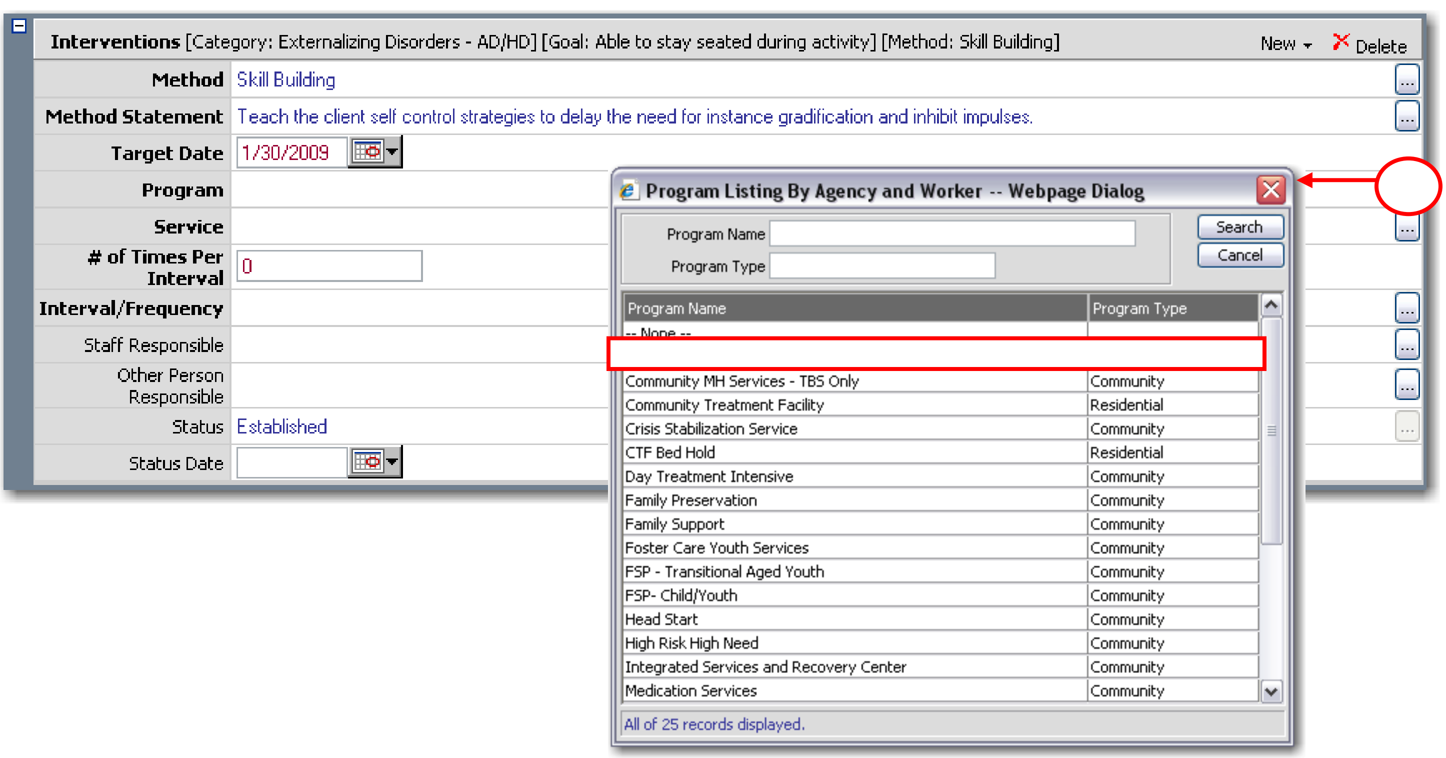
- Either type in date or click on the calendar and select the date



PROGRAM

The program the client is enrolled in.

- First click on the Program ellipse at the far right
- A drop down box will open with a list of all SBHG programs
- Select Community MH Services
- This is the only Program Name you should ever choose
- The field will then populate with the chosen Program Name

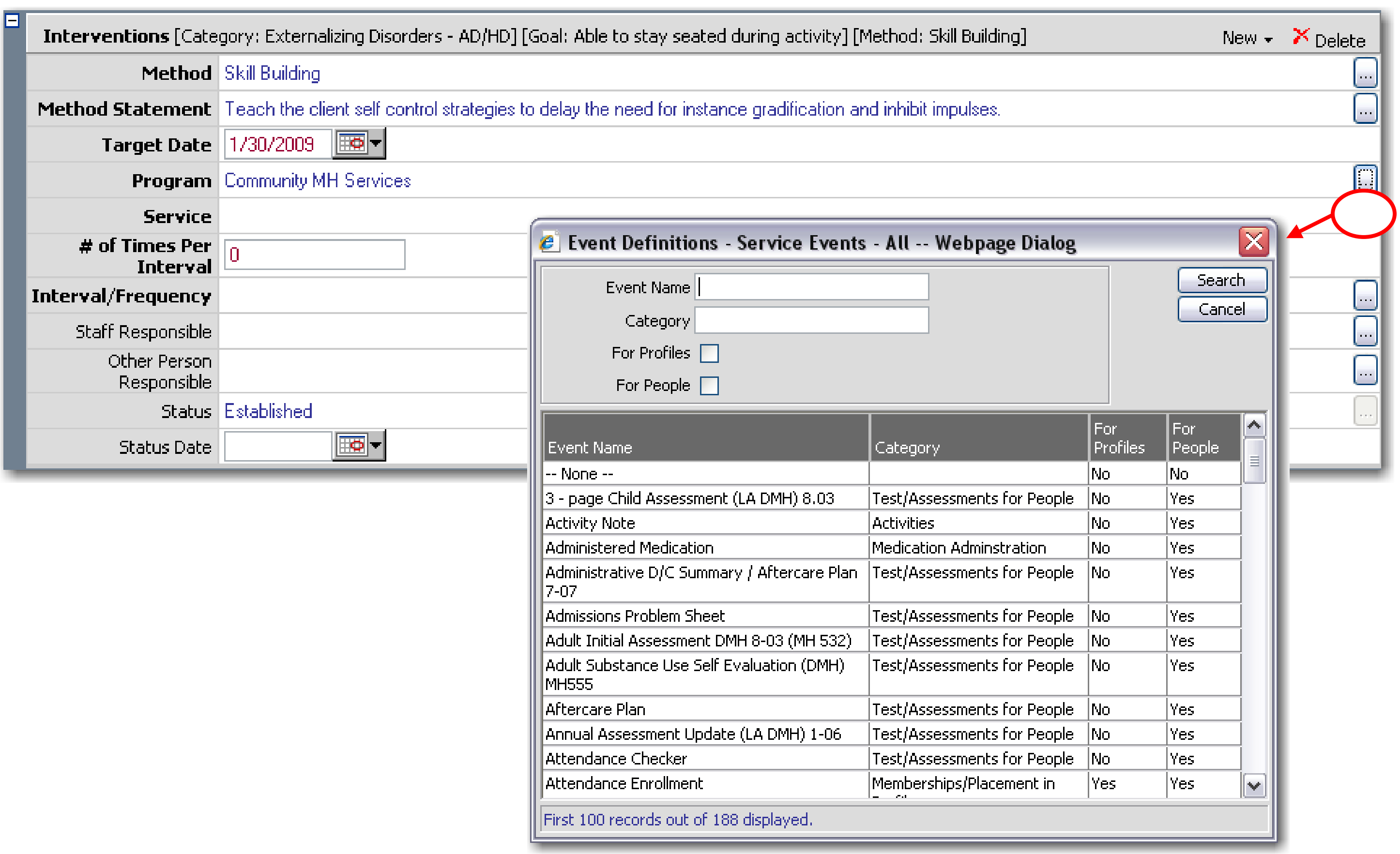


SERVICE

This is the service mode of the intervention used to accomplish the objective(s).

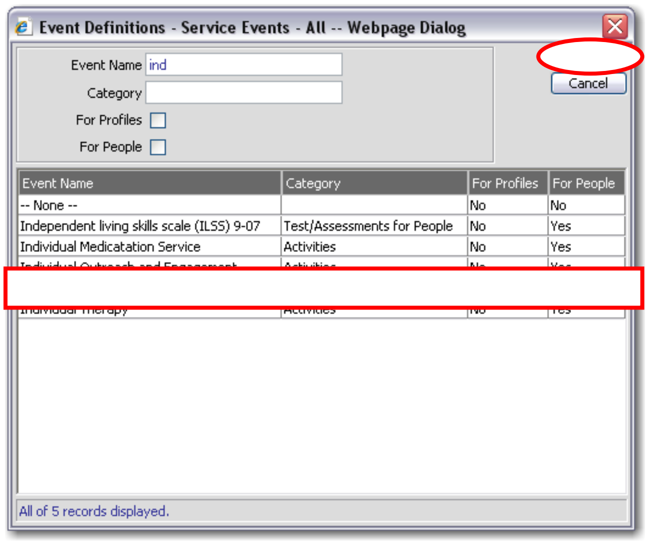
- First click on the Service ellipse at the far right
- A drop down box will open with a list of all SBHG service events
- One of these 5 service events listed below should be selected:

1. Individual Therapy
2. Individual Rehabilitation
3. Targeted Case Management
4. Family Therapy
5. Collateral (if the collateral is going to be a consistent part of treatment)



When you click on the service ellipse a search box will open. It contains a scroll down listing of the first 100 of 188 possible SBHG services available in the company. If the service event is not listed within the first 100 possible choices you will need to narrow your search by using the first few letters of the service event name.

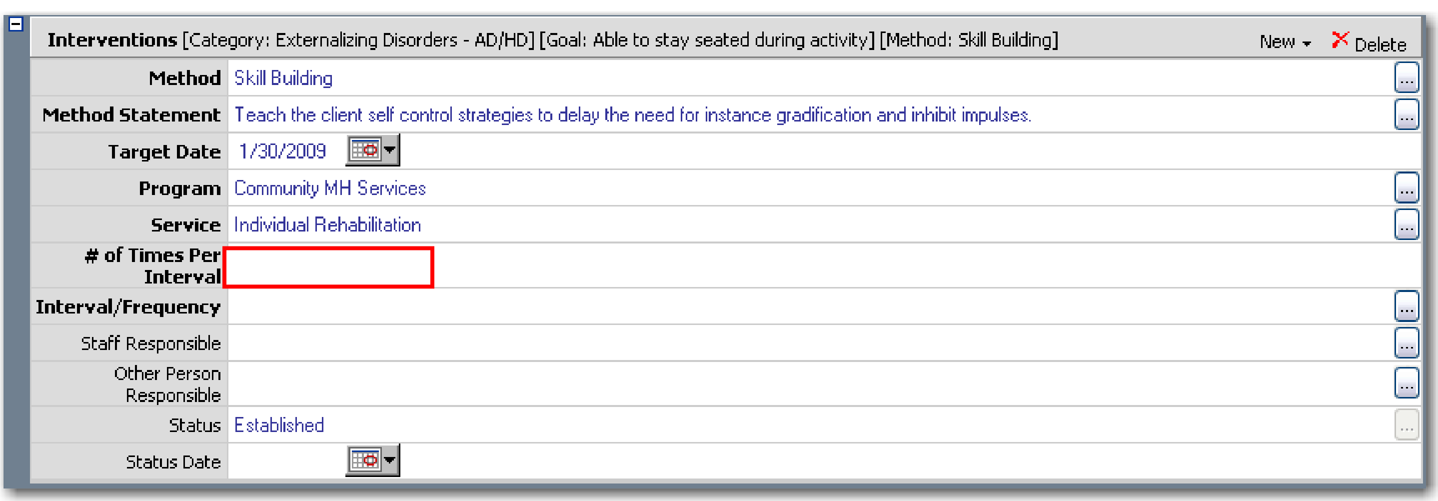
For example, in the event name field, if you type the letters ind and click search. The search will return the following services:



- Click on the appropriate service event name
- The field will then populate with the chosen service event name

OF TIMES PER INTERVAL

This is the frequency of how many times you will be providing the specific service event. This field auto-populates to 0 (zero). You will need to change the 0 (zero) to the minimum number of sessions or service events you plan to provide. **This field must be populated with only a whole number. You can not type in a times symbol (x), a percentage sign, decimal, fraction or dashes after the number.** The interval/frequency is delineated in the next field.

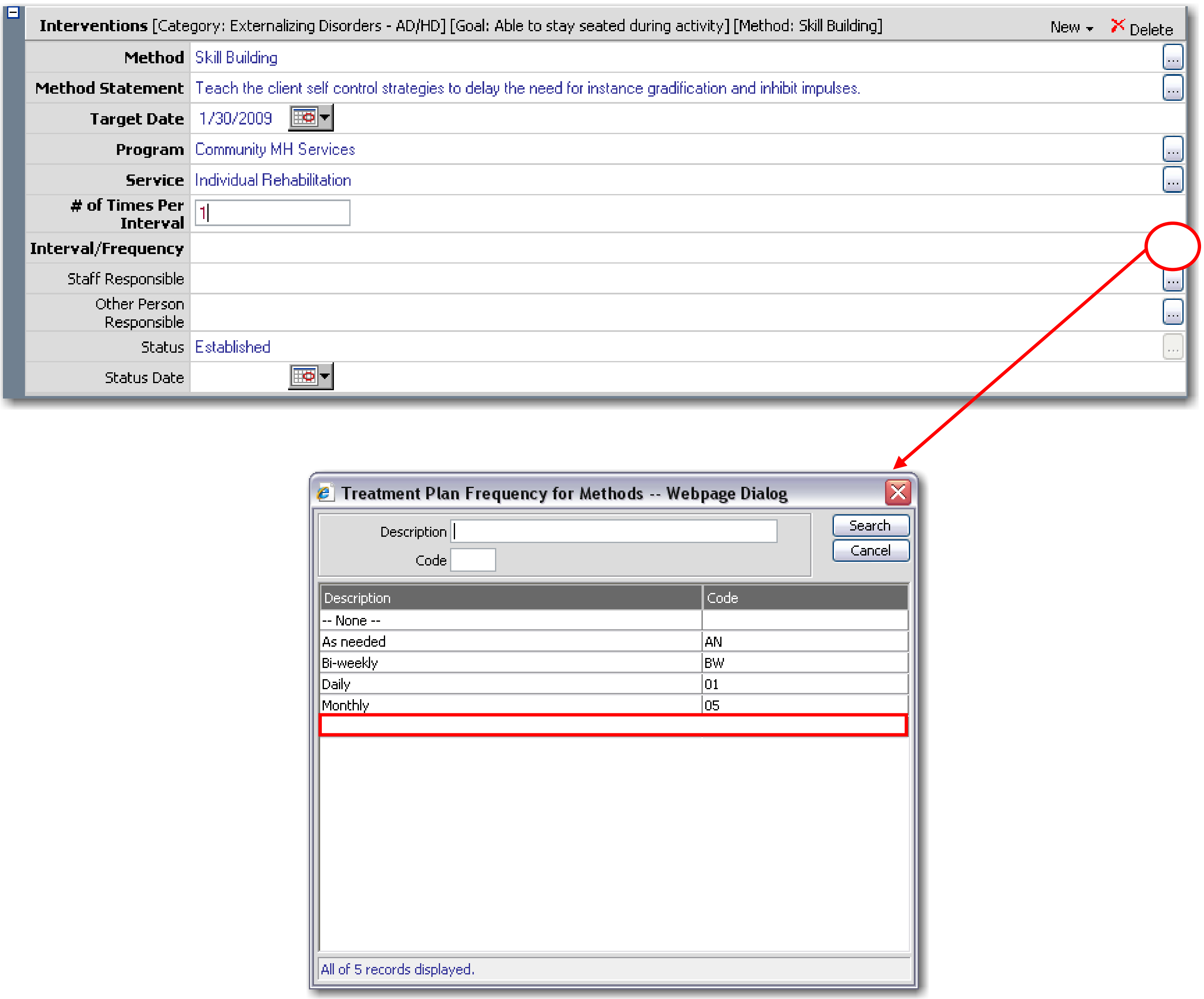


- Type in a number in the # of Times Per Interval field

INTERVAL / FREQUENCY

The frequency the intervention will be performed (example daily, monthly, etc.)

- First click on the Interval/Frequency ellipse at the far right
- A drop down box will open with a list of frequencies
- Select a frequency
- The field will then populate with the chosen frequency

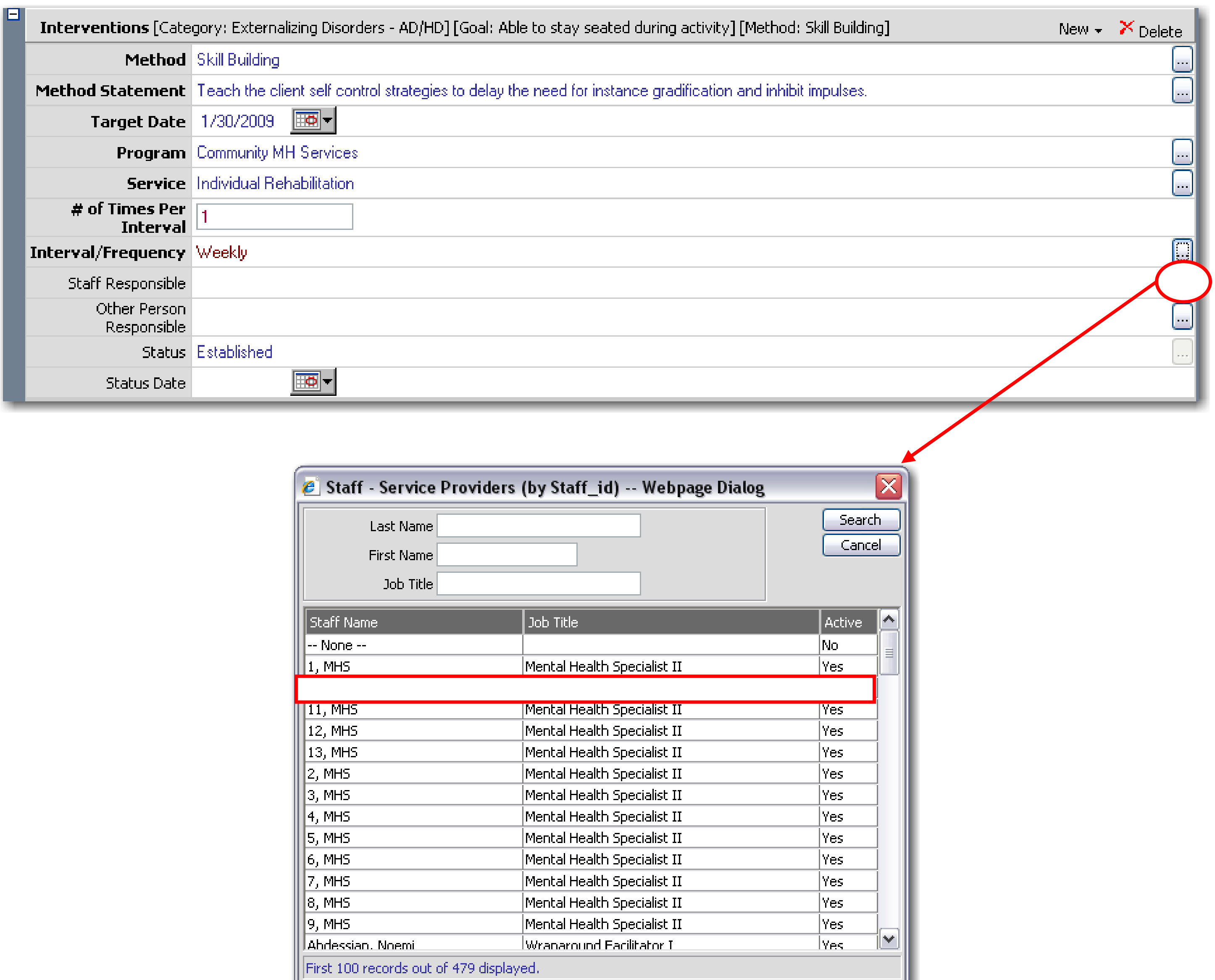


Select the As needed frequency only when you are not planning on providing the selected service on a regular basis. The As needed frequency should not be used as a catch-all.

STAFF RESPONSIBLE

This field identifies the staff responsible for the service provided. If the person who establishes the goal is also responsible for the service provided their name must be selected again.

- First click on the Staff Responsible ellipse at the far right
- A search box will open
- Search for the staff's name
- Click on the desired name
- The field will then populate with the chosen name

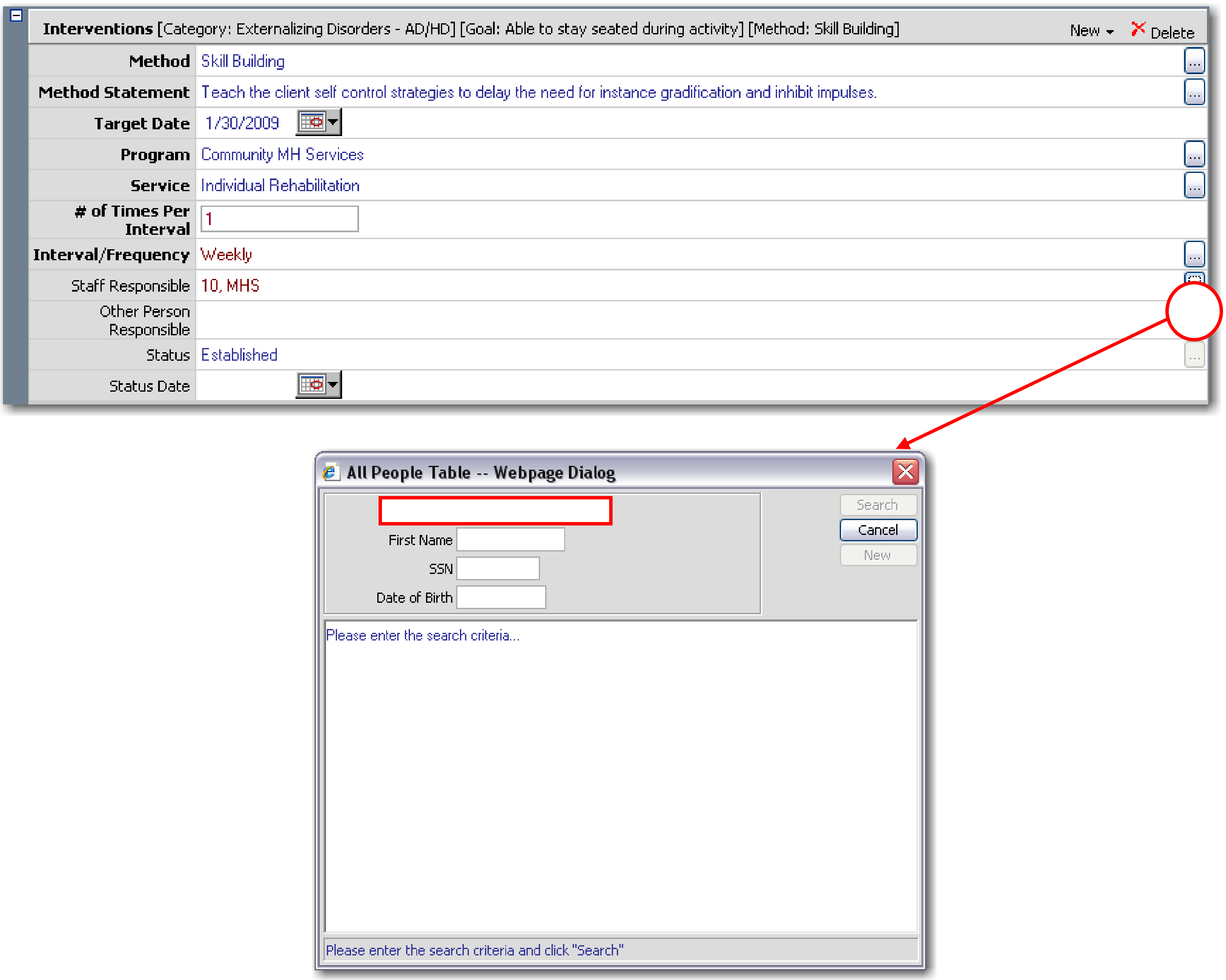


OTHER STAFF RESPONSIBLE

This field identifies the additional staff responsible for the service provided. If there are two staff identified providing the same service with the client, a clear distinction **must** be made between the interventions provided by each staff.

IF there will be additional staff follow the steps outlined below. If there is no other staff person responsible you can leave this field blank.

- First click on the Staff Responsible ellipse at the far right
- A search box will open
- Search for the staff's name
- Click on the desired name
- The field will then populate with the chosen name



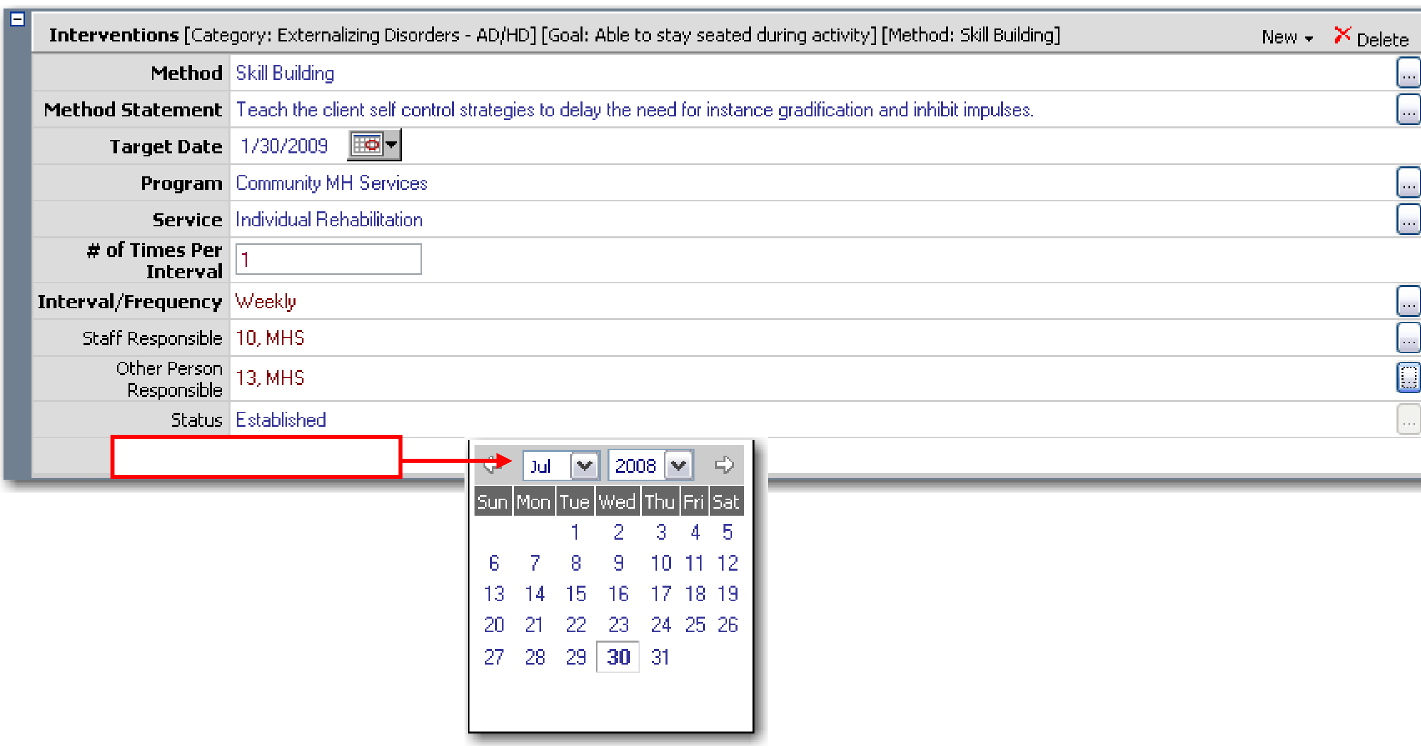
STATUS

Status will always default to Established for the Initial Plan. Any future updates of the treatment plan will indicate revised.

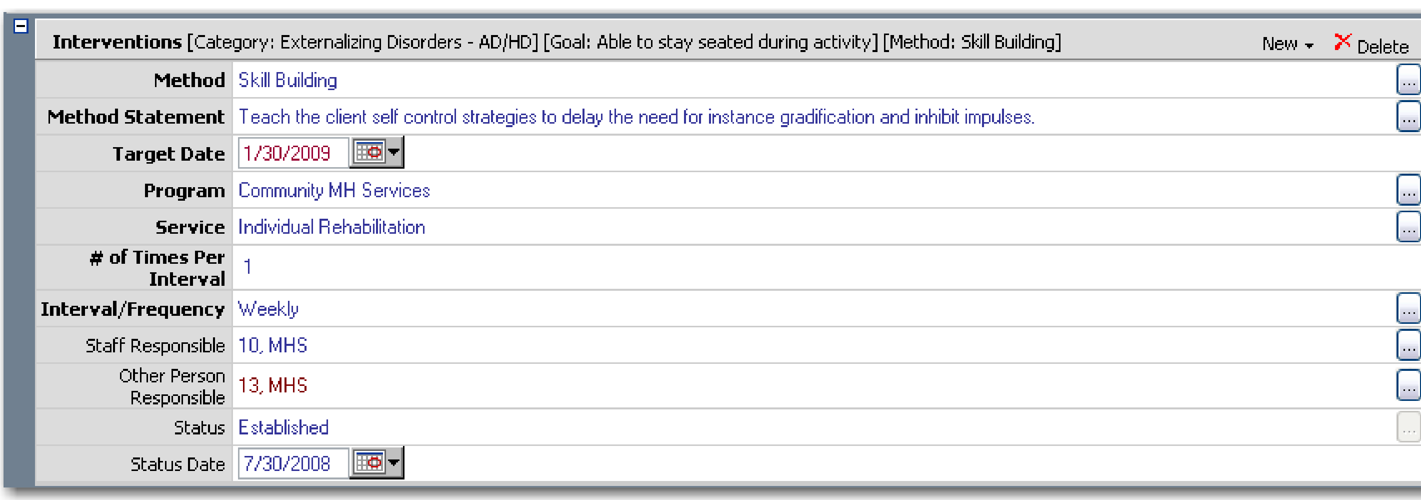
STATUS DATE

This is the date the Method/Intervention was established

- Either type in date or click on the calendar and select the date
- Have the participants select today's date.
- The date will populate the filed



Completed Intervention should resemble screen shot below.



CURRENT DIAGNOSIS

This is a **view only** display of the current diagnosis. It can not be edited here. If there is a need to change the Diagnosis an MHS II must complete a Change of Diagnosis form and turn it into the Center/TM Intake Coordinator. Then complete the billing for the Change of Diagnosis in the EMR.

⊟ Current Diagnosis

Diagnosis

Axis	Date	Priority	Priority Description	Diagnosis	DSMIV	ICD9	GAF Score
	6/6/2006	2	Secondary	DEPRESSIVE DISORDER NEC	311	311.	
1	6/1/2008	1	Primary	AD/HD Combined Type	314.01	314.01	
2	6/1/2006	9	Other	Diagnosis Deferred on this Axis	799.9	799.9	
3	6/1/2006			Premature Infant	765.1	765.1	
4	6/5/2008			Problems with primary support group			
5	6/1/2006			45			45

SIGNATURES

The signature section can not be edited. They are place holders for signatures when printed.

⊟ Signatures

*Client Signature and Date

* Document reason for lack of Signature in note. Signature must be obtained at next visit.

Caregiver Signature and Date

LPHA Signature and Date

* Psychiatrist/MD Signature and Date

* N/A if client is not being treated by the Psychiatrist

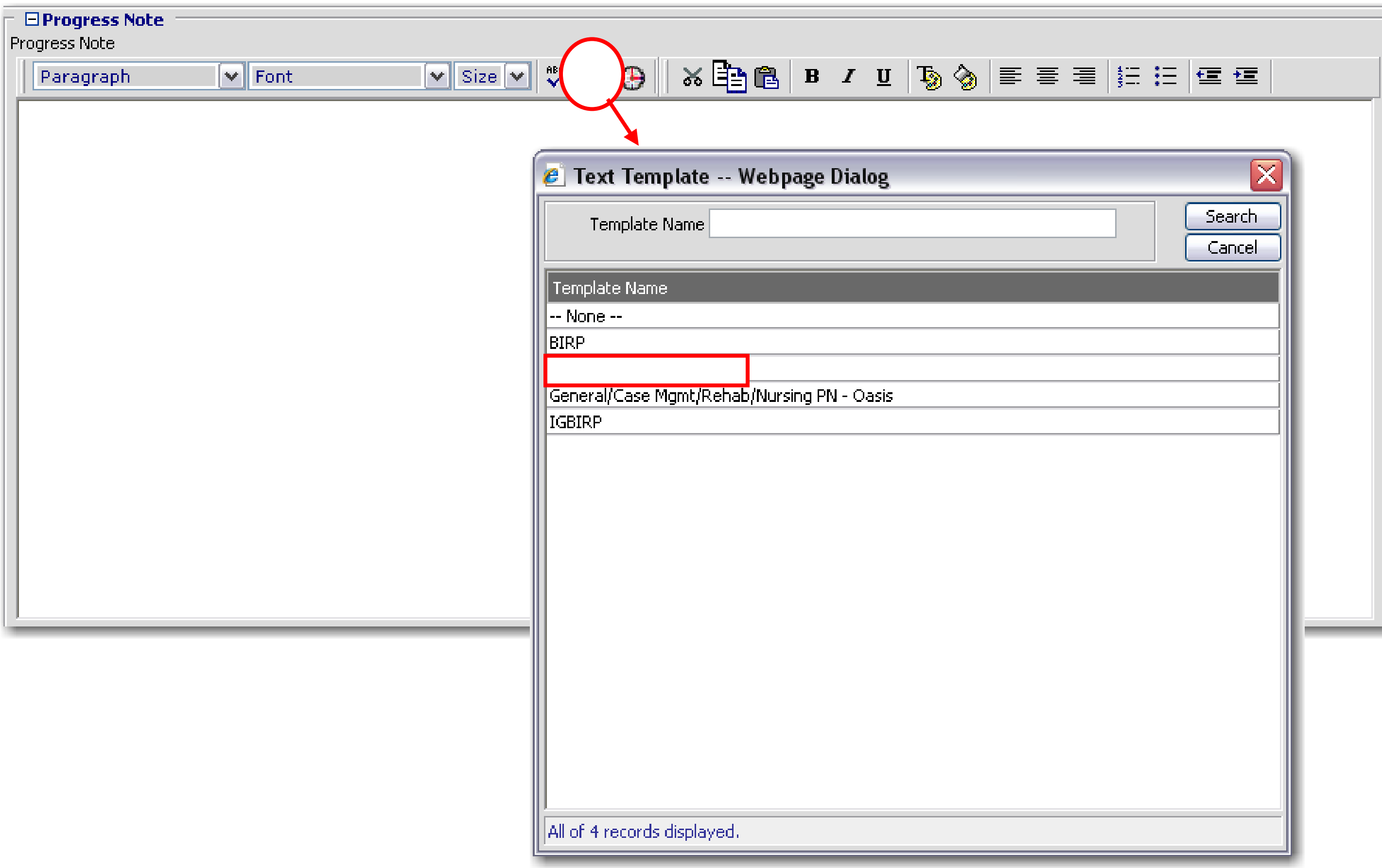
Cx received copy of Care Plan (Cx initials / date)

When you print the Care Plan to bring to the Caregiver and client to obtain their signatures make sure that you obtain ALL the signatures listed above. Sometimes when the Care Plan is printed some of the signature lines will end up on a separate printed page. You are REQUIRED to obtain ALL relevant signatures including the Client's Initials indicating they have received a copy of the Care Plan.

PROGRESS NOTE

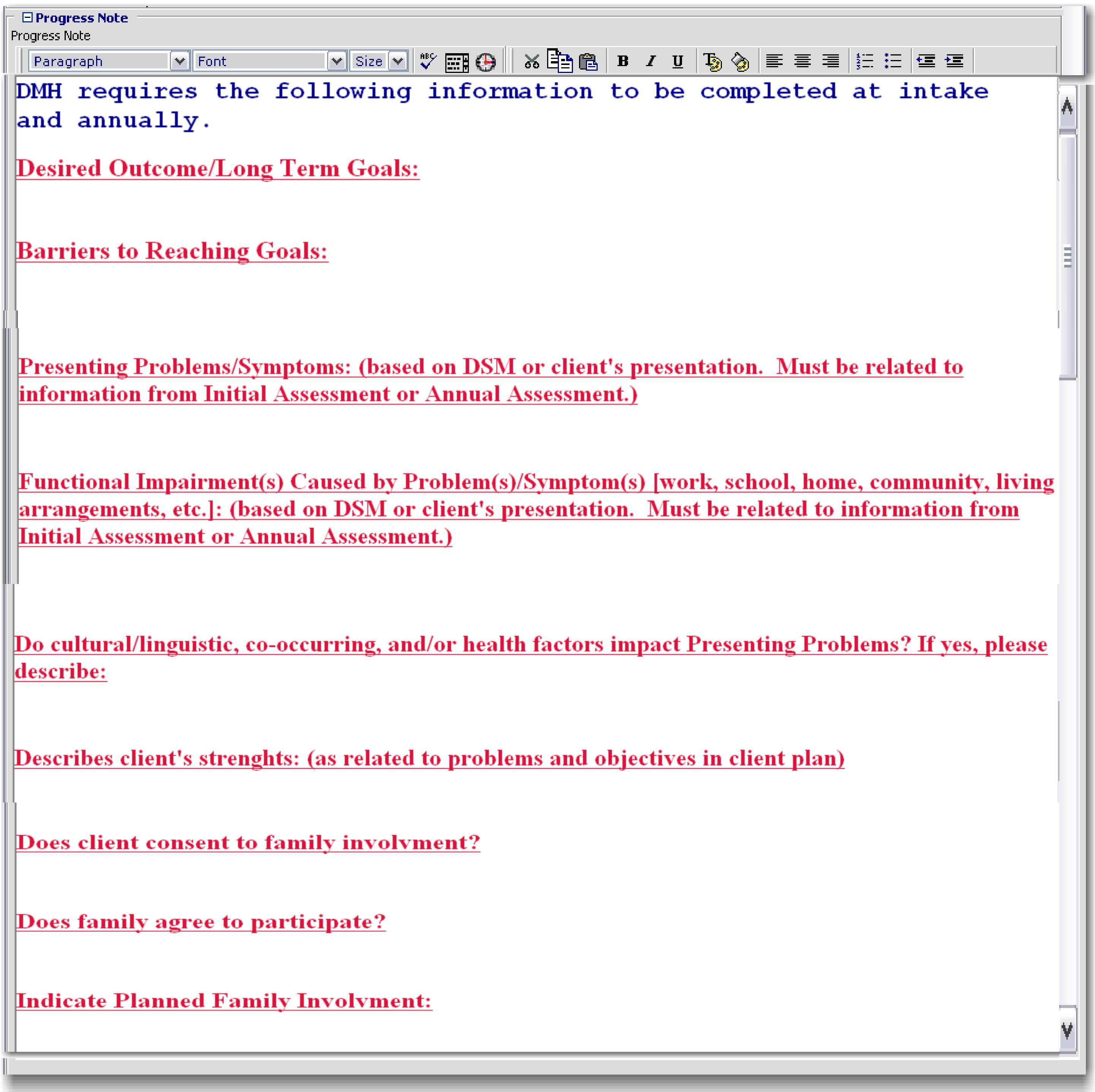
For the Initial Care Plan and Annual update you would select the Care Plan PN template. NOTE: For the 6-month update you would type in the progress note field "completed client care plan".

- To select the Care Plan PN template click on the template icon (circled below)
- Click on Care Plan PN Template

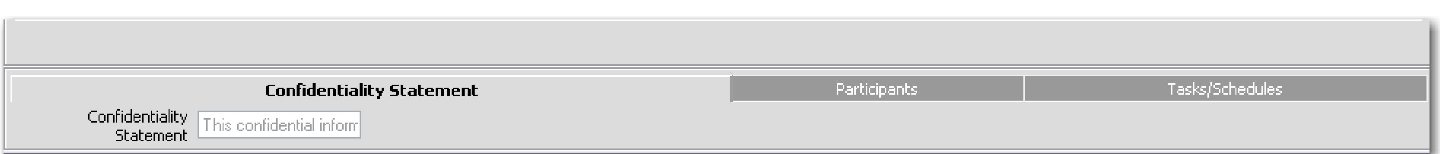


Care Plan Progress Note Template

The following headers will populate the Progress Note field. Type appropriate information under each header.



You do not need to enter or complete the Confidentiality Statement, Participants or Tasks/Schedules tabs.

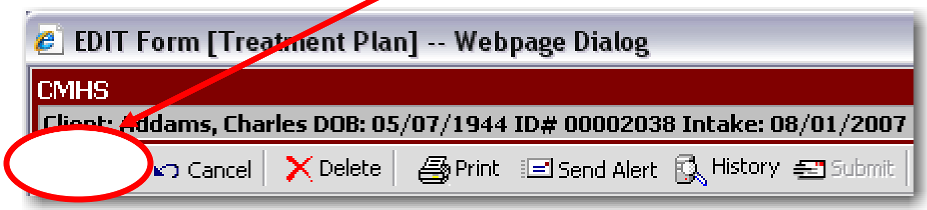


SAVING THE CARE PLAN / TREATMENT PLAN

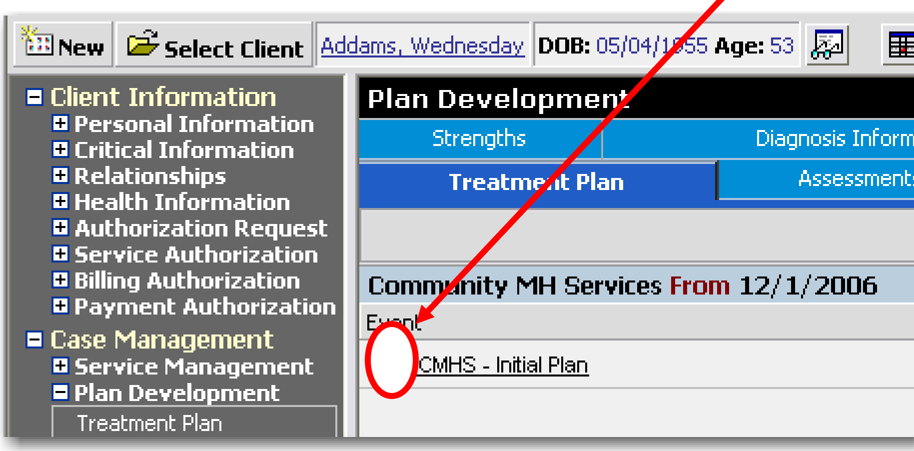
After **ALL** required **(bolded)** fields are complete you are ready to save the Care Plan/Treatment Plan. You MUST save the Care Plan first before you can submit it to your supervisor or designee; notice the "submit" button is not available.

At the top of the Care Plan/Treatment Plan click on the 

button.



The Care Plan/Treatment Plan will close and you will be brought back to the Treatment Plan page. You can now see the Care Plan/Treatment Plan in draft format indicated by the  (pencil) to the left of the Care Plan.

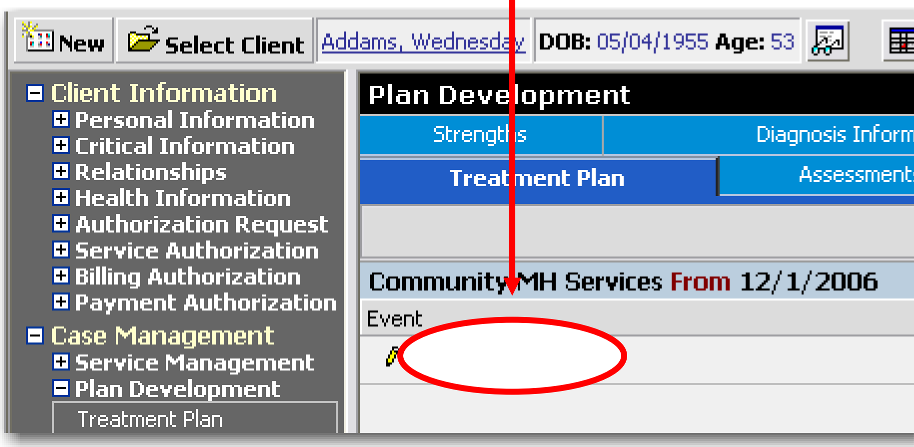


If you have missed any of the bolded (required) fields, you will receive an error message indicating what information must be complete before you can save. Below you can see an example of the error message you will get if you did not complete the "Other Time" field.

Submitting the Care Plan / Treatment Plan

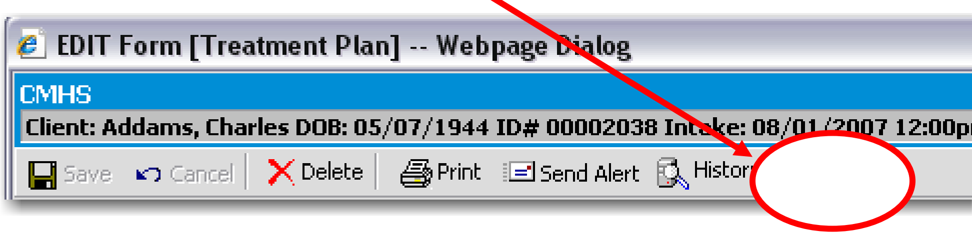
In order to submit the Care Plan to your supervisor or to the designee you MUST open up the Care Plan again. Do NOT leave the Care Plan in Draft status after its due date. A Care Plan in draft status will not be billed and is not considered a final Care Plan until the supervisor approves it.

To open the Care Plan again, click on the words "CMHS – Initial Plan" or "Review Plan".

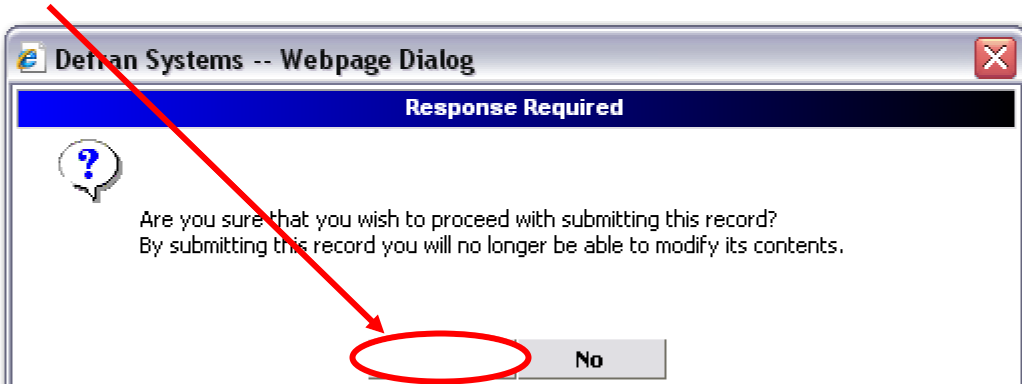


The Care Plan will open in Draft format.

At the top of the Care Plan the  button is now available; Click on it.

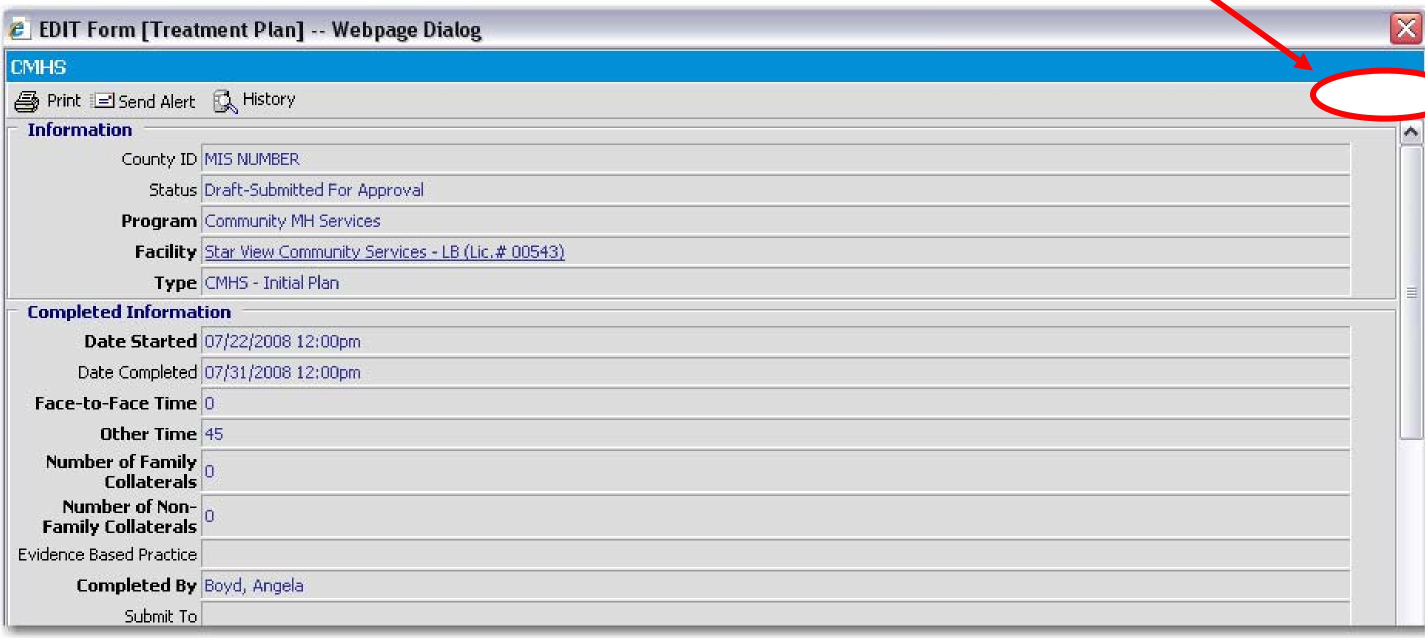


You will receive this message asking you if you are sure you want to proceed with submitting the Care Plan. Click  .

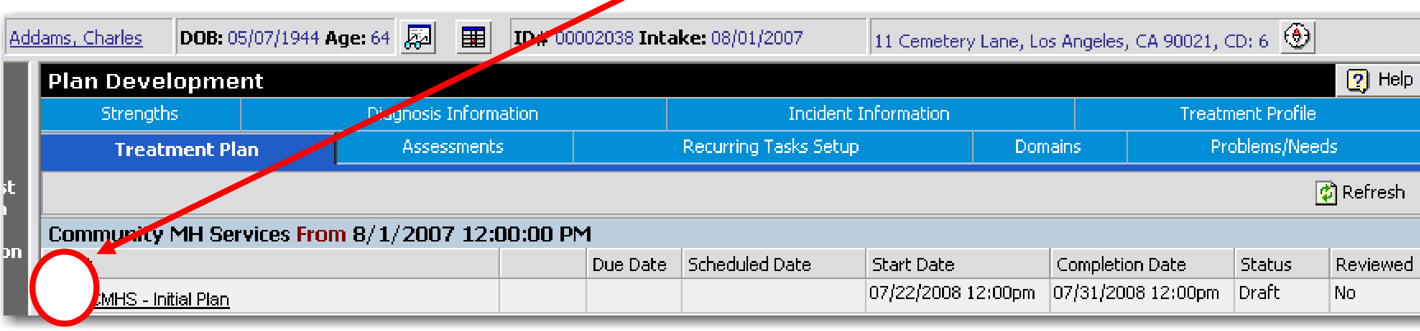


The Care Plan will now show in a format that is not editable. Click the 

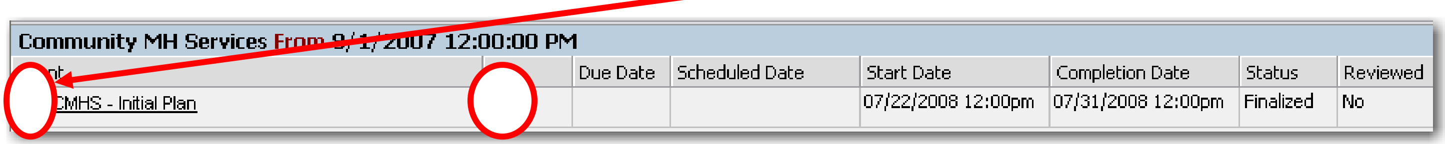
button to return to the Treatment Plan screen.



You will now see the Care Plan listed with an envelope  to the left of the service in the Treatment Plan screen.



When your supervisor or designee APPROVES the Care Plan you will see a green check mark  to the left of the service.



Also notice the eyeglass icon  to the right of the service. The eyeglass icon indicates the Care Plan can be updated.

BEFORE UPDATING THE CARE PLAN / TREATMENT PLAN

STOP: Before updating the Care Plan ask yourself the following two questions:

<u>First,</u> Is your client displaying any new Problems-Needs and/or Strengths?

- If <u>yes</u>, then PRIOR to updating the Care Plan, you **<u>MUST</u>** first add the Problems-Needs and/or Strengths (see pages 5 – 12 in this manual on how to add new Problems-Needs and/or Strengths).
- If not, then ask yourself the next question.

<u>Second,</u> Did any of the current Problems-Needs END during the previous 6-months?

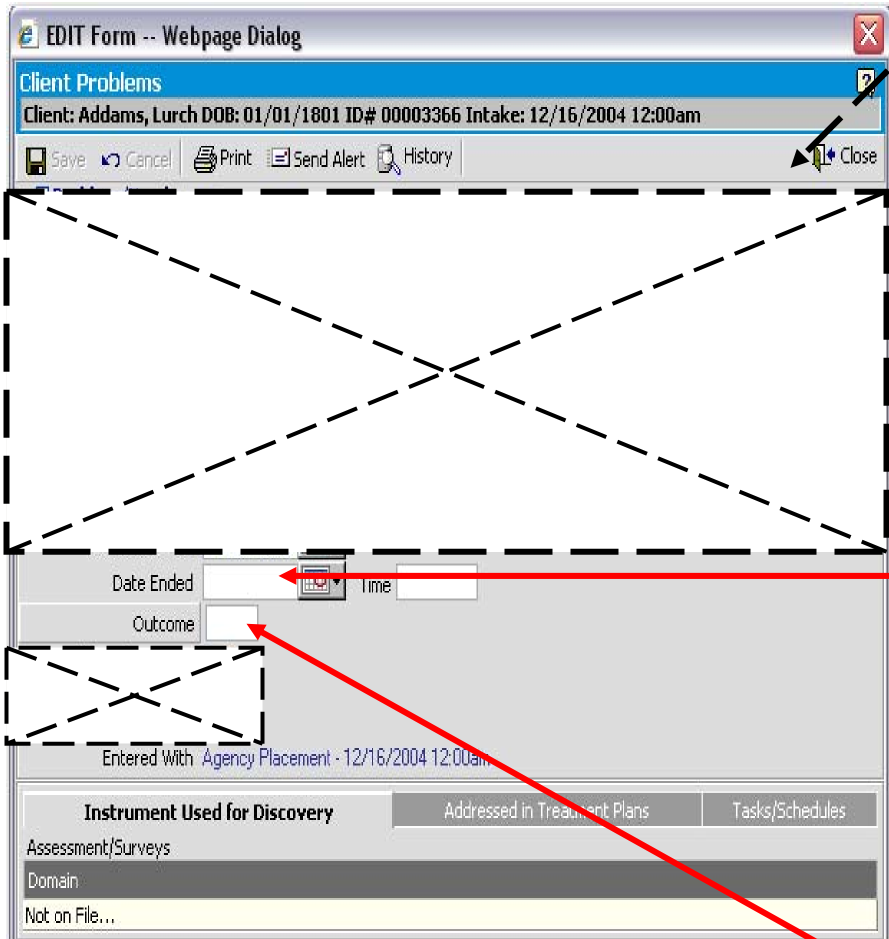
- If yes, then you will need to add an END date to the specific Problem-Need. To end a Problem-Need; follow the instructions in the next section of this manual.
- If not, then you can skip to page 42 of this manual on how to Update the Care Plan.

ENDING A PROBLEM/NEED

See page 3 of this manual on where Problem-Needs are located.

To add an End Date to a current Problem-Need click on the pencil icon at the right hand corner.

The Problem-Need box will open. The system will allow you to edit ANY field of the Problem-Need, but the <u>ONLY two fields</u> you should edit are the Date Ended and the Outcome.



DO NOT *EDIT/CHANGE* the:

- **PRIORITY**
- **PROBLEM CATEGORY**
- **PROBLEM/NEED**
- **PROBLEM/NEED NARRATIVE**
- **DATE IDENTIFIED**
- **WILL NOT BE TREATED**
- **REASON NOT BEING TREATED.**

Doing so will cause problems. Remember that you have already written objectives with this Problem/Need identified.

Date Ended:
The date this specific problem/need was extinguished or stopped. If unsure of the exact end date use the date the Care Plan will be reviewed/updated.

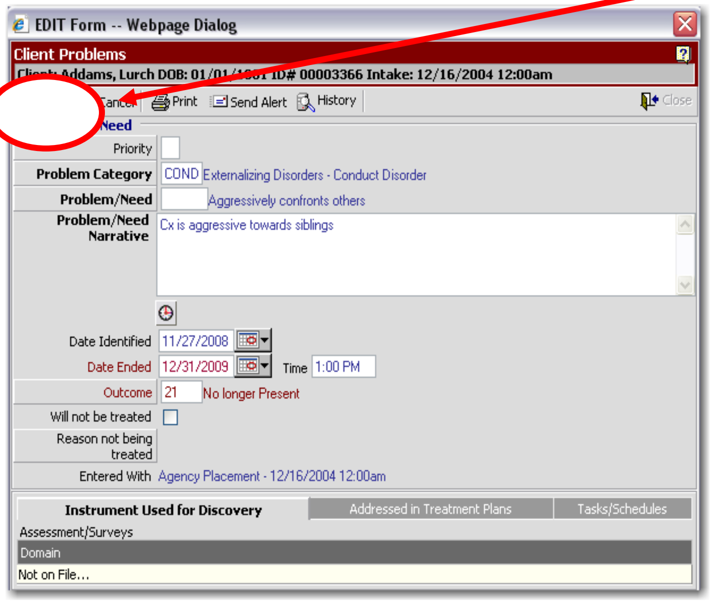
You can either type in the date or select it from the calendar.

Outcome: (use ONLY when ending a Problem/Need)
This allows you to indicate the outcome of the Problem/Need.

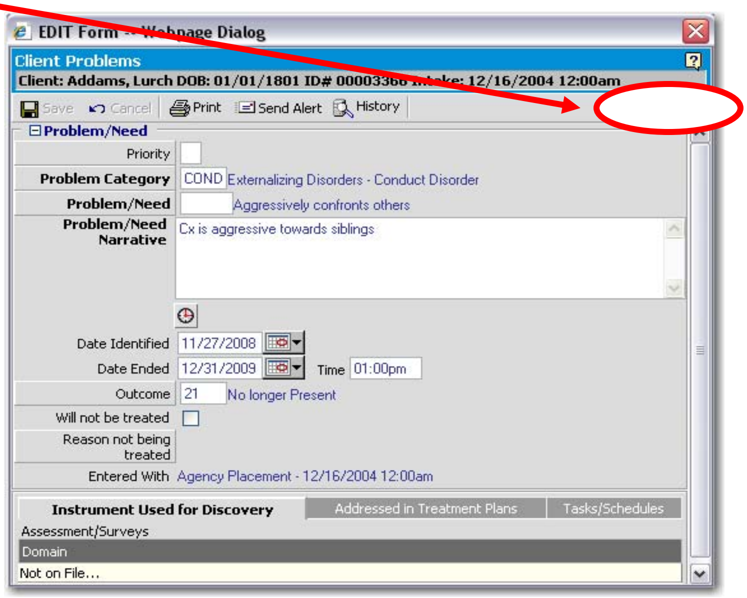
- Click the Outcome button

- A drop down list will open
- Select the Outcome of this Problem/Need
  - Achieved
  - Can't be achieved
  - No longer present
  - Not achieved

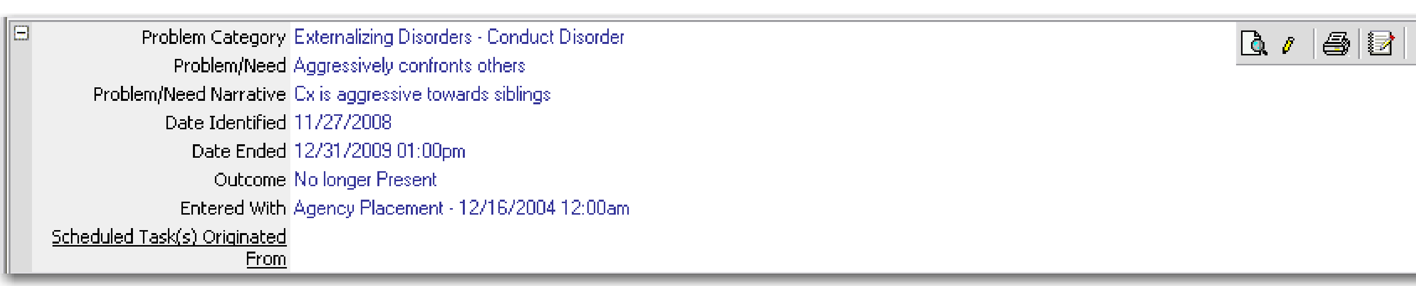
When you have entered the End Date and the Outcome you will need to click Save  at the top left hand corner.



The box will remain open, notice the Save button is now grayed out. You will then have to click the Close  button at the top right hand corner.



The box will close and you will be brought back to the Problem/Needs screen. The Problem/Need you just ended will look like this. Notice the End Date and Outcome section.



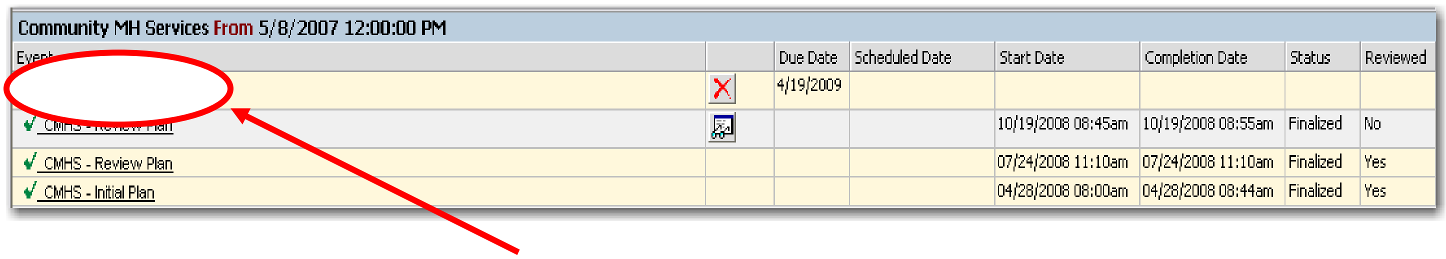
You are now ready to Update the Care Plan.

Updating the Care Plan / Treatment Plan

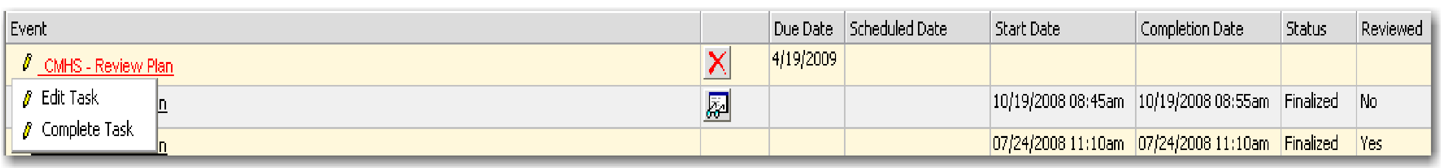
You can update the Care Plan at any time but at the very minimum the objectives MUST be updated every 6-months per DMH regulations. You should consider updating the Plan of Care earlier than the 6-month workflow if the client experiences a significant change of condition (such as hospitalization, other dramatic Tx-life event). Refer to the top of page 13 in this manual to locate the Care Plan in the EMR.

There are **<u>TWO</u>** options when updating a Care Plan:

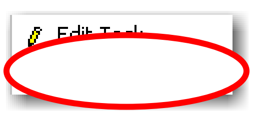
<u>First,</u> the EMR will automatically schedule the CMHS – Review Plan for the next 6-months based on the date you completed the previous Care Plan. If, when you are in the Treatment Plan section of the EMR, you see a CMHS – Review Plan in RED then the EMR had scheduled the CMHS – Review Plan for you to complete. You can complete the Care Plan this way regardless if you are updating the Care Plan early or not.



Click on the CMHS – Review Plan in RED

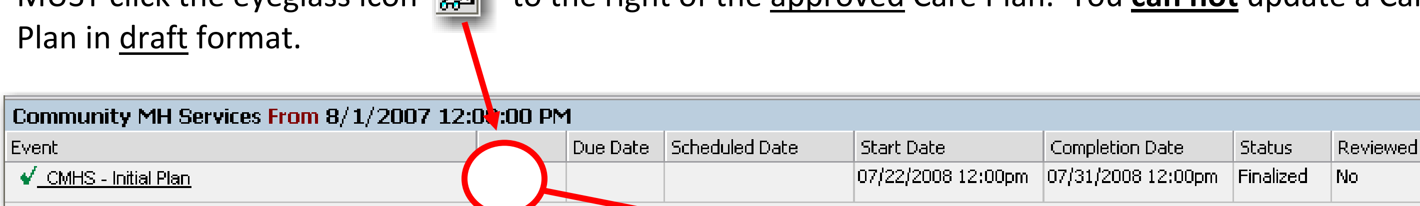


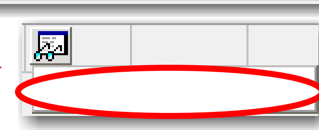
A drop down list will open asking you to Edit the Task or Complete the Task

Click on Complete Task 

If there is already a scheduled CMHS – Review Plan in RED, you will need to update the Care Plan by following the above steps. **Only use the eyeglass icon (explained below) if there is <u>NOT</u> a scheduled CMHS – Review Plan in RED.** If you do not click on the RED CMHS – Review Plan you will see multiple scheduled CMHS – Review Plans the next time you update a Care Plan.

<u>Second,</u> if the EMR did not schedule the CMHS – Review Plan for you to Update the Care Plan, you MUST click the eyeglass icon  to the right of the <u>approved</u> Care Plan. You **<u>can not</u>** update a Care Plan in <u>draft</u> format.



A drop down box will open. Click on the CMHS – Review Plan. 

The Service Plan Review Item box will open. This box will show ALL Problem Categories, objectives and methods with a status of open and closed on file for the client.

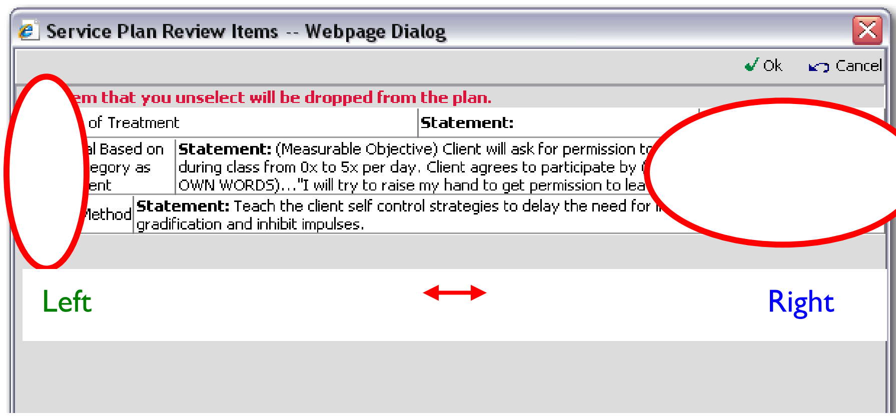
The following statuses are considered OPEN:

- Continued – No Change
- Continued – Positive Change
- Continued – Negative Change
- Revised – No Change
- Revised – Positive Change
- Revised – Negative Change
- Established

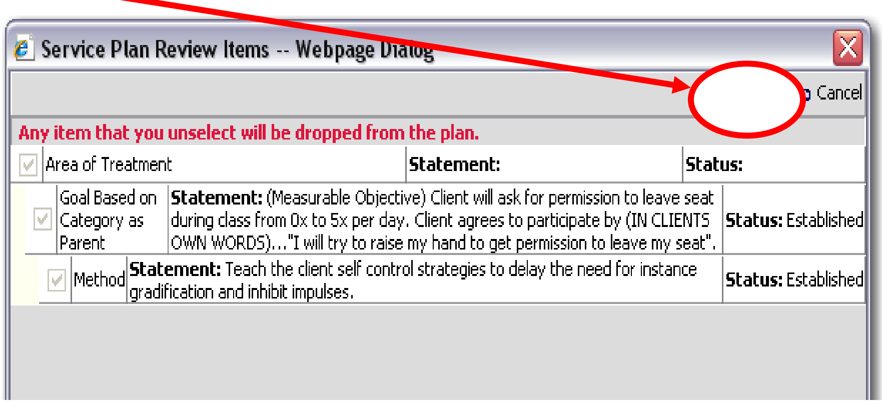
The following statuses are considered CLOSED:

- Discontinued
- Achieved

Notice the status column to the right of the objective and method. If the Status of the Area of Treatment (Problem Category), Goal (Objective) and/or Method (Intervention) fall under the OPEN category listed above, **you will not** have the choice to drop the Problem Category, Objective or Method.   This is indicated by the grayed out check marks to the left of the Area of Treatment, goal and/or method. The EMR will NOT let OPEN Area of Treatment, Goals or Methods to be dropped without given it a closed status.



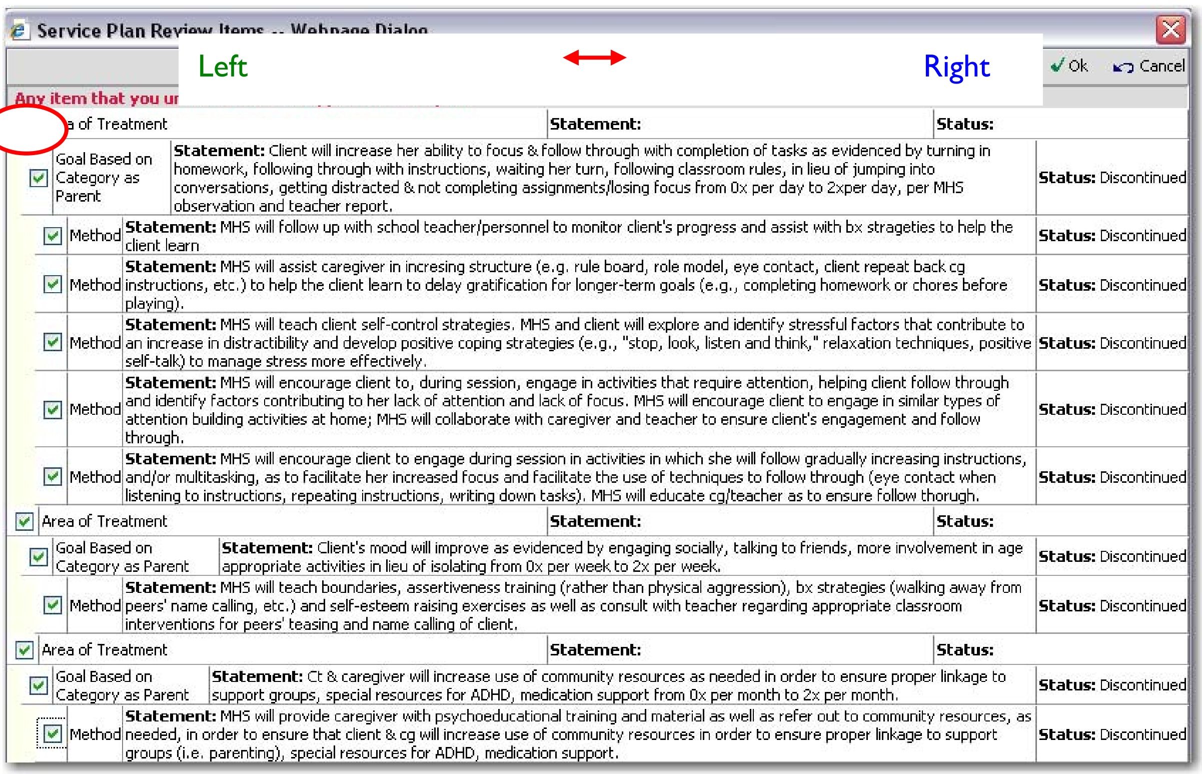
If all the check marks to the left of the Area of Treatment, Goal and Method are grayed out then click the OK button  at the top right hand corner of the box. Then SKIP to page 47 of this manual.



Based on the closed status of the Problem Categories, objectives and/or interventions you will be able to "drop" the Area of Treatment, goal and/or method from the Care Plan you are about to Update OR you have the option to make them active again.

In the screen shot example below notice the Status column to the right of the Area of Treatment, Goal and Method, they all indicate Discontinued. This means that all the Area of Treatment, Goals and Methods are closed. Notice to the left of the Area of Treatment, Goal and Method. The check boxes are not grayed out. You now have the ability to un-check an Area of Treatment, Goal and/or Method.

- The <u>Area of Treatment</u> is the Problem Category (remember the problem category is the clinical pathway linked to the diagnosis – i.e. Internalizing Disorder – Dysthymic)
- The <u>Goal Based on Category as Parent</u> is the Objective
- The <u>Method</u> is the Intervention

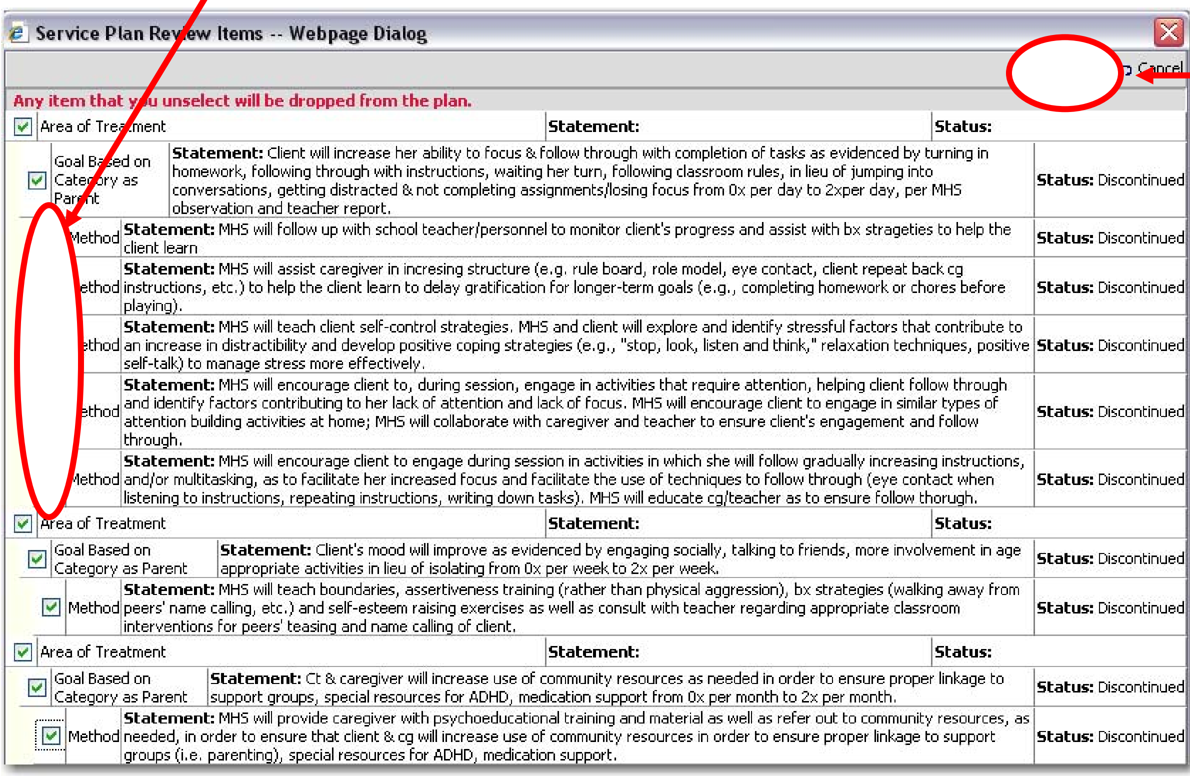


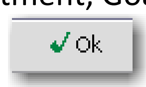
If you would like to make an objective previously discontinued or achieved <u>active again</u> you should leave the Area of Treatment (Problem Category) checked.

If you <u>do not</u> want the discontinued or achieved objective to show on your updated Care Plan then you MUST **<u>uncheck the AREA OF TREATMENT</u>** that corresponds to that objective. For instance, I do not want the first objective to show on my updated Care Plan so I would need to uncheck the AREA OF TREATMENT that corresponds to the first objective.

If you uncheck only the objective that corresponds to an AREA OF TREATMENT then when you update the Care Plan the AREA OF TREATMENT will show and not the objective. **You will then be REQUIRED to add another objective under that AREA OF TREATMENT. If this happens and you did not want that AREA OF TREATMENT to show you will be required to start your Care Plan over again and loose any data you entered.**

You also have the option of making an AREA OF TREATMENT and GOAL active again and not the METHOD. To do this, uncheck the METHODS you do not want to show on the updated Care Plan.



When you have checked or unchecked ALL the Area of Treatment, Goals and/or Methods you would like to have on the updated Care Plan you are ready to click 

at the top right hand corner.

The Care Plan page will open showing the objectives with a open status AND those closed objectives not unchecked (see next page).

ADD Form [Treatment Plan] -- Webpage Dialog

CMHS

Client: Addams, Lurch DOB: 01/01/1801 ID# 00003366 Intake: 12/16/2004 12:00am

Save | Cancel | Print | Close

Information

County ID	
Status	Draft
Program	CMHS Community MH Services
Facility	
Type	CMHS - Review Plan

Completed Information

Date Started	Time
Face-to-Face Time	
Other Time (Service + Documentation + Travel)	
Total Time	00:00
Number of Family Collaterals	
Number of Non-Family Collaterals	
Evidence Based Practice	
Completed By	Boyd, Angela
Submit To	

Client Care Plan

Problems Currently on file

Category	Problem	Statement	Date Identified	End Date
Externalizing Disorders - Conduct Disorder	Aggressively confronts others	Cx is aggressive towards siblings	11/27/2008	

Strengths Currently on file

Category	Strength	Statement	Date Identified	End Date
Externalizing Disorders - Conduct Disorder	Completes schoolwork	Cx listens to his teachers and turns his hw	11/26/2008	

Planning

Problems [Category: Externalizing Disorders - Conduct Disorder] New

Category	Externalizing Disorders - Conduct Disorder

Objective [Category: Externalizing Disorders - Conduct Disorder] [Goal: Terminate all acts of violence/cruelty to people] New

Problem Addressed	Problem:Aggressively confronts others, Statement:Cx is aggressive towards siblings
Goal	Terminate all acts of violence/cruelty to people
Goal Statement	(Measurable Objective) Cx will decrease hitting sibling fron 4x a week to 0 times per week Client agrees to participate by (IN CLIENTS OWN WORDS)... "I will will outside when I want to hit my siblings"
Target Date	5/31/2009
Staff Who Established	5, MHS
Status	
Status Date	
Review Remarks	

Interventions [Category: Externalizing Disorders - Conduct Disorder] [Goal: Terminate all acts of violence/cruelty to people] [Method: Teach client mediation/self-control techniques] New

Method	Teach client mediation/self-control techniques
Method Statement	MHS will work with this client on deep brfeathing skills
Target Date	5/31/2009
Program	Community MH Services
Service	Individual Rehabilitation
# of Times Per Interval	1
Interval/Frequency	Weekly
Staff Responsible	5, MHS
Other Person Responsible	
Status	
Status Date	
Review Remarks	

Current Diagnosis

Current Diagnosis

Axis	Date	Priority	Priority Description	Diagnosis	DSMIV	ICD9	GAF Score
Not on File...							

Signatures

*Client Signature and Date

*** Document reason for lack of Signature in note. Signature must be obtained at next visit.**

Caregiver Signature and Date

LPHA Signature and Date

* Psychiatrist/MD Signature and Date

*** N/A if client is not being treated by the Psychiatrist**

Cx received copy of Care Plan (Cx initials / date)

Progress Note

Progress Note

Paragraph | Font | Size

Confidentiality Statement | Participants | Tasks/Schedules

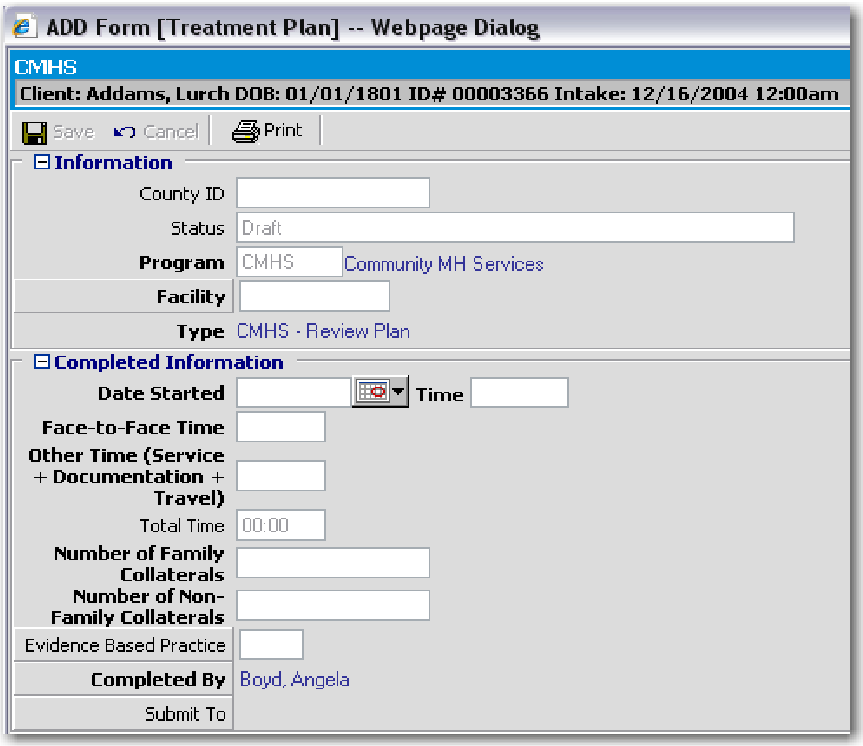
Confidentiality Statement: This confidential inform

The Care Plan looks exactly the same as the first Care Plan with the exception of the objectives. The Review Care Plan will list the problem categories, objectives and interventions either in an OPEN status or what you have indicated you wanted to show on the Care Plan for the client.

Let's review each section of the Review Care Plan.

To complete a Treatment Plan start with the Information section. You will notice there are similarities between this section and other Service Entry forms. You will need to complete the required fields.

INFORMATION AND COMPLETED INFORMATION SECTIONS



Refer to page 15 of this manual or pages 20 – 24 of Phase I manual if you need assistance in completing the information and Completed Information sections.

CLIENT CARE PLAN SECTION

This is where all Problems/Needs and Strengths information currently on file for the client shows.

Client Care Plan

Problems Currently on file

Category	Problem	Statement	Date Identified	End Date
Externalizing Disorders - Conduct Disorder	Aggressively confronts others	Client is agressive towards siblings.	11/27/2008	
Externalizing Disorders - Disruptive Disorder NOS	Refuses to comply with adult rules	Foster mom reports that she has to prompt cx 5 times before cx obey	11/12/2008	
Internalizing Disorders - Depression NOS	Low interest in Activity	Low interest in activities leading to moderate isolation and avoidance	1/16/2009	
Internalizing Disorders - Dysthymic	Irritable Mood (with duration of at least 1 year)	(In children and adolescents, mood can be irritable and duration must be at least 1 year)	12/18/2008	

Strengths Currently on file

Category	Strength	Statement	Date Identified	End Date
Externalizing Disorders - Conduct Disorder	Completes schoolwork	Client listens to teachers and turns in his work on time.	11/27/2008	
Externalizing Disorders - Disruptive Disorder NOS	Attends school regularly	Cx states he enjoys school	11/12/2008	
Internalizing Disorders - Depression NOS	Ability to envision long-term goals	Client wants to go to college	1/16/2009	
Internalizing Disorders - Dysthymic	A positive relationship with caregiver(s)	Client is able to identify need for assistance.	12/18/2008	

Planning Section

Achieving an Objective

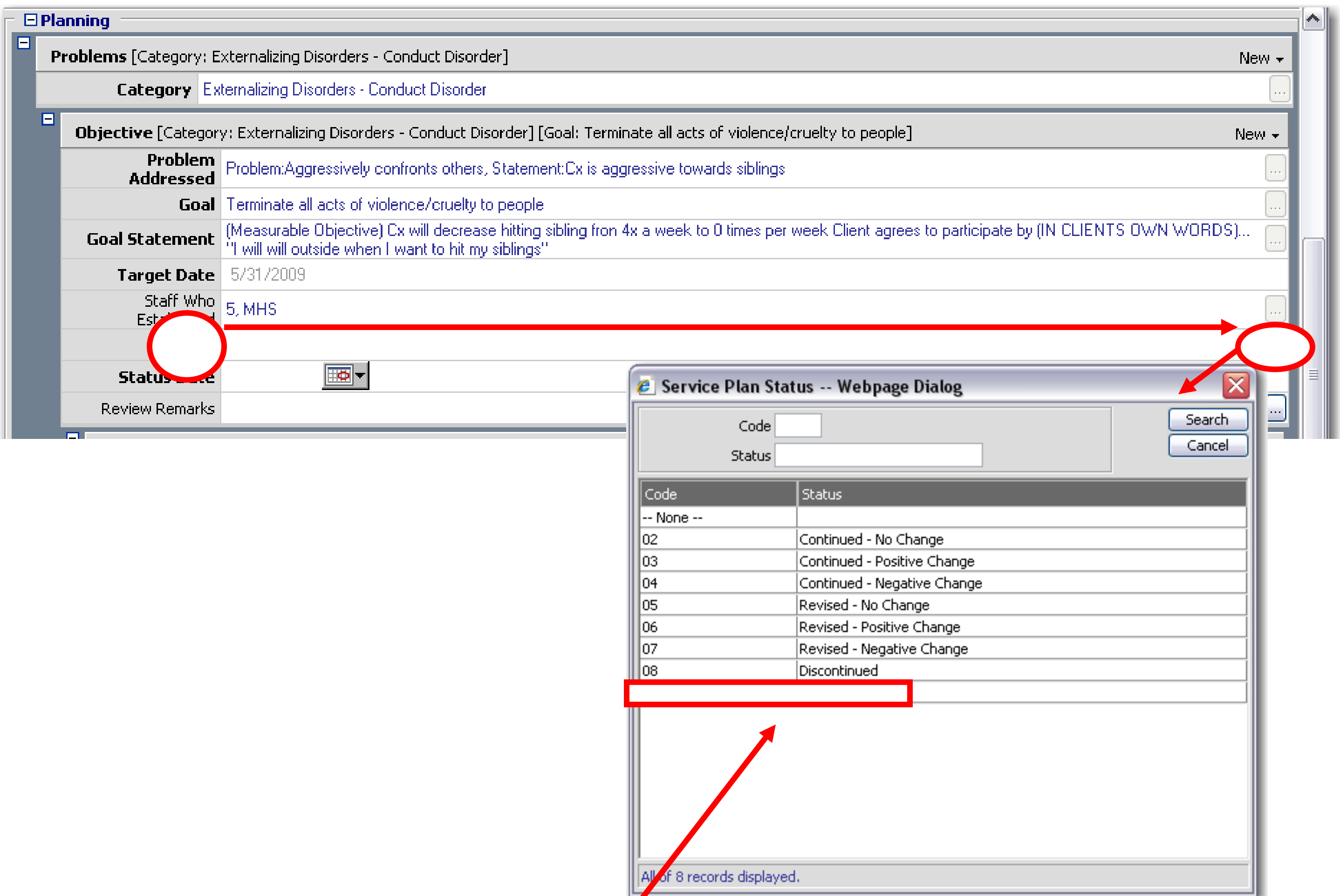
<u>You MUST give a Status to EVERY objective listed in order to Review the Care Plan.</u>

If the client has achieved the Objective and the Objective will not be continued you need to select Achieved under the status field.

When selecting Achieved you will be required to complete the following fields under both the Objective and Intervention:

- Status
- Status Date
- Review Remarks

Click the ellipses button to the left of the Status field.

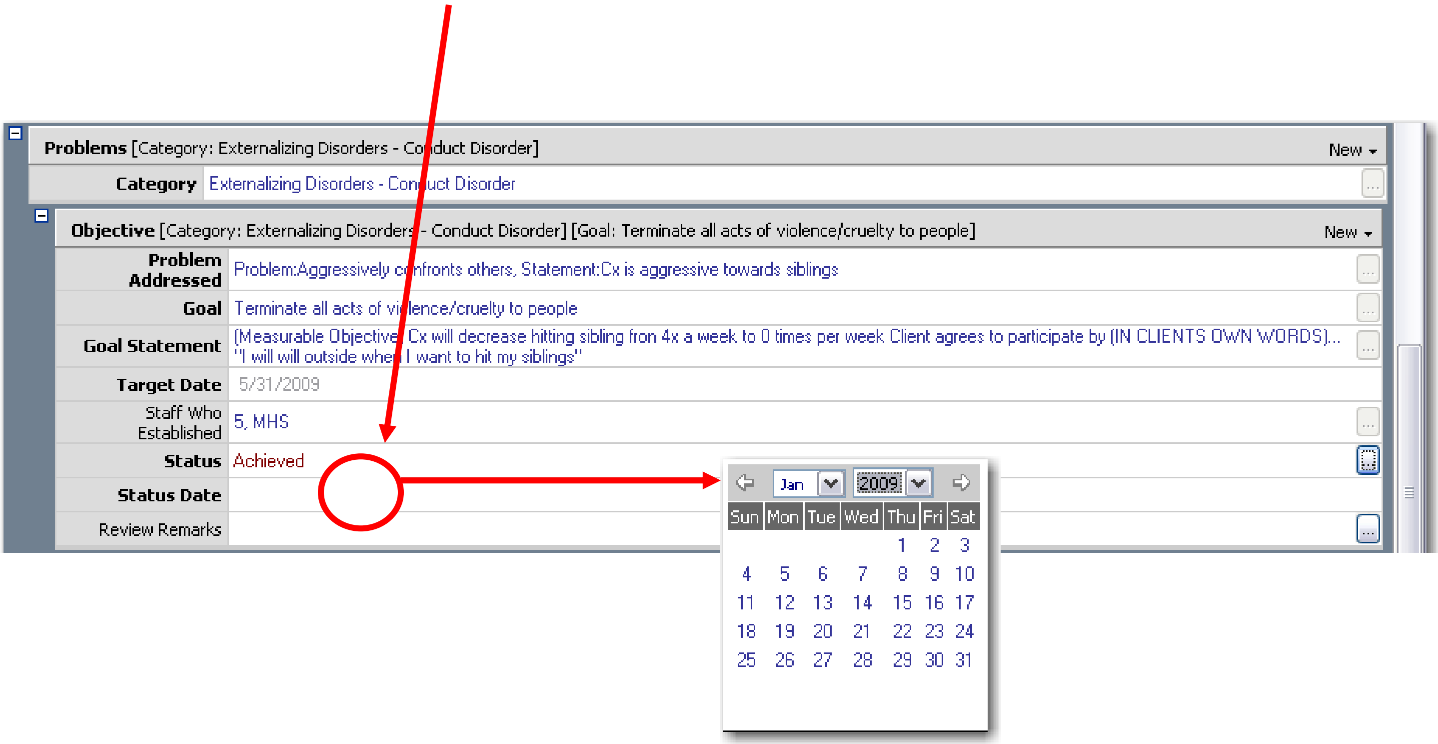


A drop down box will open, click on Achieved.

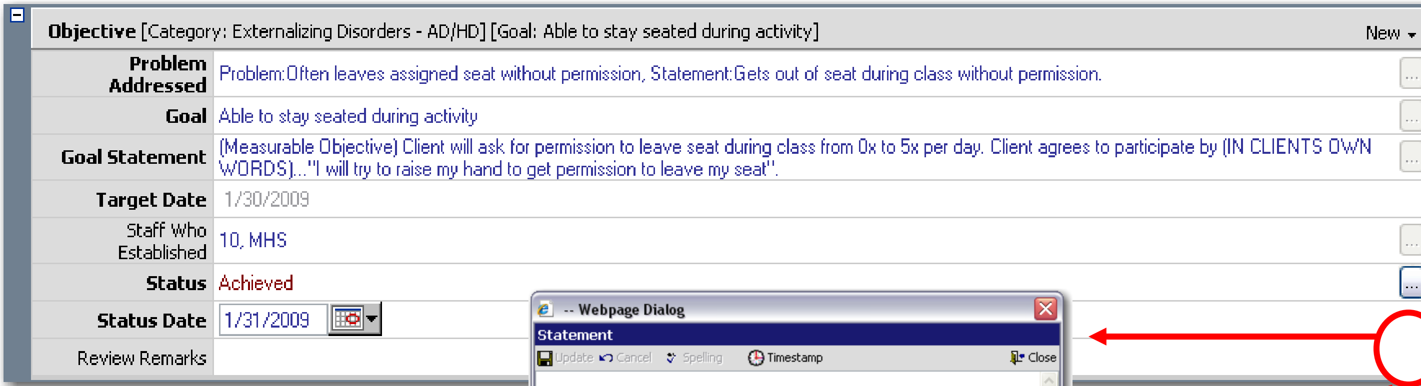
Next, you will need to indicate a **Status Date** of the objective.

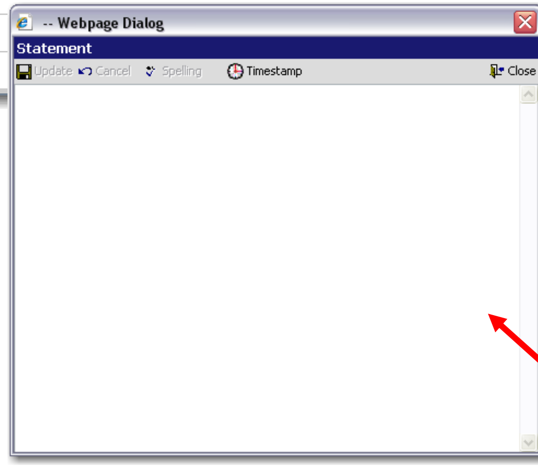
This is the date the objective was reviewed.

- Either type in date or click on the calendar and select the date
- The date will populate the filed



Next, you need to indicate more detailed information about the status of the objective on why/how it was achieved in the **Review Remarks** field.

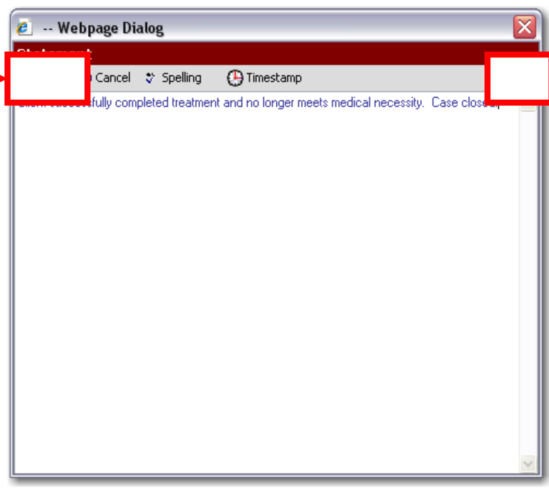




To open the Review Remarks box, click on the Ellipses button to the far right.

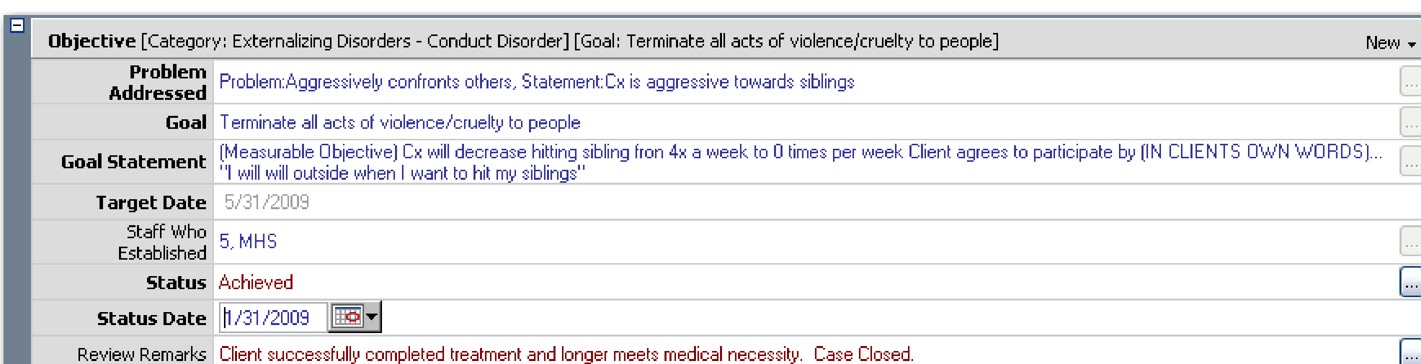
A blank statement page will open allowing you to free type information about the objective.

 To save the information you **MUST** click update at the far left corner.



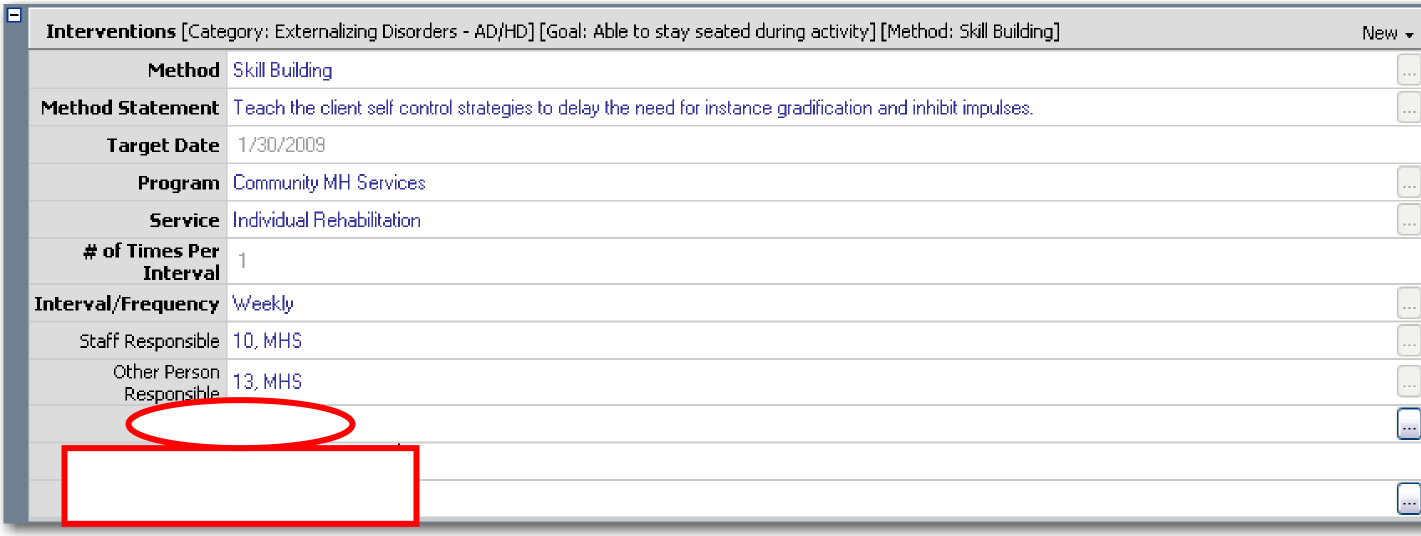
Close the box by clicking  in the right hand corner.

A completed objective section should look like this:



ACHIEVING AN INTERVENTION

Notice that when you selected Achieved under the Objective Status, the system auto-populated Achieved under the Status field of the Intervention. You are able to change the status of the Intervention if desired and leave the Objective status as is. To do so, click on the ellipses button to the far right of the Intervention status and select a different status.

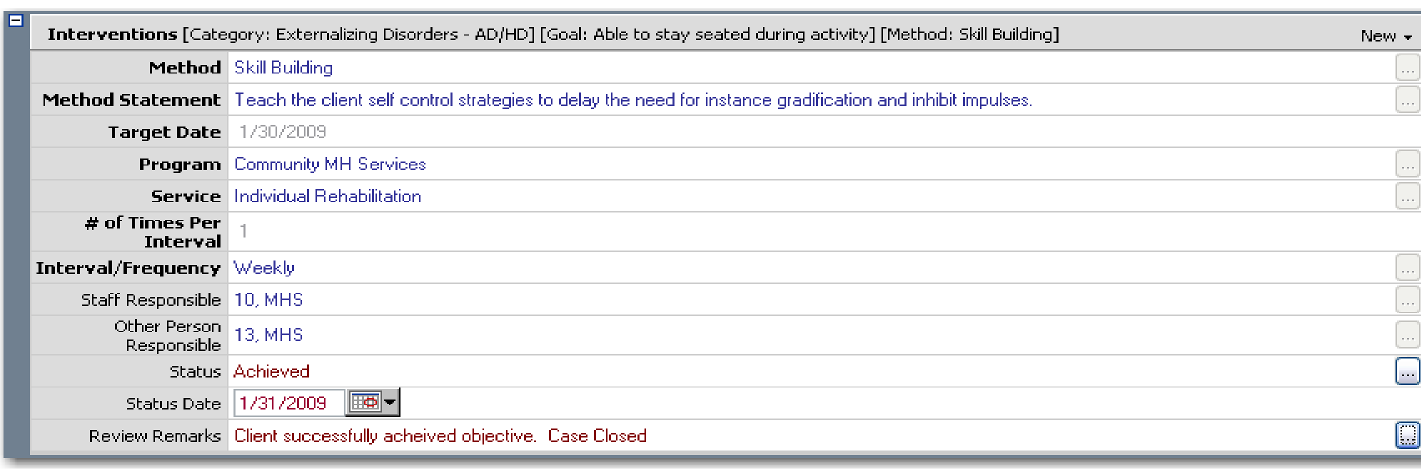


Interventions [Category: Externalizing Disorders - AD/HD] [Goal: Able to stay seated during activity] [Method: Skill Building] New

Method	Skill Building
Method Statement	Teach the client self control strategies to delay the need for instance gradification and inhibit impulses.
Target Date	1/30/2009
Program	Community MH Services
Service	Individual Rehabilitation
# of Times Per Interval	1
Interval/Frequency	Weekly
Staff Responsible	10, MHS
Other Person Responsible	13, MHS

Follow the same process for the Intervention **Status date** and **Review Remarks** as you did with the Objective Status date and Review remarks (refer to the previous three pages if needed).

A completed Intervention section should look like this:



Interventions [Category: Externalizing Disorders - AD/HD] [Goal: Able to stay seated during activity] [Method: Skill Building] New

Method	Skill Building
Method Statement	Teach the client self control strategies to delay the need for instance gradification and inhibit impulses.
Target Date	1/30/2009
Program	Community MH Services
Service	Individual Rehabilitation
# of Times Per Interval	1
Interval/Frequency	Weekly
Staff Responsible	10, MHS
Other Person Responsible	13, MHS
Status	Achieved
Status Date	1/31/2009
Review Remarks	Client successfully acheived objective. Case Closed

DISCONTINUING AN OBJECTIVE

Follow the same steps outlined on pages 48 – 50 with the only difference being that you select Discontinued in the Status field.

DISCONTINUING AN INTERVENTION

Follow the same steps outlined on this page for Invention Status date and Review Remarks as you did with the Objective Status date and Review remarks.

REMEMBER that Achieving or Discontinuing an Objective will CLOSE the objective.

CONTINUED-NO CHANGE, CONTINUED-POSITIVE CHANGE, OR CONTINUED-NEGATIVE CHANGE OBJECTIVE STATUS

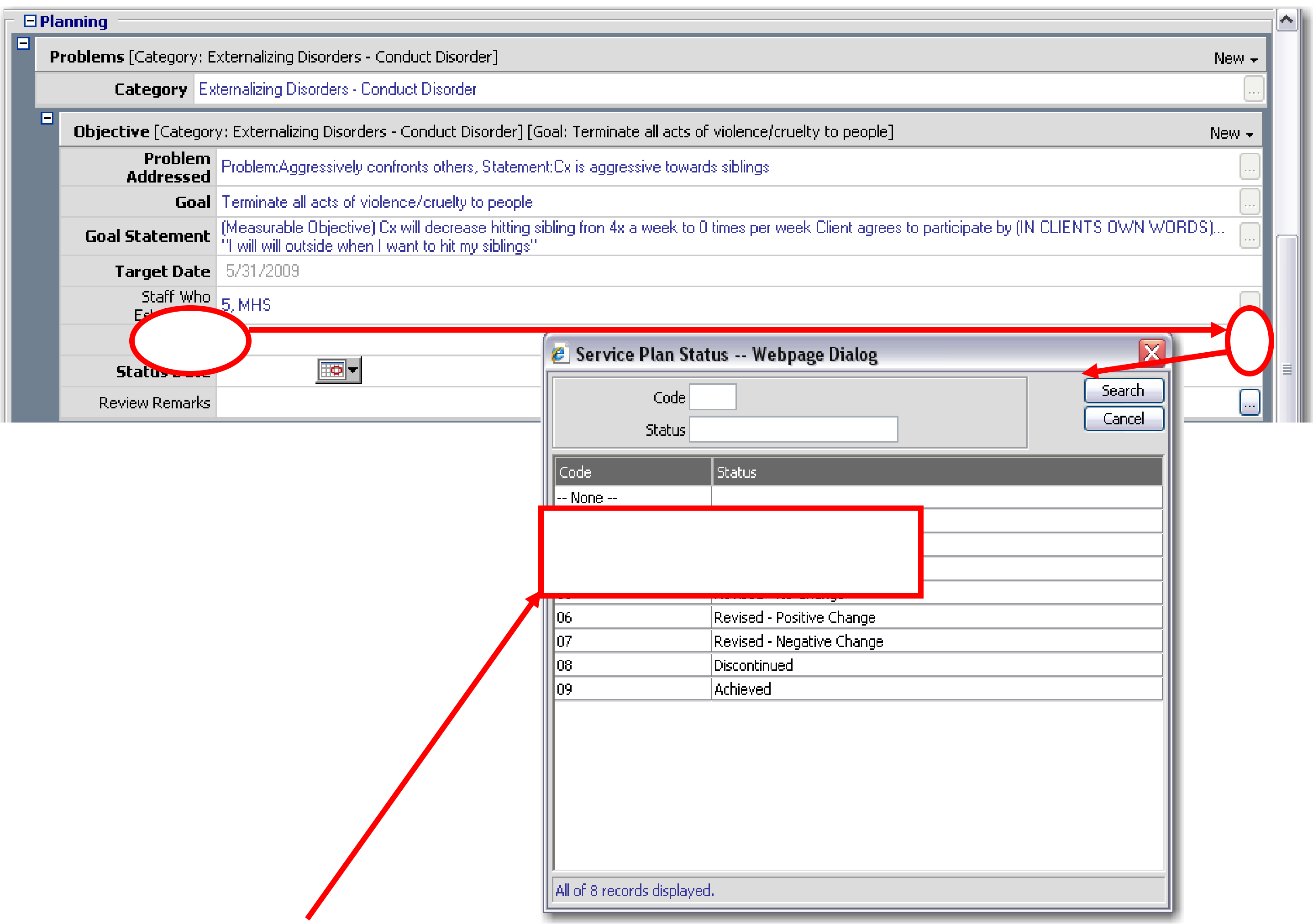
The status of CONTINUED-No Change, CONTINUED-Positive Change and CONTINUED-Negative Change does NOT mean the objective or intervention is changing. It literally means the objective or intervention is going to be continued WITHOUT changing any of the content (including the measurable part of the objective).

When you select Continued-No Change, Continued-Positive Change or Continued-Negative Change for the objective you can only edit the following fields:

- Target Date
- Staff Who Established
- Status
- Status Date
- Review Remarks

First you have to give the objective a **Status** before you can change the Target Date or Staff Who Established.

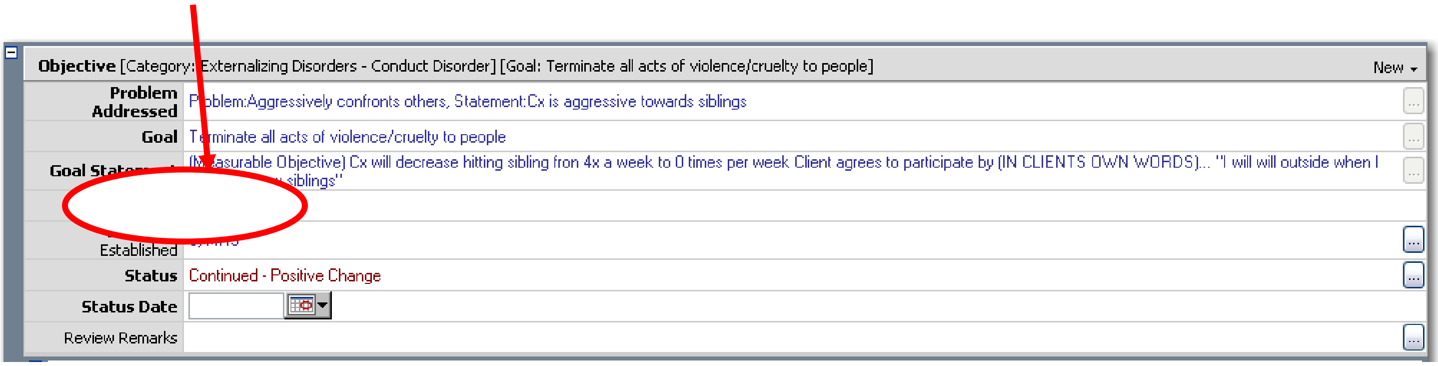
To select a Status, click the ellipses button to the left of the Status field.



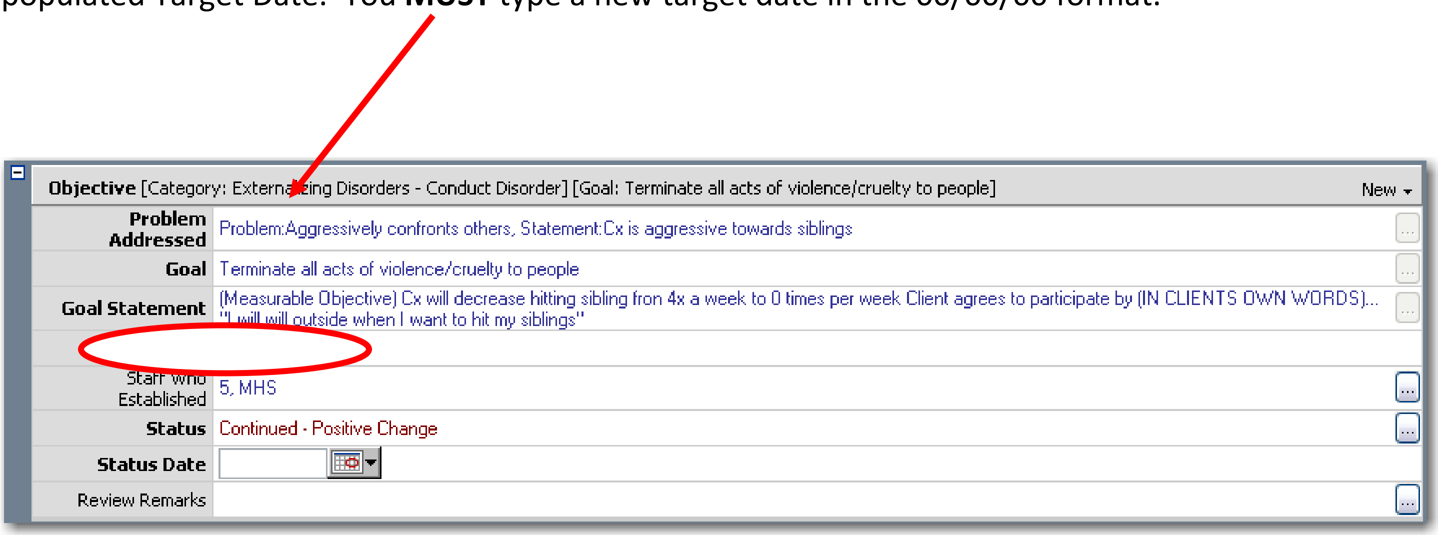
A drop down box will open, click on either Continued-No Change, Continued-Positive Change OR Continued –Negative Change.

Changing the Target Date

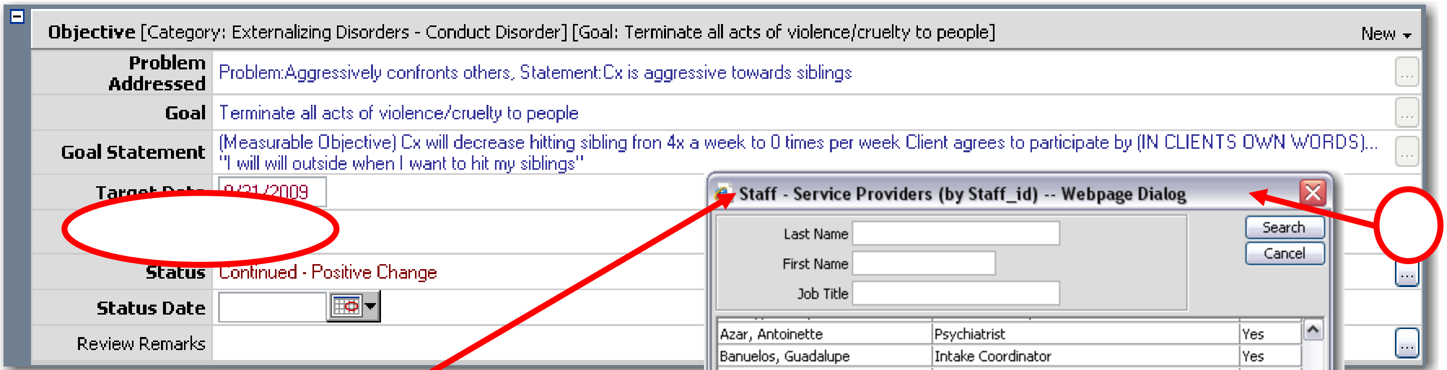
The system automatically populates the Target Date field based on the target date you entered in the previous Care Plan. You will need to change the Target Date of this objective. Remember the Target Date is the last day of the month PRIOR to the due date of the Care Plan.

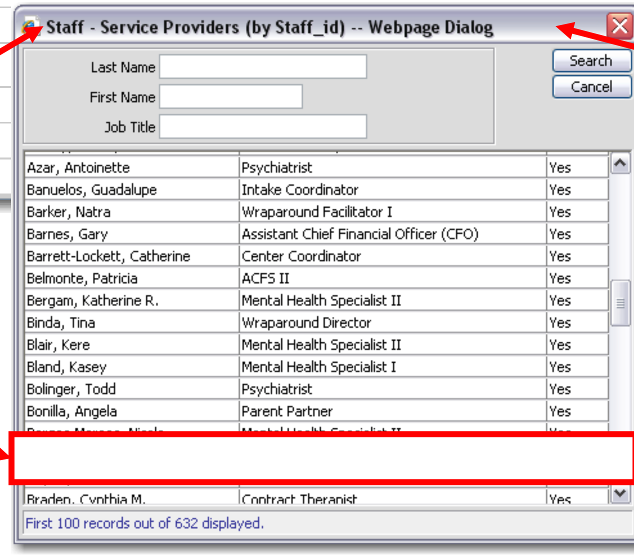


To change the Target Date you will need to click into the Target Date field and delete the pre-populated Target Date. You **MUST** type a new target date in the 00/00/00 format.



To change the **Staff Who Established** the Objective, click on the ellipses to the far right of the field.



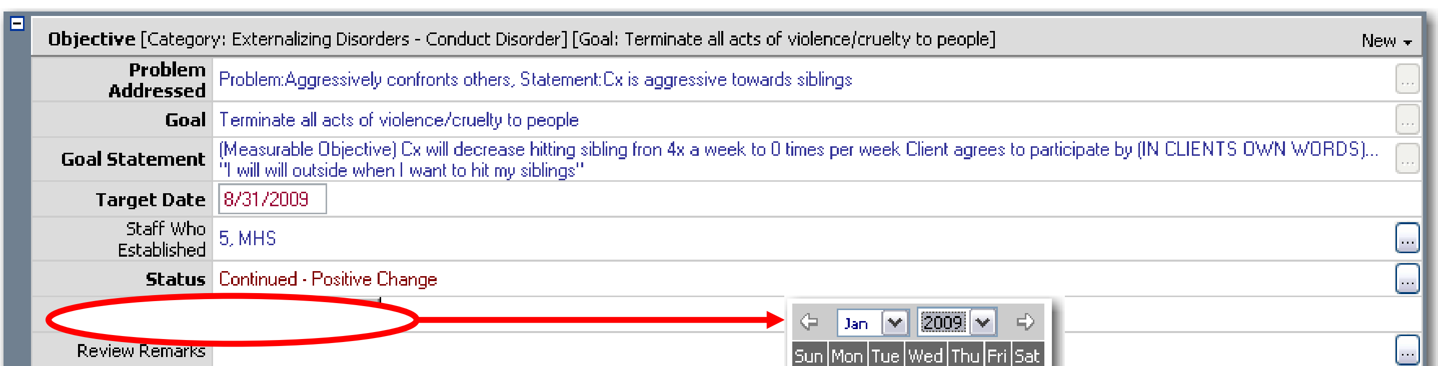


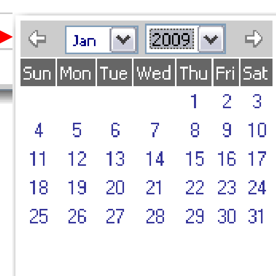
A drop down list will open.

Select the staff member's name of the person who established the objective.

If the Staff Who Established has not changed, leave the pre-populated name in the field.

Next, you will need to indicate a **Status Date** of the objective.

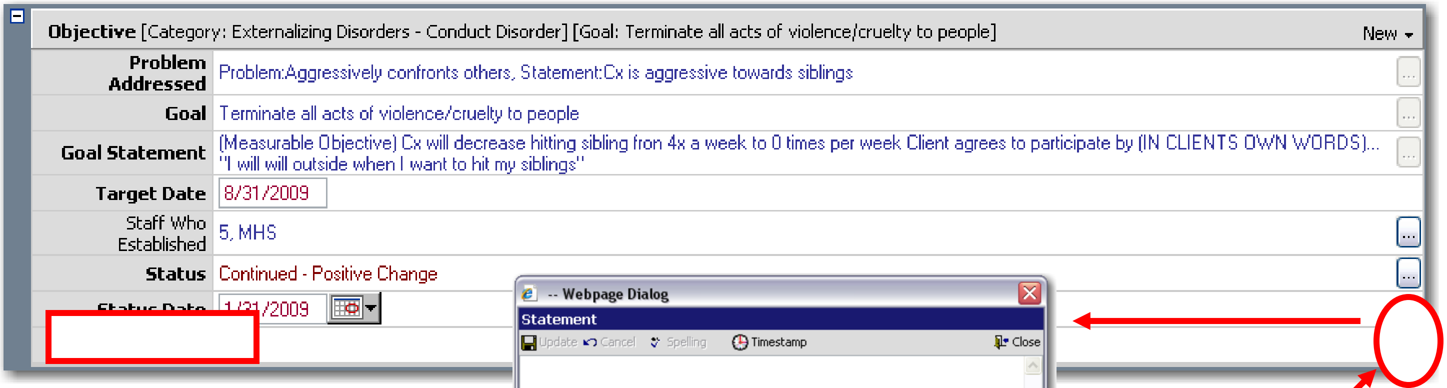


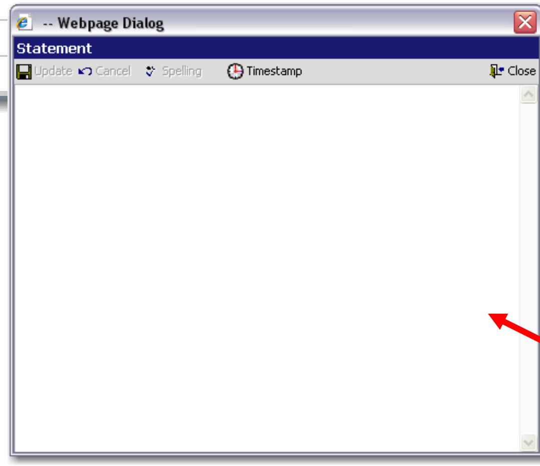


This is the date the objective was reviewed.

- Either type in date or click on the calendar and select the date
- The date will populate the filed

Next, you need to indicate more detailed information about the status of the objective on why/how it was continued in the **Review Remarks** field.

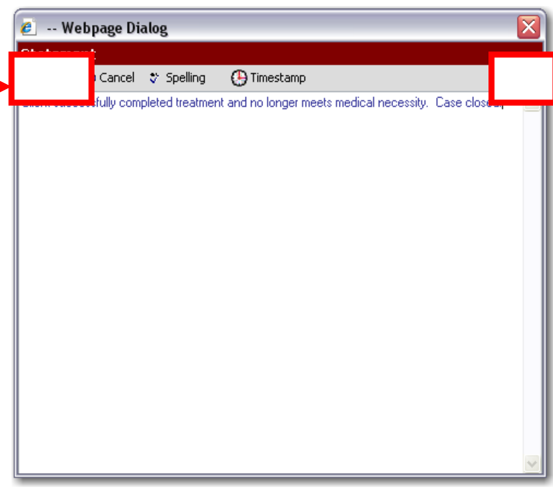




To open the Review Remarks box, click on the Ellipses button to the far right.

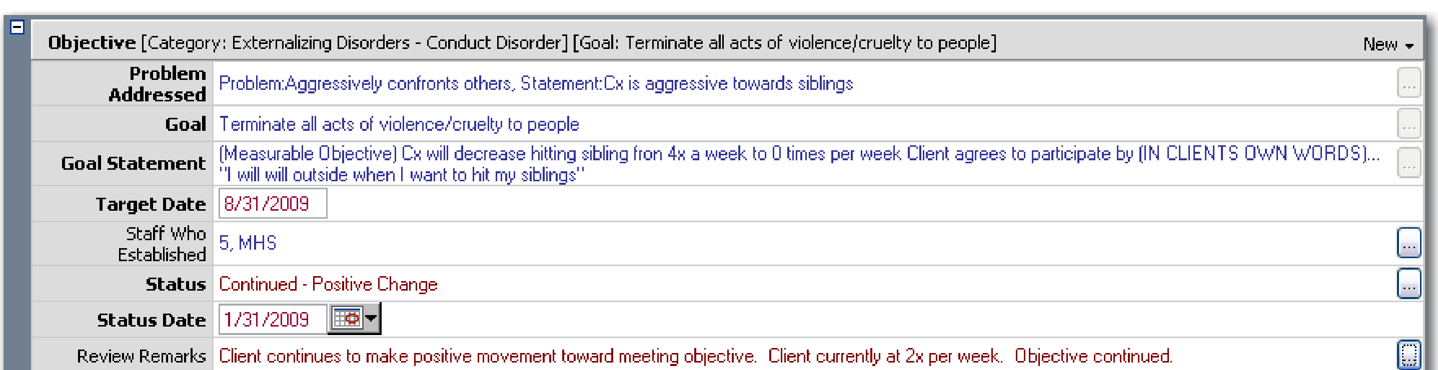
A blank statement page will open allowing you to free type information about the objective.

 To save the information you **MUST** click update at the far left corner.



Close the box by clicking  in the right hand corner.

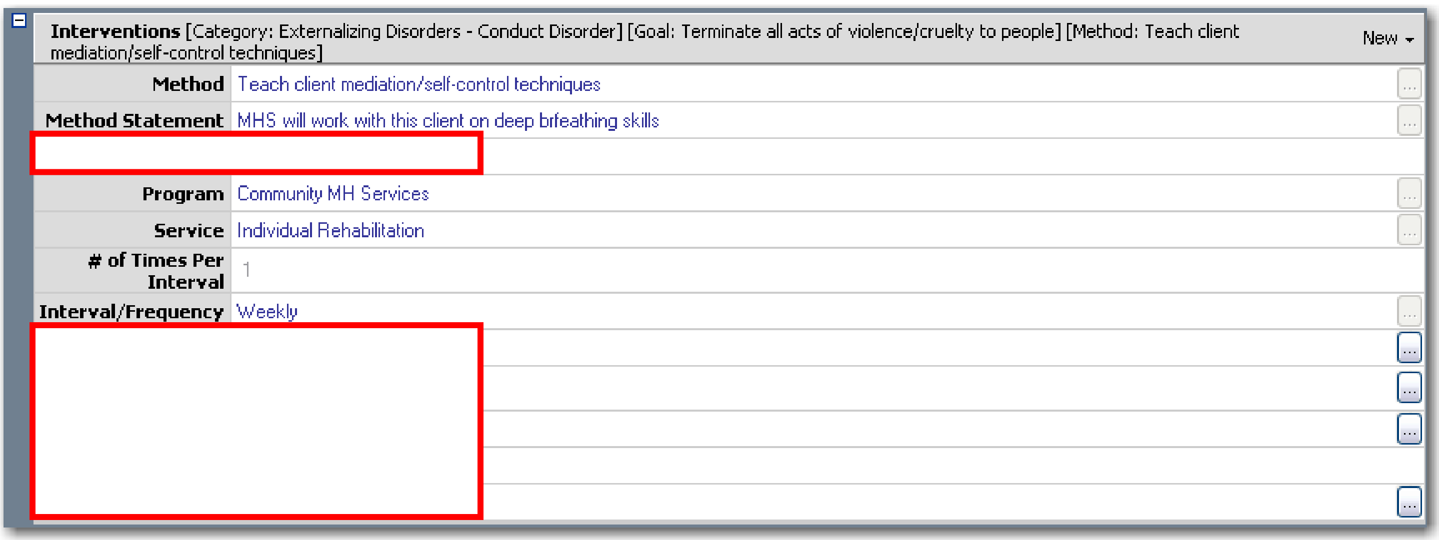
A completed objective section should look like this:



CONTINUED-NO CHANGE, CONTINUED-POSITIVE CHANGE, OR CONTINUED-NEGATIVE CHANGE INTERVENTION STATUS

When you select Continued-No Change, Continued-Positive Change or Continued-Negative Change in the intervention Status you can edit the following fields:

- Target Date
- Staff Responsible
- Other Person Responsible (if needed)
- Status
- Status Date
- Review Remarks



Changing the Target Date

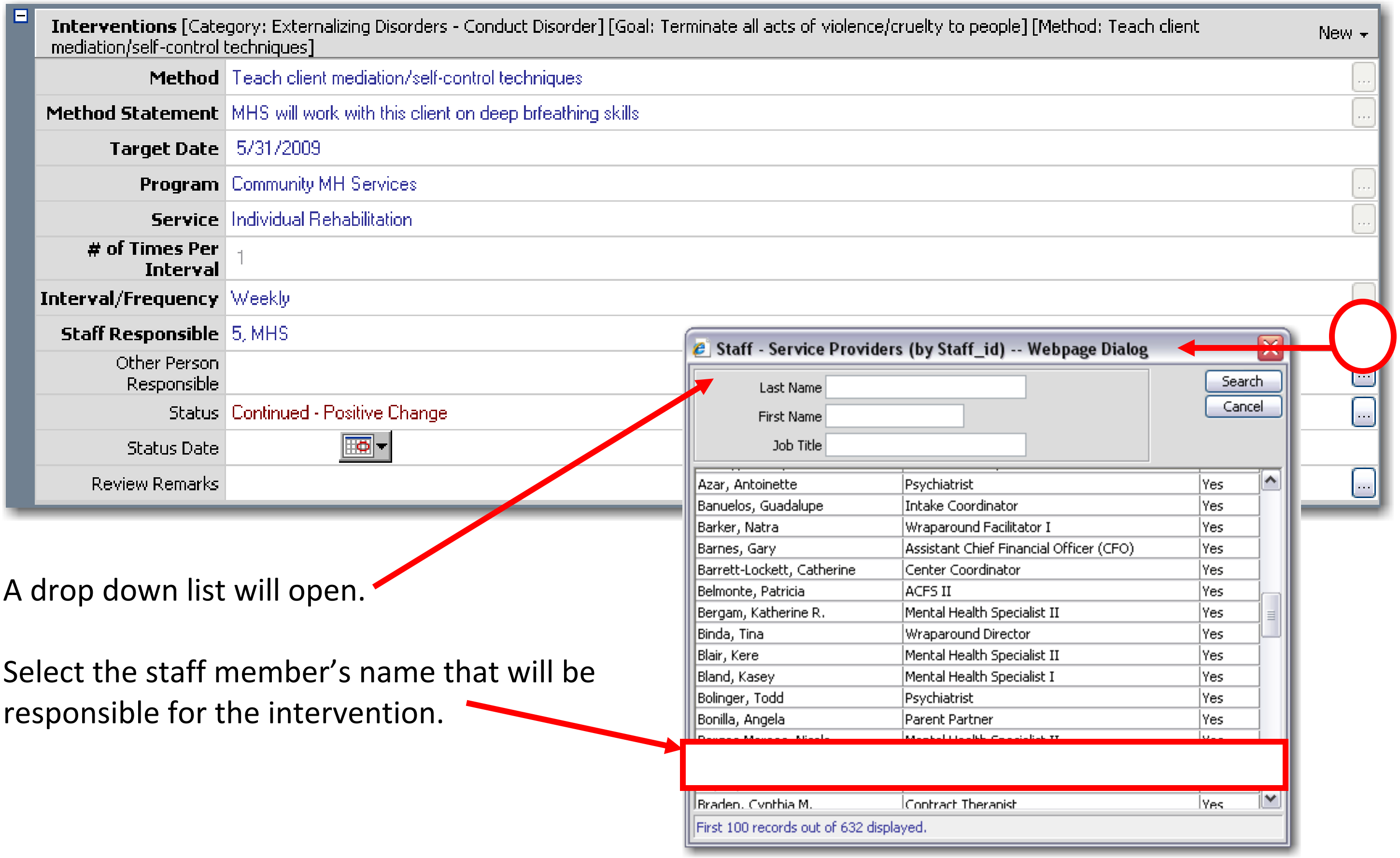
The system automatically populates the Target Date field based on the target date you entered in the previous Care Plan. You will need to change the Target Date of this objective. Remember the Target Date is the last day of the month PRIOR to the due date of the Care Plan.

To do this you will need to click into the Target Date field and delete the pre-populated Target Date. You MUST type a new target date in the 00/00/00 format.

Changing the Staff Responsible if needed

Staff Responsible for the intervention will auto-populate based on the name entered in the previous Care Plan. If the person responsible for the intervention is longer responsible (maybe they no longer working with the client) then you will need to change the Staff Responsible.

To change the Staff Responsible, click on the ellipses to the far right of the field.

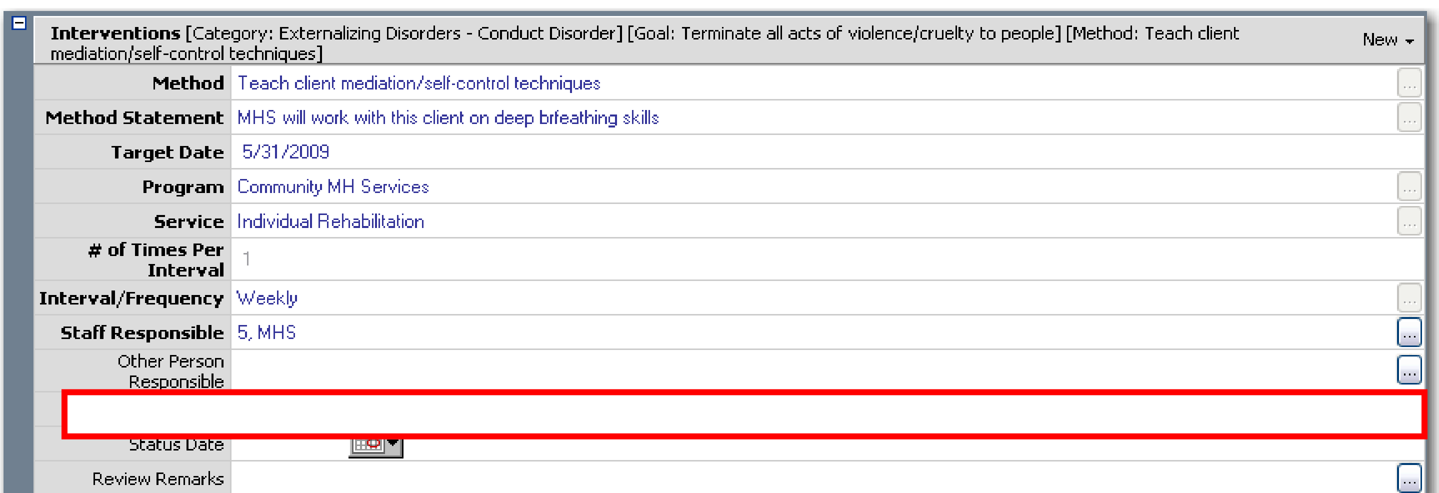


A drop down list will open.

Select the staff member's name that will be responsible for the intervention.

If there is an additional Staff Responsible for the intervention you are able to select them in the Other Person Responsible field by following the same steps. If the Staff Responsible has not changed then leave the pre-populated name in this field.

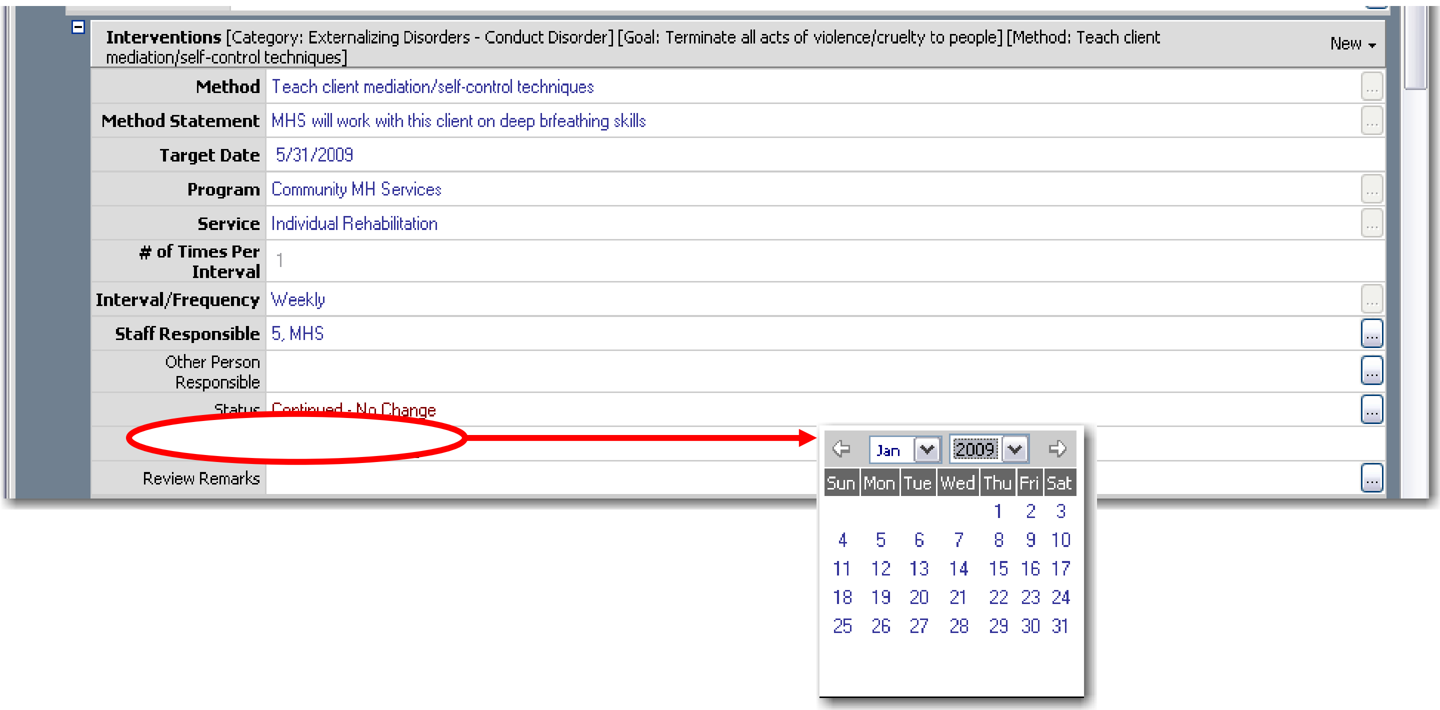
Changing the Status if needed



Remember, when you selected the Continued status in the Objective the EMR auto-populates the same status in the Intervention. You are able to change the status of the Intervention if desired and leave the Objective status as is. To do so, click on the ellipses button to the far right of the Intervention status and select a different status.

Status Date

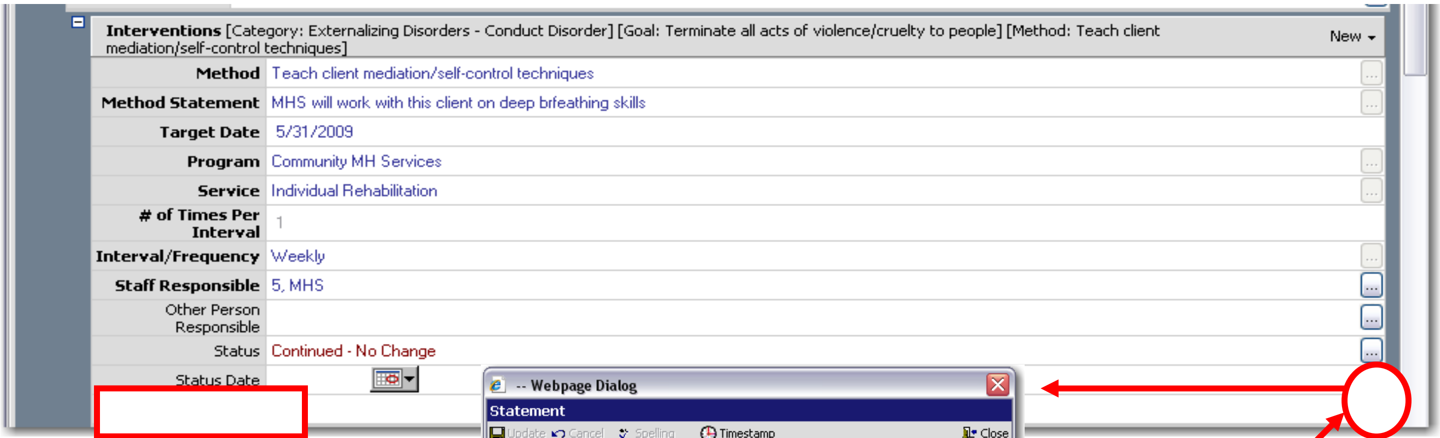
Next, you will need to indicate a “Status Date” of the intervention.

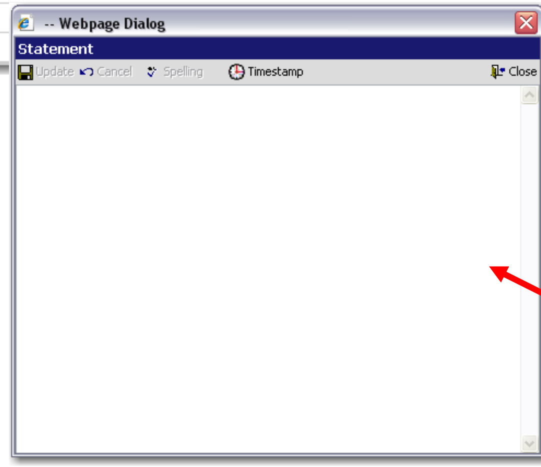


This is the date the intervention was reviewed.

- Either type in date or click on the calendar and select the date
- The date will populate the filed

Next, you need to indicate more detailed information about the status of the intervention on why/how it was continued in the **Review Remarks** field.

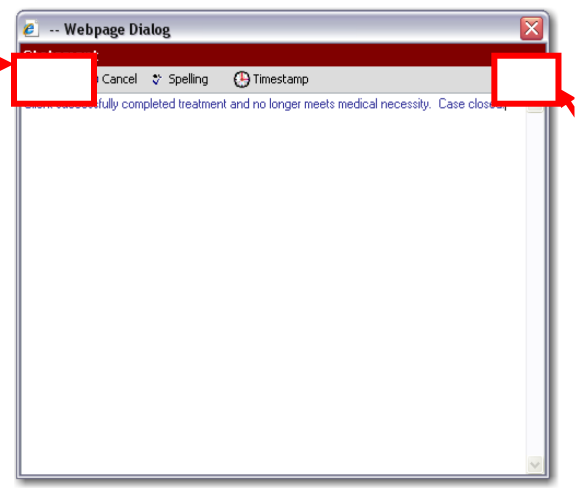


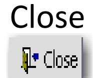


To open the Review Remarks box, click on the Ellipses button to the far right.

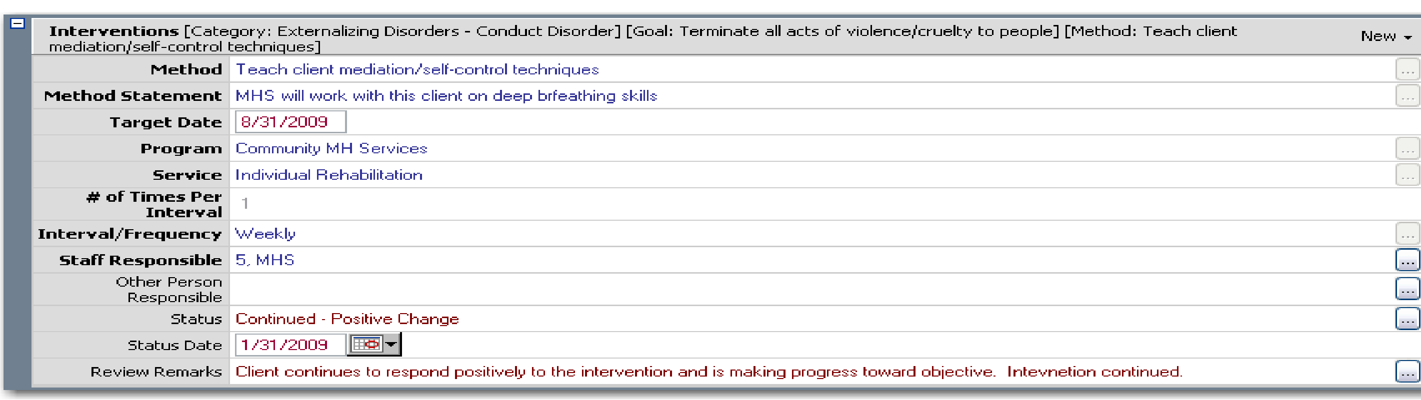
A blank statement page will open allowing you to free type information about the objective.

 To save the information you **MUST** click update at the far left corner.



Close the box by clicking  in the right hand corner.

A completed Intervention section should look like this:



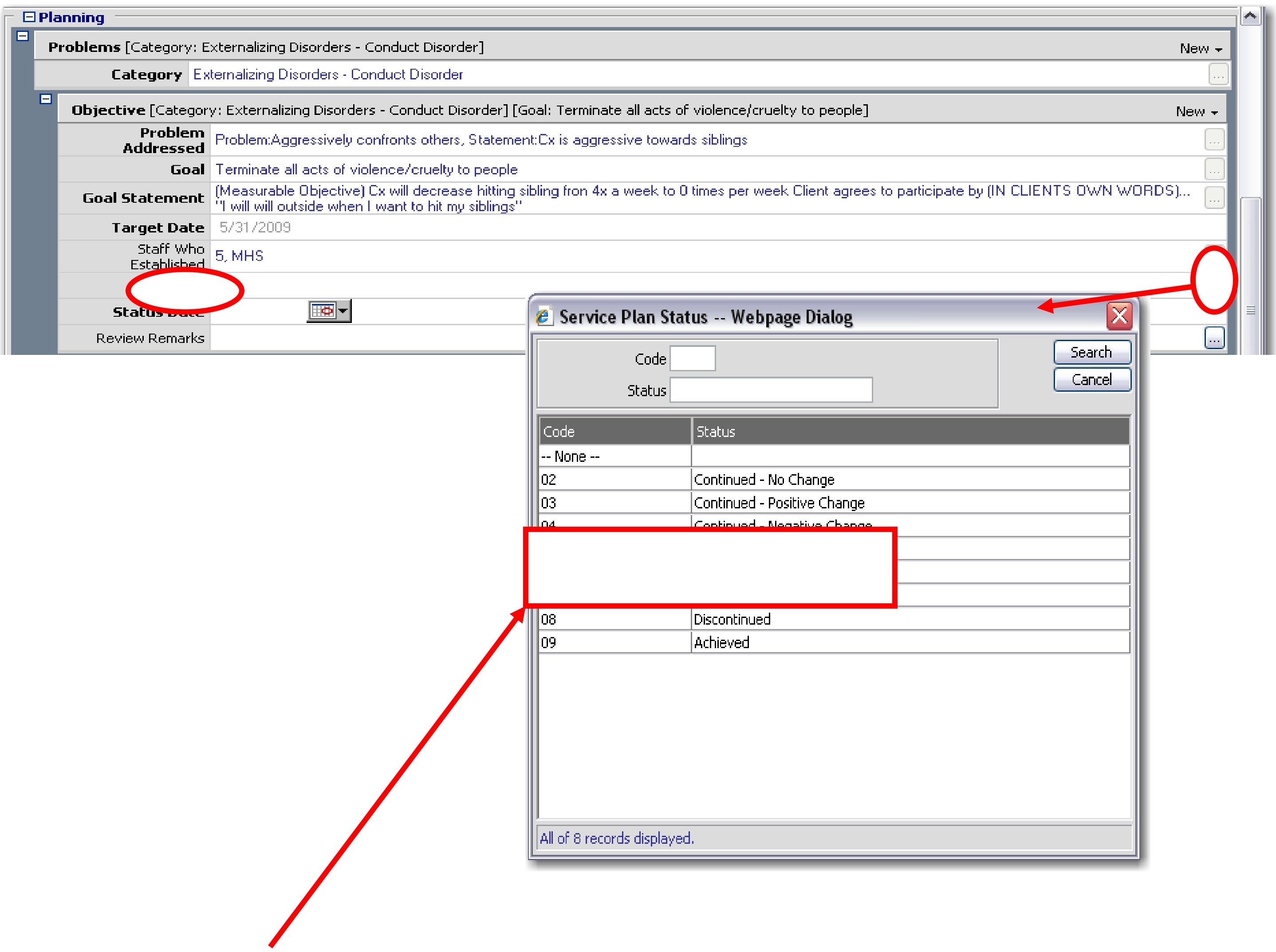
Revised-No Change, Revised-Positive Change, or Revised-Negative Change Objective Status

The Revised-No Change, Revised-Positive Change or Revised-Negative Change Status literally means the content of the Objective and/or Intervention will be changing (including the measurable part of the Objective).

When you select Revised-No Change, Revised-Positive Change or Revised-Negative Change for the objective you can edit the following fields:

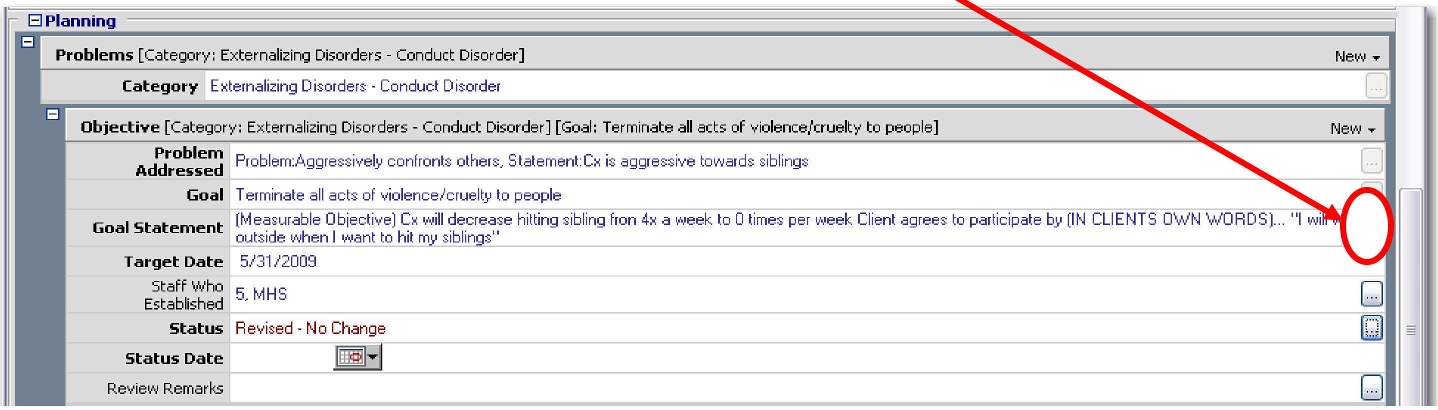
- Goal Statement
- Target Date
- Staff Who Established
- Status
- Status Date
- Review Remarks

First you have to give the objective a **Status** before you can change the Goal Statement and Target Date. To select a Status, click the ellipses button to the left of the Status field.

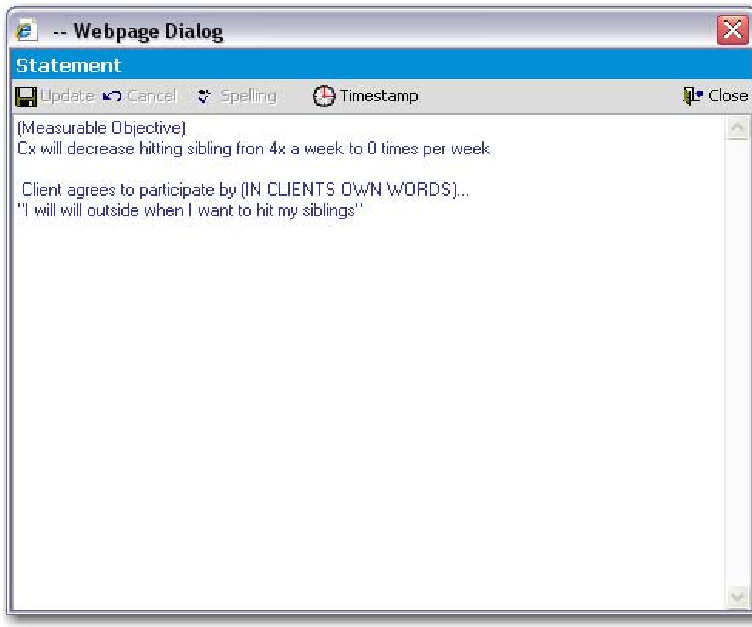


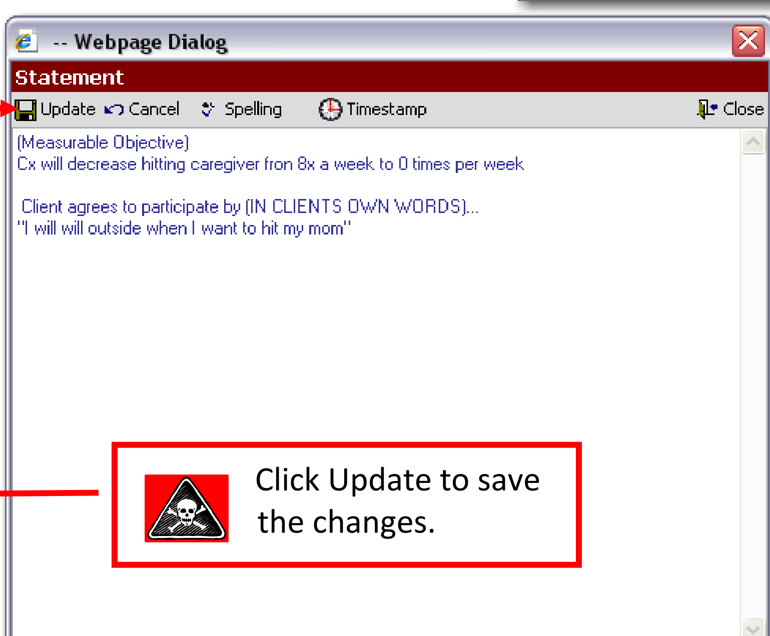
A drop down box will open, click on either Revised-No Change, Revised-Positive Change OR Revised-Negative Change.

Once the Status field is populated with any of the Revised status' you are able to **change the Goal Statement**. To do this click on the ellipses to the far right of the Goal Statement field.



A Statement drop down box will open allowing you to change the content of the objective.

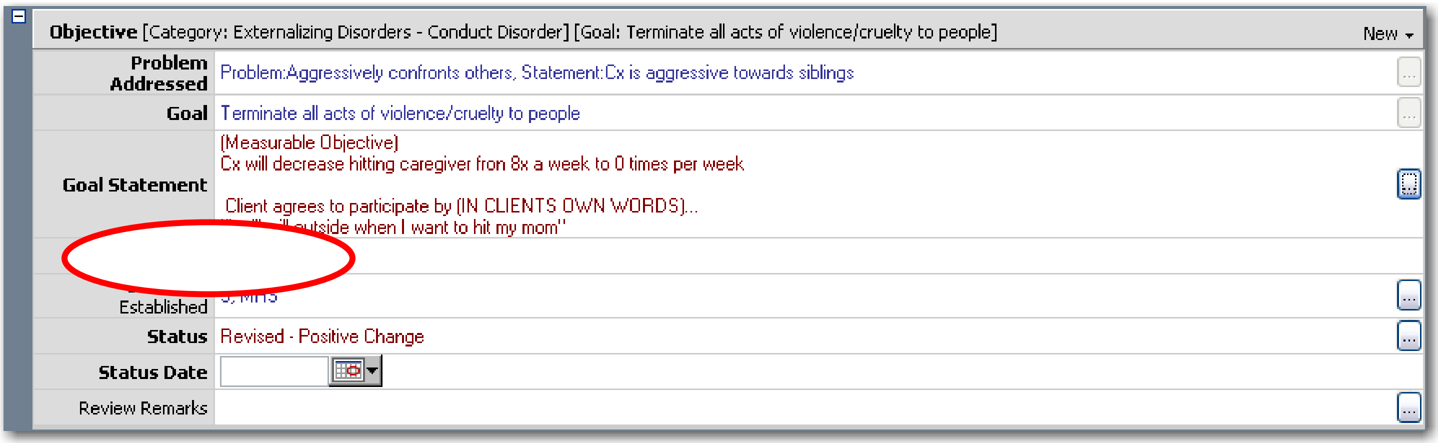




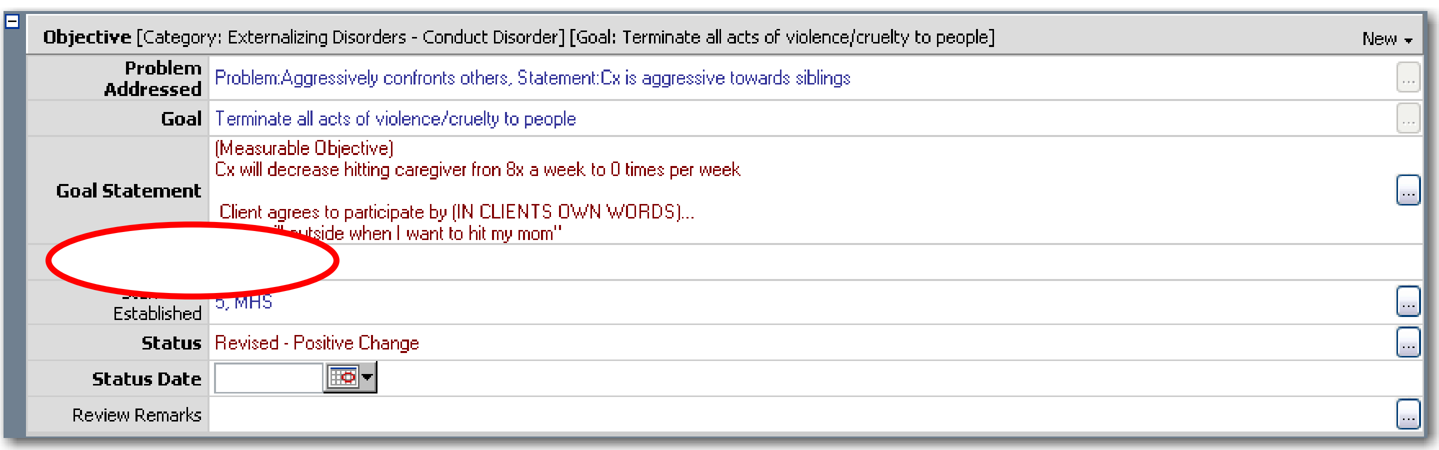
Click anywhere in the statement box and change the desired information. Changing the information DOES NOT change the original objective. You are now creating a revised objective.

Changing the Target Date

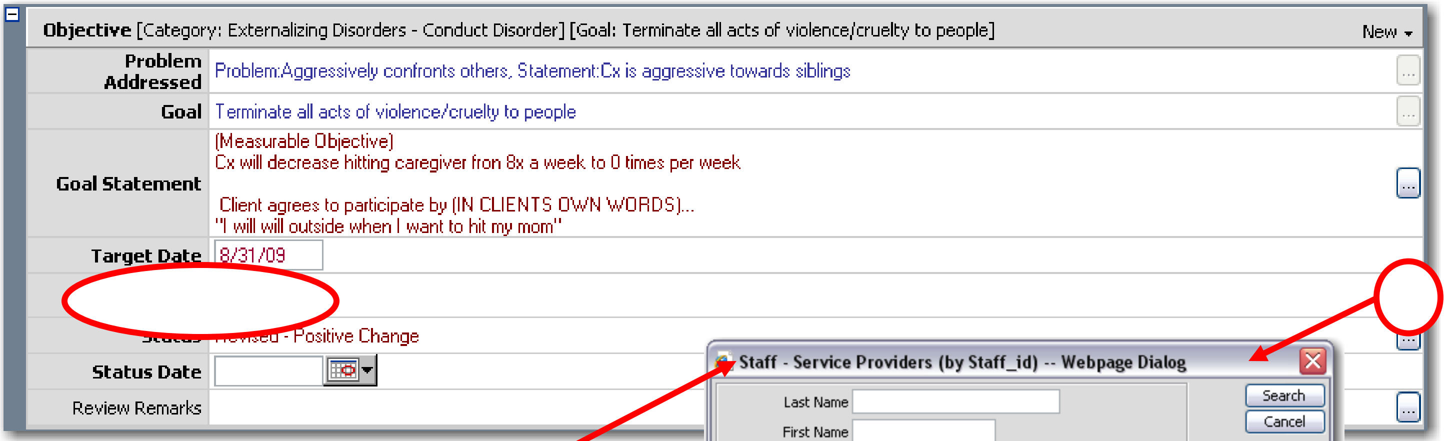
The system automatically populates the Target Date field based on the target date you entered in the previous Care Plan. You will need to change the Target Date of this objective. Remember the Target Date is the last day of the month PRIOR to the due date of the Care Plan.

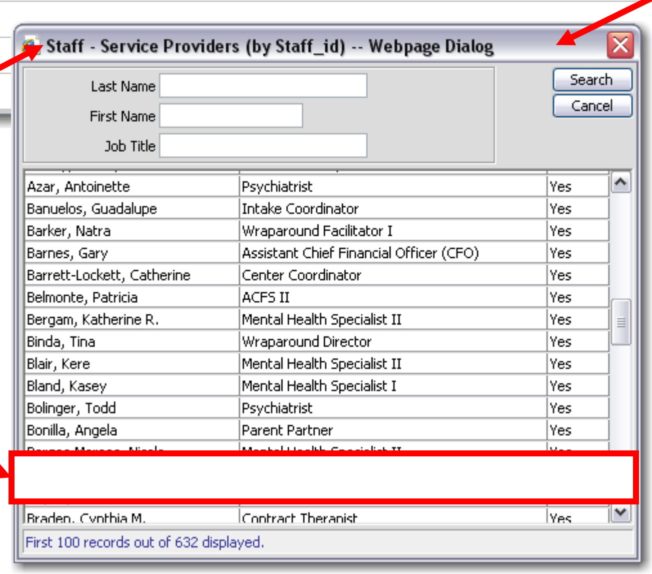


To change the Target Date you will need to click into the Target Date field and delete the pre-populated Target Date. You **MUST** type a new target date in the 00/00/00 format.



To **change the Staff Who Established** the Objective, click on the ellipses to the far right of the field.



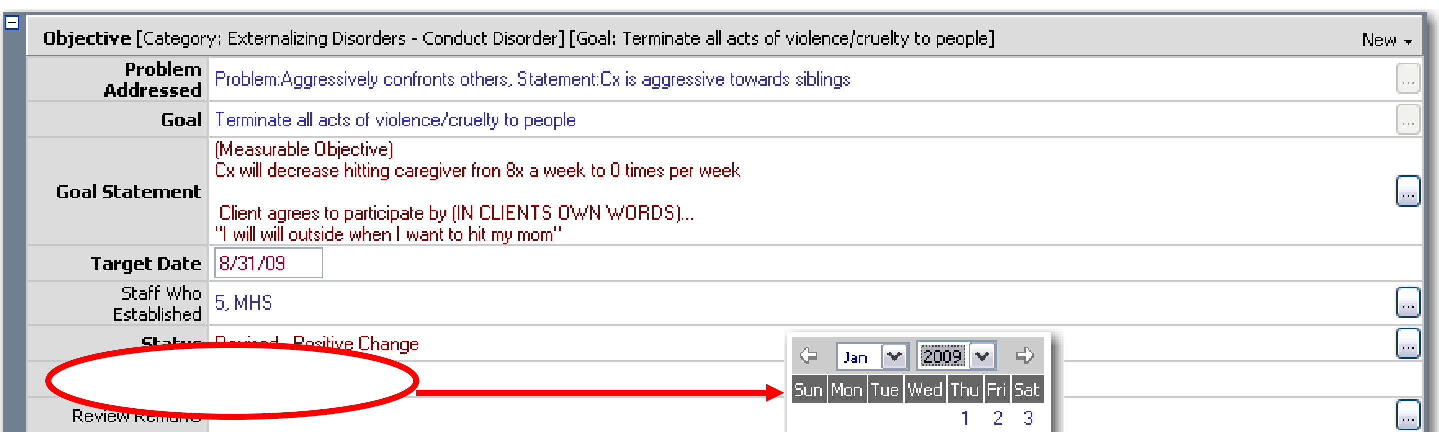


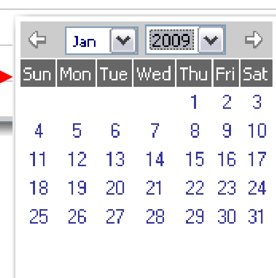
A drop down list will open.

Select the staff member's name of the person who established the objective.

If the Staff Who Established is not changing then leave the pre-populated name in this field.

Next, you will need to indicate a **Status Date** of the objective.

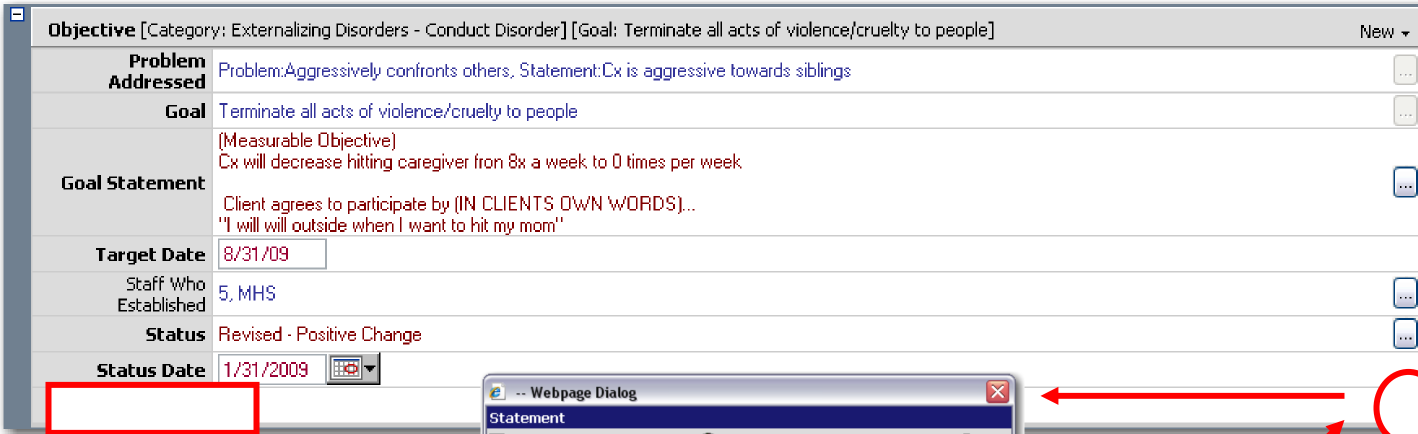


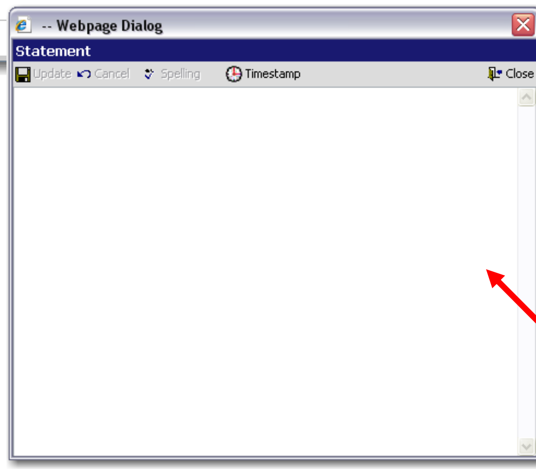


This is the date the objective was reviewed.

- Either type in date or click on the calendar and select the date
- The date will populate the filed

Next, you need to indicate more detailed information about the status of the Objective on why/how it was continued in the **Review Remarks** field.

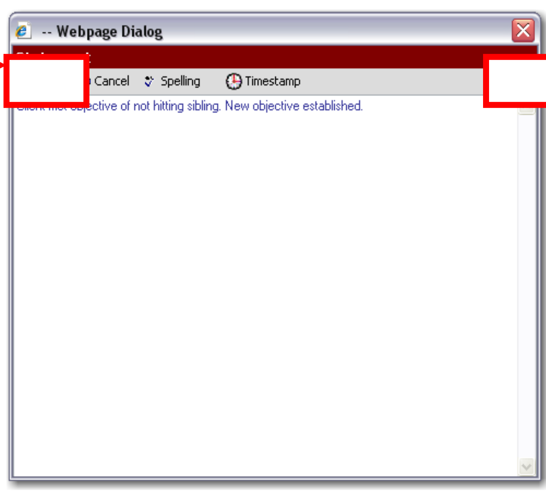


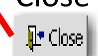


To open the Review Remarks box, click on the Ellipses button to the far right.

A blank statement page will open allowing you to free type information about the objective.

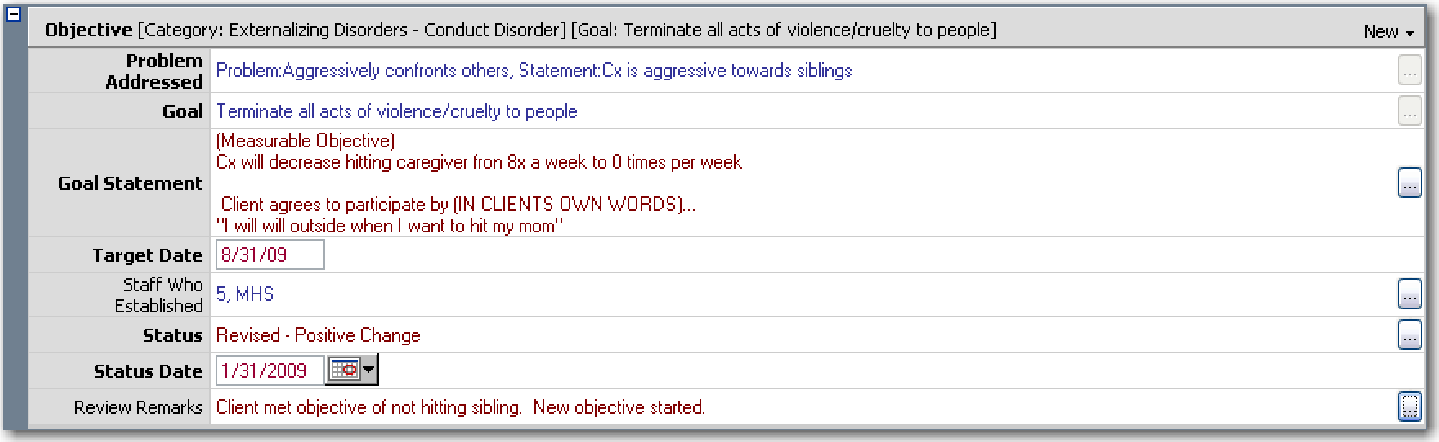

To save the information you **MUST** click update at the far left corner.



Close the box by clicking 

in the right hand corner.

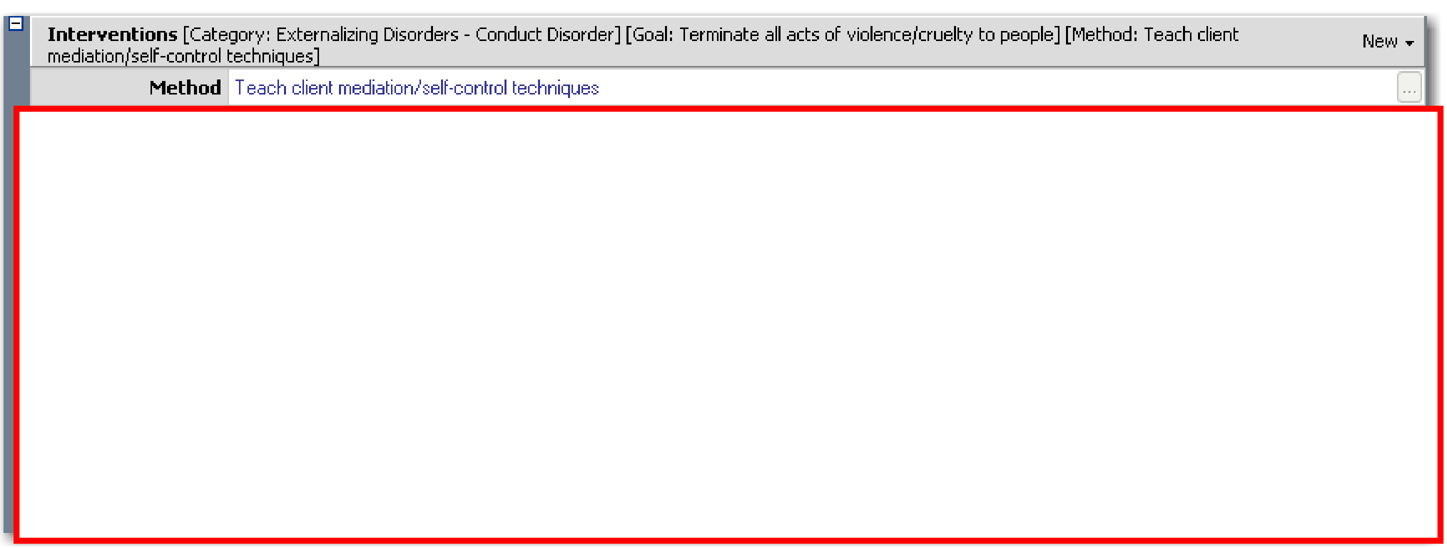
A completed Objective section should look like this:



REVISED-NO CHANGE, REVISED-POSITIVE CHANGE, OR REVISED-NEGATIVE CHANGE INTERVENTION STATUS

When you select Revised-No Change, Revised-Positive Change or Revised-Negative Change in the intervention Status you can edit the following fields:

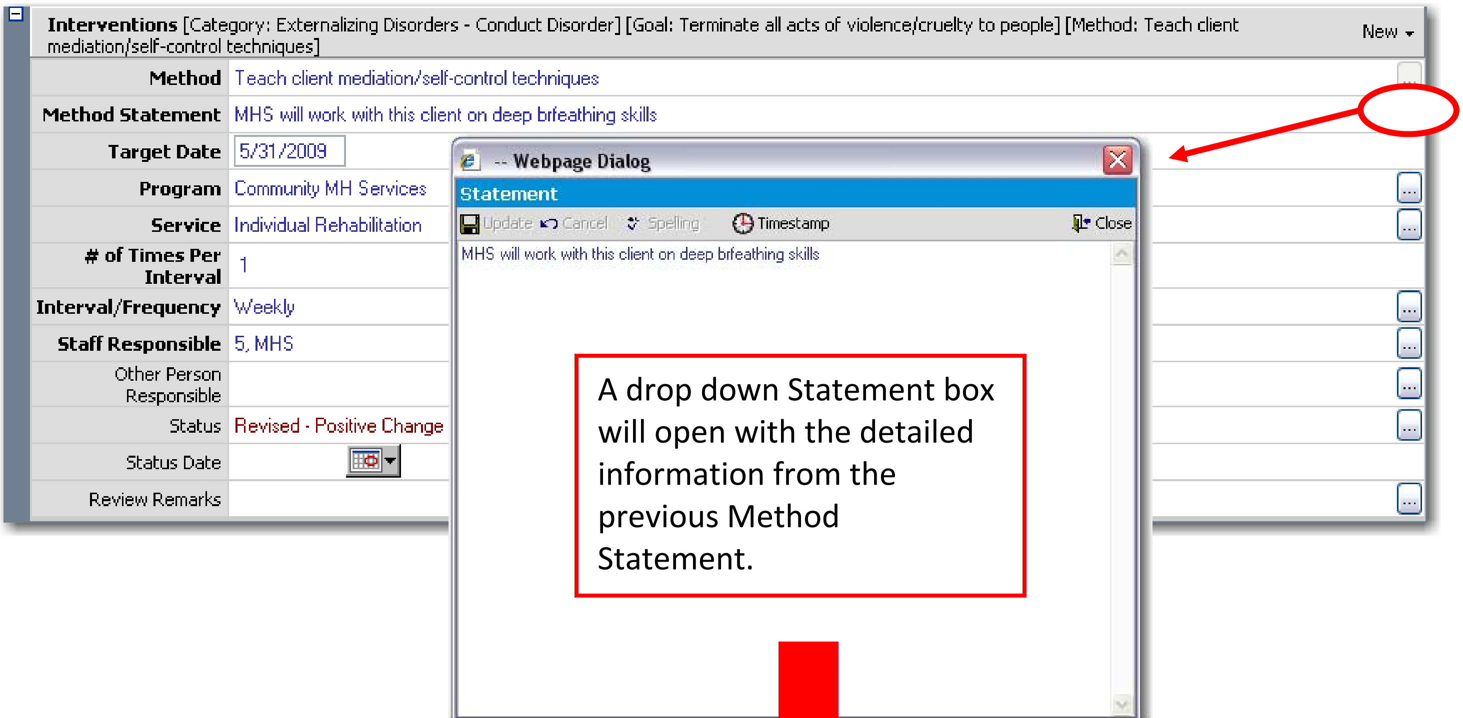
- Method Statement
- Target Date
- Program Responsible
- Service
- # of Times Per Interval
- Interval / Frequency
- Staff Responsible
- Other Person Responsible (if needed)
- Status
- Status Date
- Review Remarks



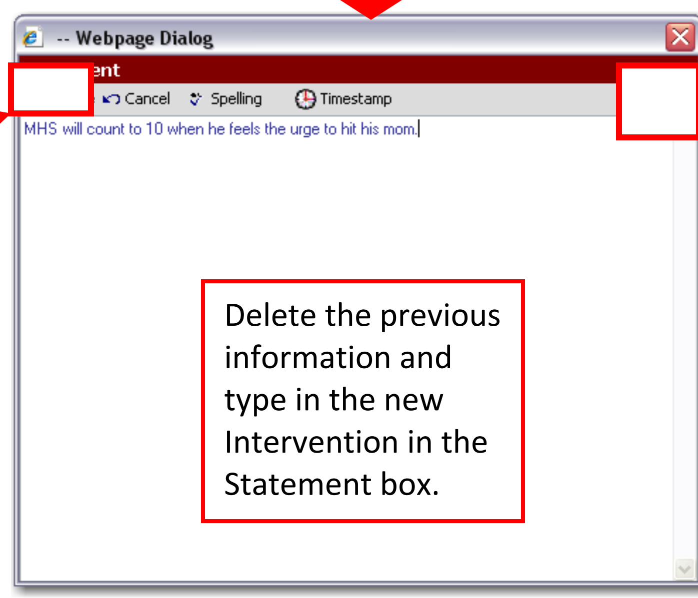
Changing the Method Statement

Changing the Method Statement is necessary if the Intervention is changing.

To change the Intervention details, click on the ellipses to the far right of the Method Statement field.



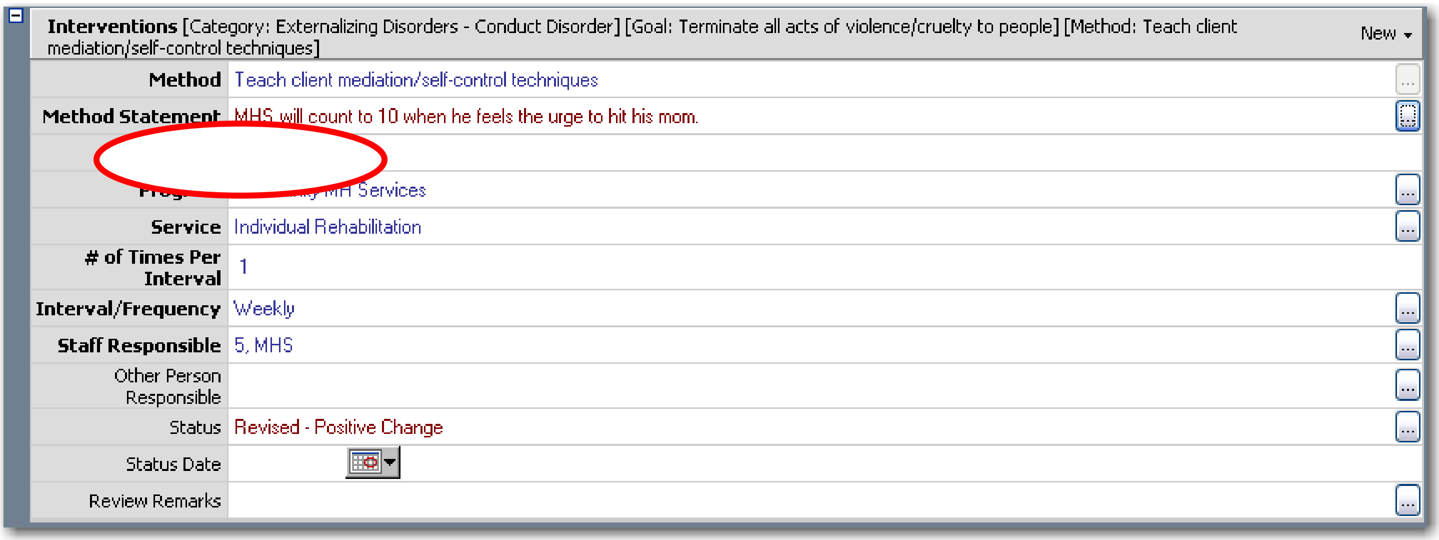
To save the information you **MUST** click update at the far left corner.



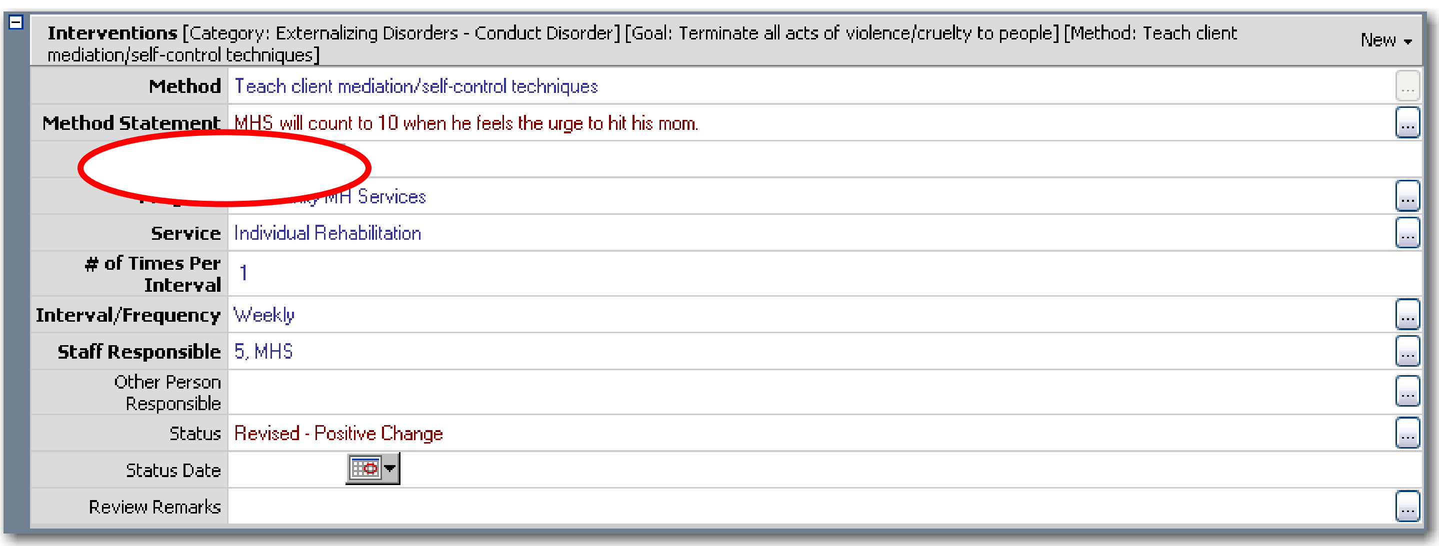
Close the box by clicking Close in the right hand corner.

Changing the Target Date

The system automatically populates the Target Date field based on the target date you entered in the previous Care Plan. You will need to change the Target Date of this objective. Remember the Target Date is the last day of the month PRIOR to the due date of the Care Plan.

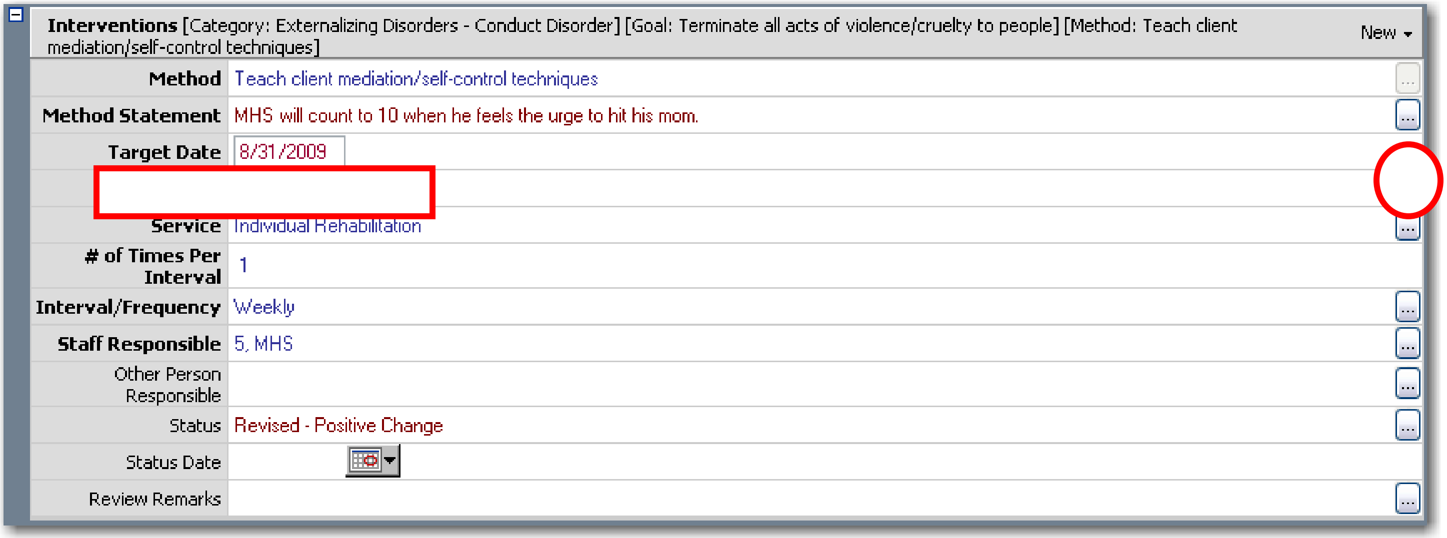


To do this you will need to click into the Target Date field and delete the pre-populated Target Date. You MUST type a new target date in the 00/00/00 format.



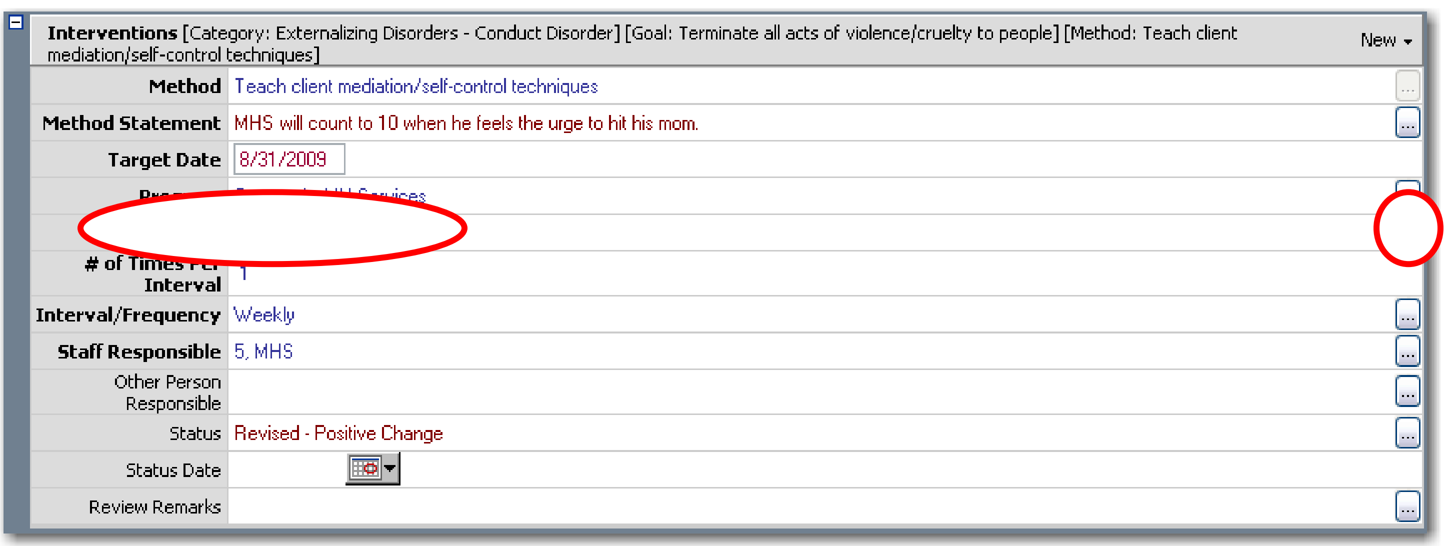
Changing the Program if needed (not likely)

If you need to change the Program that the service will be provided under you will need to click the ellipses to the right of the Program field. Changing the Program is NOT likely in which case you will leave Community Mental Health pre-populated in this field.



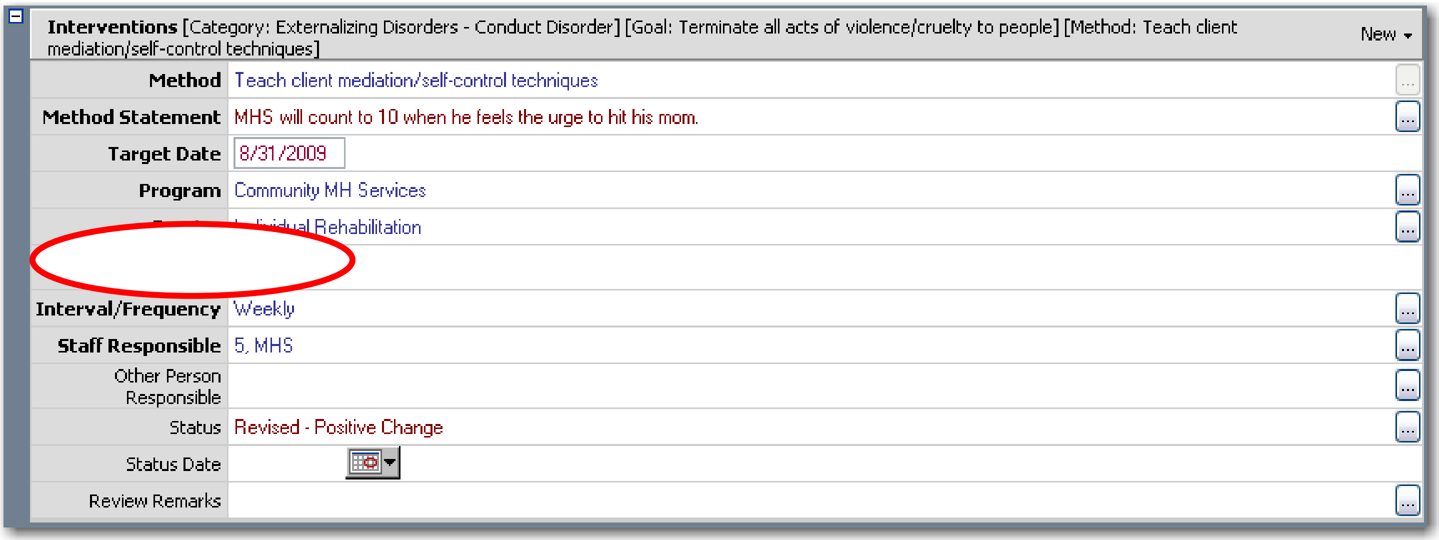
Changing the Service if needed

If the mode of Service to be used in the Intervention is going to be changed, you will need to click the ellipses to the far right of the Service field. Refer to page 27 – 28 of this manual on selecting mode of service. If nothing has changed then leave the pre-populated mode of Service in this field.



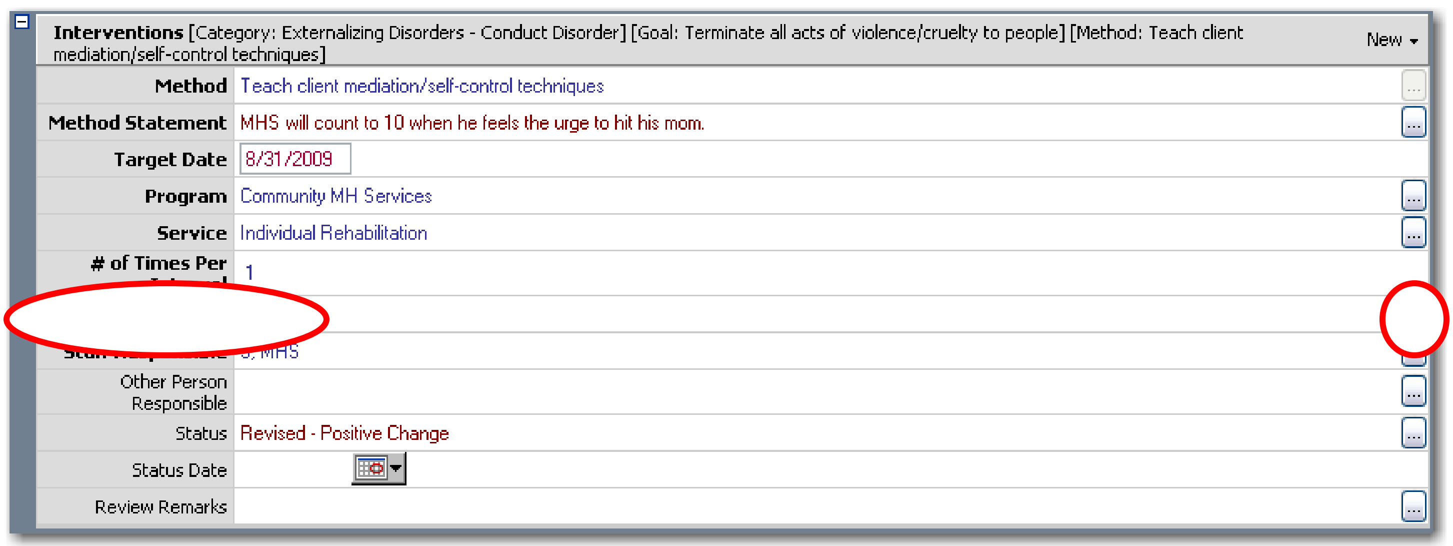
Changing the # of Times Per Interval if needed

If the # of Times Per Interval needs to be changed then click in the # of Times Per Interval field and delete the pre-populated number and type in the new number. Refer to page 28 of this manual on completing the # of Times Per Interval field. If nothing has changed then leave the pre-populated # of Times Per Interval in this field.



Changing the Interval/Frequency if needed

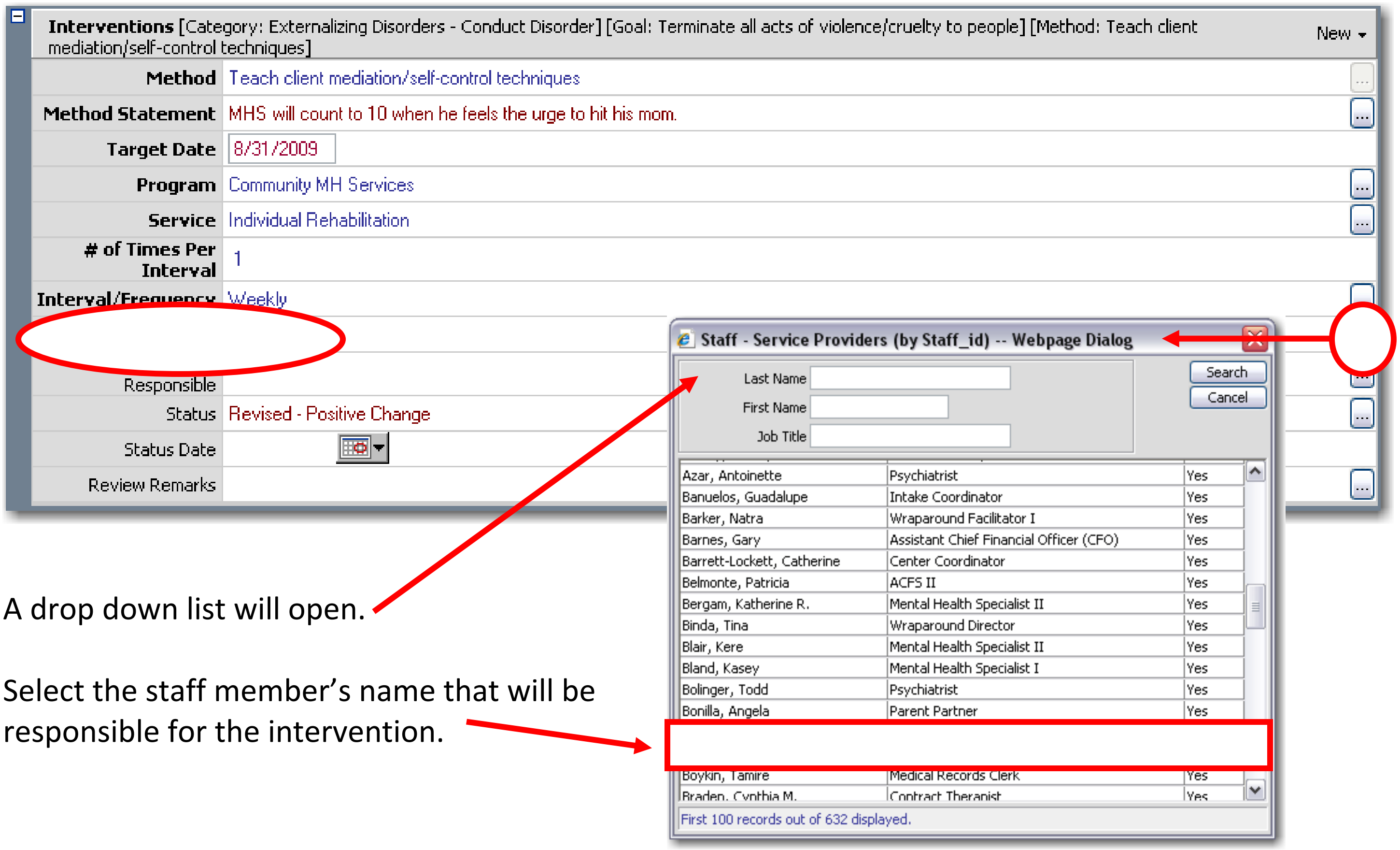
If the Interval/Frequency needs to be changed then click ellipses to the far right of the Interval/Frequency field. Refer to page 29 of this manual on completing the Interval/Frequency field. If nothing has changed then leave the pre-populated Interval/Frequency in this field.



Changing the Staff Responsible if needed

Staff Responsible for the intervention will auto-populate based on the name entered in the previous Care Plan. If the person responsible for the intervention is longer responsible (maybe they no longer working with the client) then you will need to change the Staff Responsible.

To change the Staff Responsible, click on the ellipses to the far right of the field.



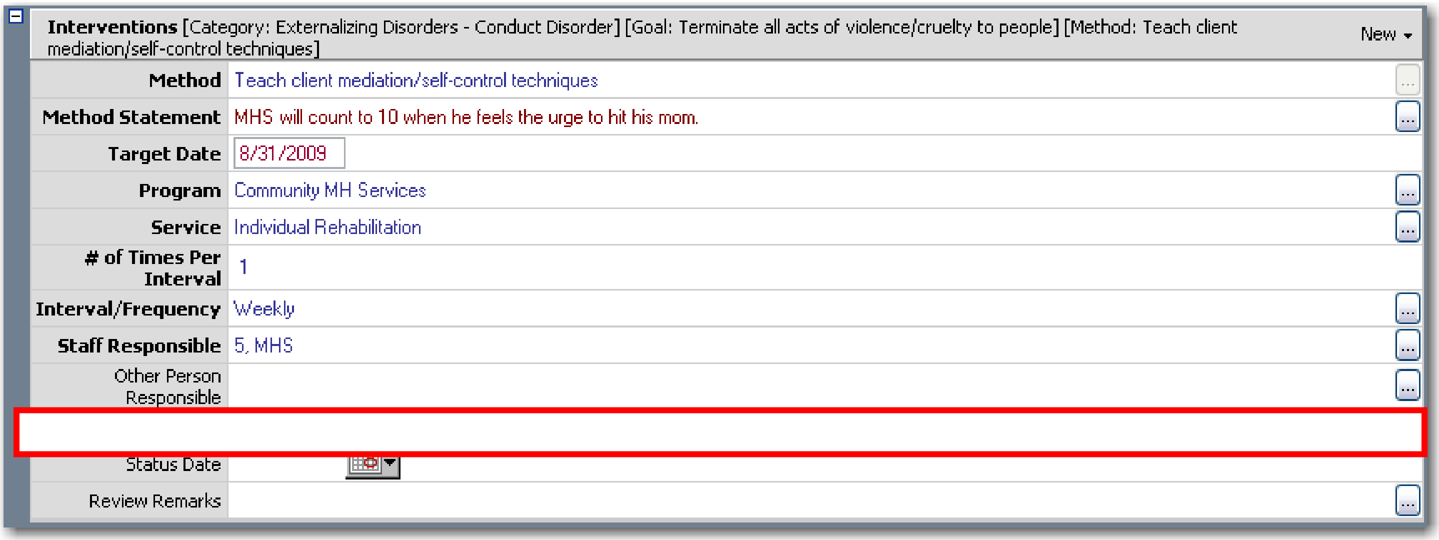
A drop down list will open.

Select the staff member's name that will be responsible for the intervention.

If there is an additional Staff Member Responsible for the intervention you are able to select them in the "Other Person Responsible" field by following the same steps. If there is no other staff responsible, leave this field blank.

Changing the Status if needed

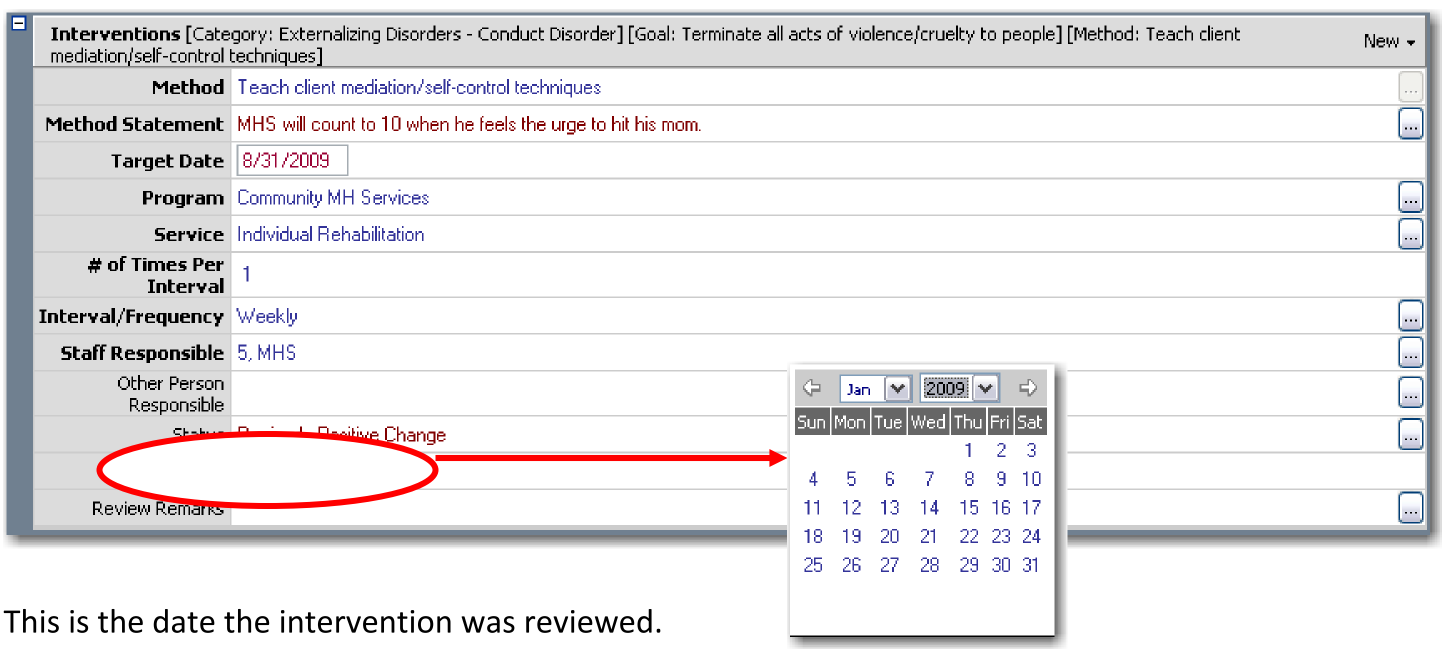
Remember, when you selected the Revised status in the Objective the EMR auto-populates the same status in the Intervention. You are able to change the status of the Intervention if desired and leave the Objective status as is.



To do so, click on the ellipses button to the far right of the Intervention status and select a different status.

Status Date

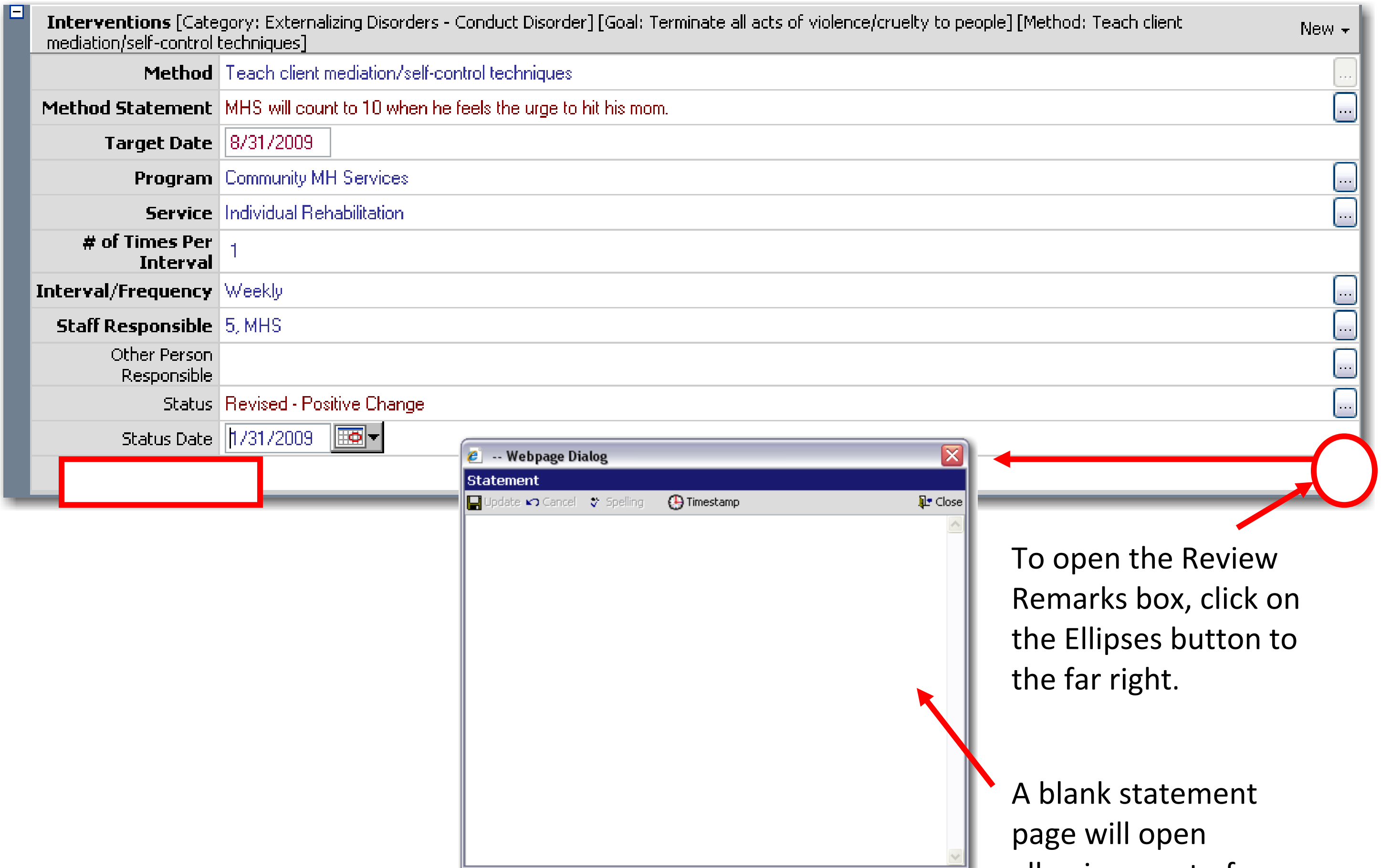
Next, you will need to indicate a "Status Date" of the intervention.



This is the date the intervention was reviewed.

- Either type in date or click on the calendar and select the date
- The date will populate the filed

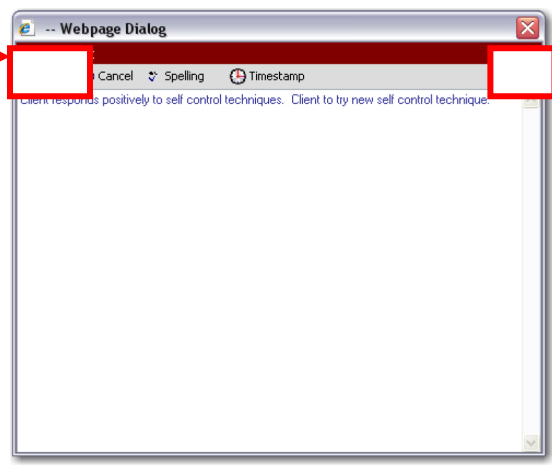
Next, you need to indicate more detailed information about the status of the intervention on why/how it was continued in the **Review Remarks** field.



To open the Review Remarks box, click on the Ellipses button to the far right.

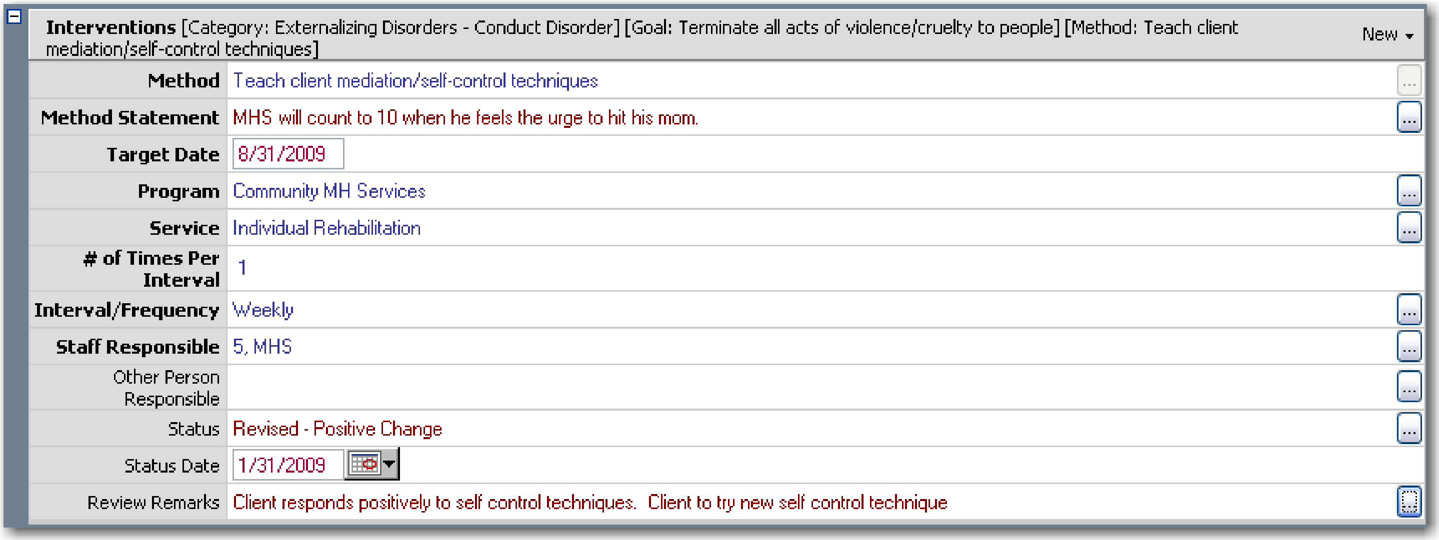
A blank statement page will open allowing you to free type information about the objective.

 To save the information you **MUST** click update at the far left corner.



Close the box by clicking  in the right hand corner.

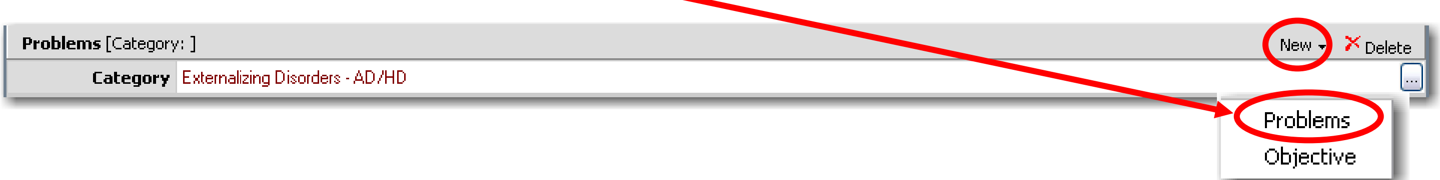
A completed Intervention section should look like this:



ADDING ADDITIONAL PROBLEM CATEGORIES

You have the ability to add additional problem categories for clients who have Axis I primary and secondary diagnoses. To do so:

- Click on New
- A drop down box will open
- Select Problems

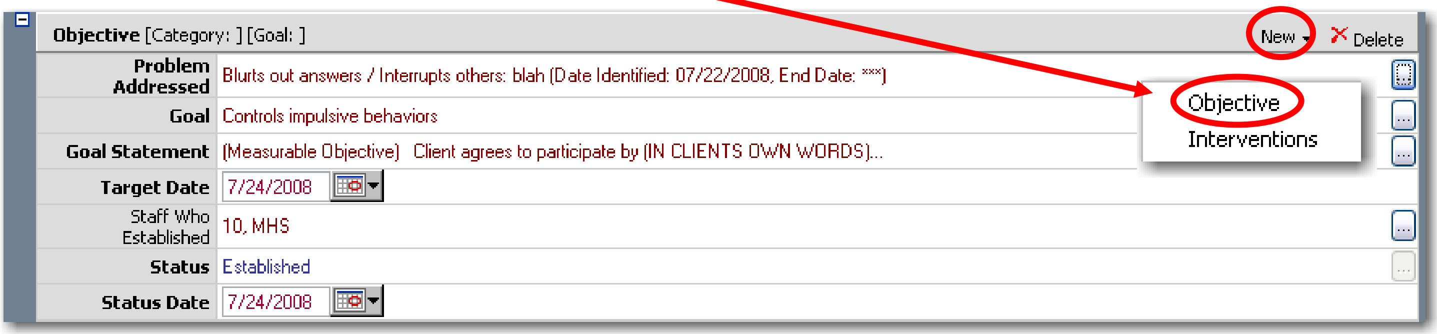


- A new Problem, Objective and Intervention section will open
- Follow the same process as when you completed the first Problem

ADDING ADDITIONAL OBJECTIVES

You have the ability to add additional objectives under this problem category. To do so:

- Click on New
- A drop down box will open
- Select Objectives

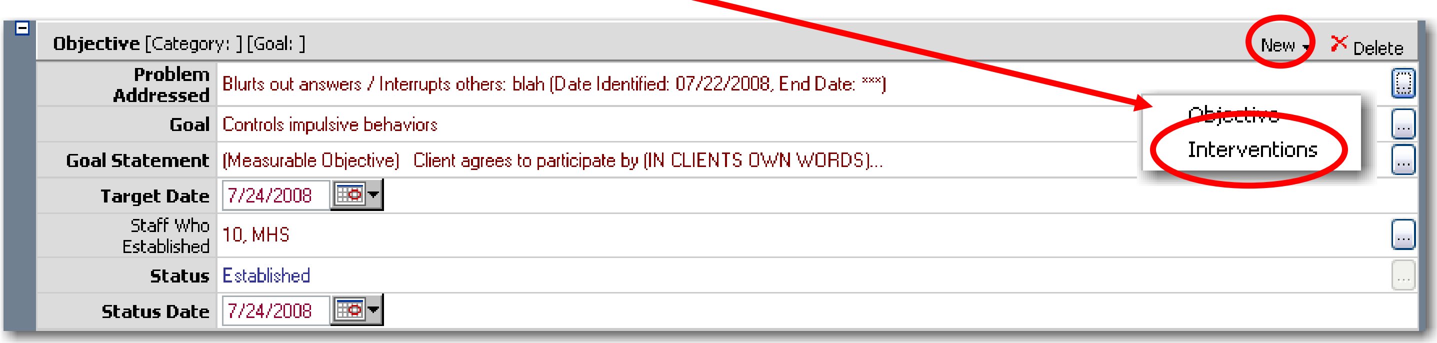


- A new Objective and Intervention section will open
- Follow the same process as when you completed your first Objective

ADDING ADDITIONAL INTERVENTIONS

You have the ability to add additional Interventions under this problem category. To do so:

- Click on New
- A drop down box will open
- Select Interventions



- A new Intervention section will open
- Follow the same process as when you completed your first Intervention

CURRENT DIAGNOSIS

This is a **view only** display of the current diagnosis. It can not be edited here. If there is a need to change the Diagnosis an MHS II must complete a Change of Diagnosis form and turn it into the Center/TM Intake Coordinator. Then complete the billing for the Change of Diagnosis in the EMR.

Current Diagnosis

Diagnosis

Axis	Date	Priority	Priority Description	Diagnosis	DSMIV	ICD9	GAF Score
	6/6/2006	2	Secondary	DEPRESSIVE DISORDER NEC	311	311.	
1	6/1/2008	1	Primary	AD/HD Combined Type	314.01	314.01	
2	6/1/2006	9	Other	Diagnosis Deferred on this Axis	799.9	799.9	
3	6/1/2006			Premature Infant	765.1	765.1	
4	6/5/2008			Problems with primary support group			
5	6/1/2006			45			45

SIGNATURES

The signature section can not be edited. They are place holders for signatures when printed.

Signatures

*Client Signature and Date

*** Document reason for lack of Signature in note. Signature must be obtained at next visit.**

Caregiver Signature and Date

LPHA Signature and Date

* Psychiatrist/MD Signature and Date

*** N/A if client is not being treated by the Psychiatrist**

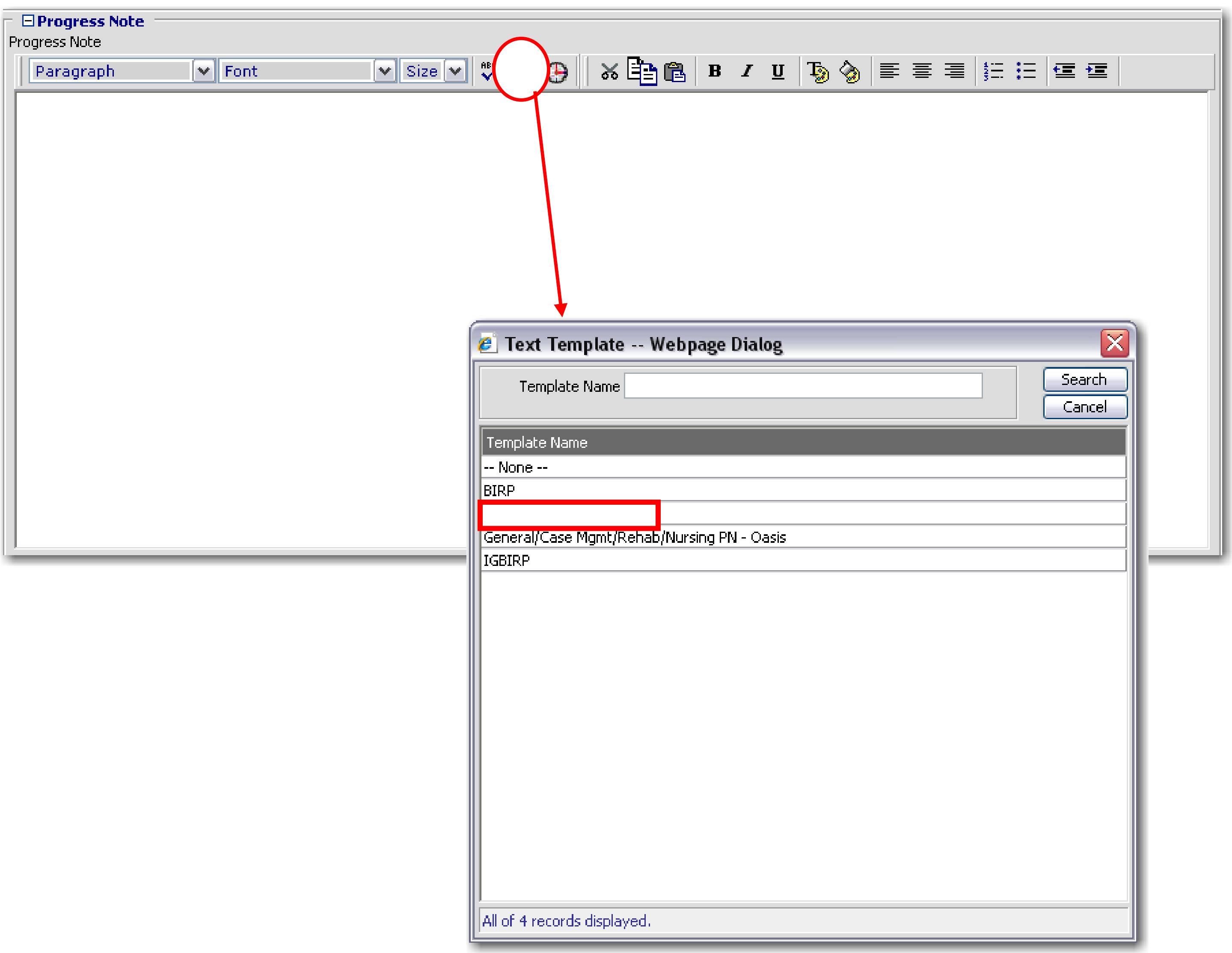
Cx received copy of Care Plan (Cx initials / date)

When you print the Care Plan to bring to the Caregiver and client to obtain their signatures make sure that you obtain ALL the signatures listed above. Sometimes when the Care Plan is printed some of the signature lines will end up on a separate printed page. You are REQUIRED to obtain ALL relevant signatures including the Client's Initials indicating they have received a copy of the Care Plan.

PROGRESS NOTE

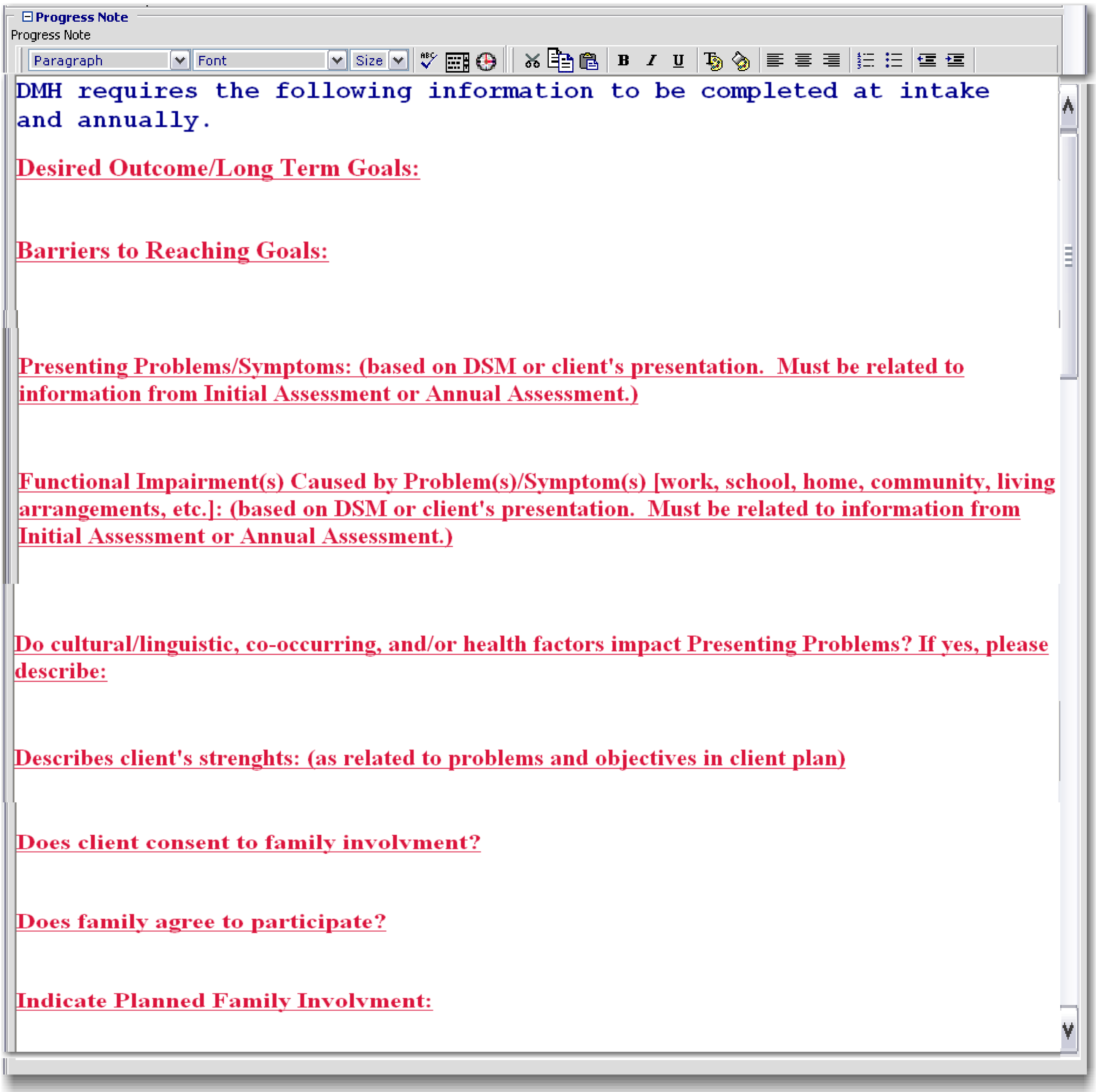
For the Initial Care Plan and Annual update you would select the Care Plan PN template. NOTE: For the 6-month update you would type in the progress note field "completed client care plan".

- To select the Care Plan PN template click on the template icon (circled below)
- Click on Care Plan PN Template

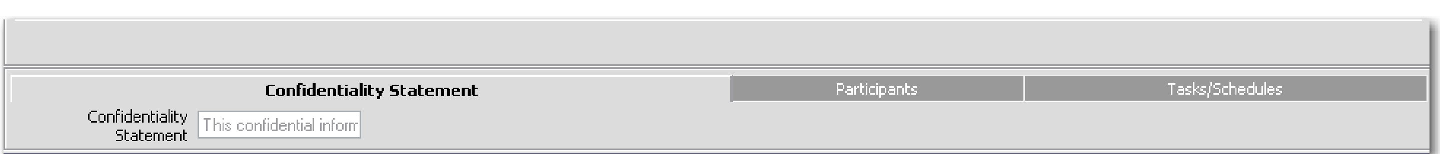


Care Plan Progress Note Template

The following headers will populate the Progress Note field. Type appropriate information under each header.



You do not need to enter or complete the Confidentiality Statement, Participants or Tasks/Schedules tabs.



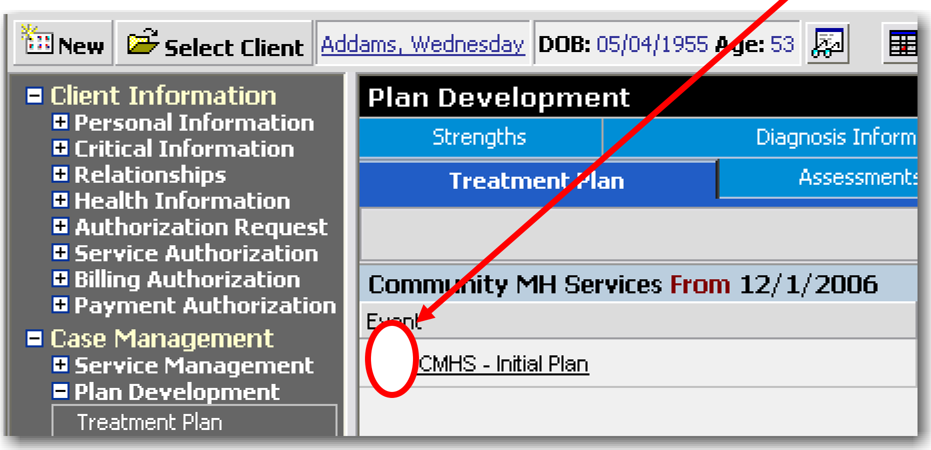
SAVING THE UPDATED CARE PLAN / TREATMENT PLAN

After **ALL** required **(bolded)** fields are complete you are ready to save the Care Plan/Treatment Plan. You MUST save the Care Plan first before you can submit it to your supervisor or designee; notice the "submit" button is not available.

At the top of the Care Plan/Treatment Plan click on the 

button.

The Care Plan/Treatment Plan will close and you will be brought back to the Treatment Plan page. You can now see the Care Plan/Treatment Plan in draft format indicated by the  (pencil) to the left of the Care Plan.

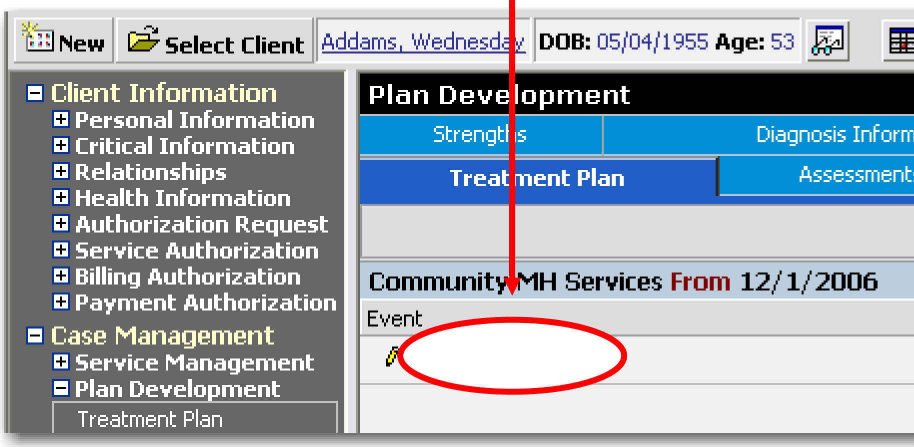


If you have missed any of the bolded (required) fields, you will receive an error message indicating what information must be complete before you can save. Below you can see an example of the error message you will get if you did not complete the "Other Time" field.

SUBMITTING THE UPDATED CARE PLAN / TREATMENT PLAN

In order to submit the Care Plan to your supervisor or to the designee you MUST open up the Care Plan again. Do NOT leave the Care Plan in Draft status after its due date. A Care Plan in draft status will not be billed and is not considered a final Care Plan until the supervisor approves it.

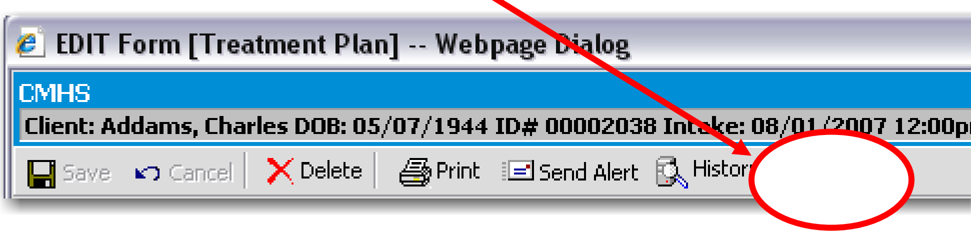
To open the Care Plan again, click on the words "CMHS – Initial Plan" or "Review Plan".

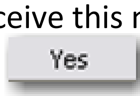


The Care Plan will open in Draft format.

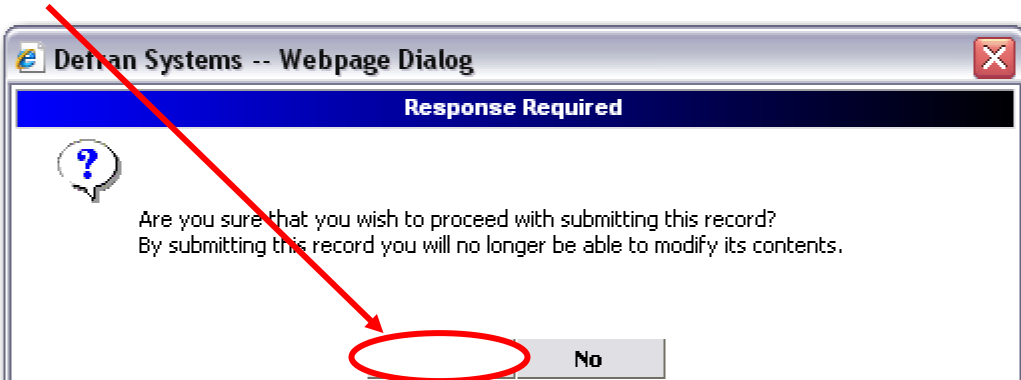
At the top of the Care Plan the 

button is now available; Click on it.



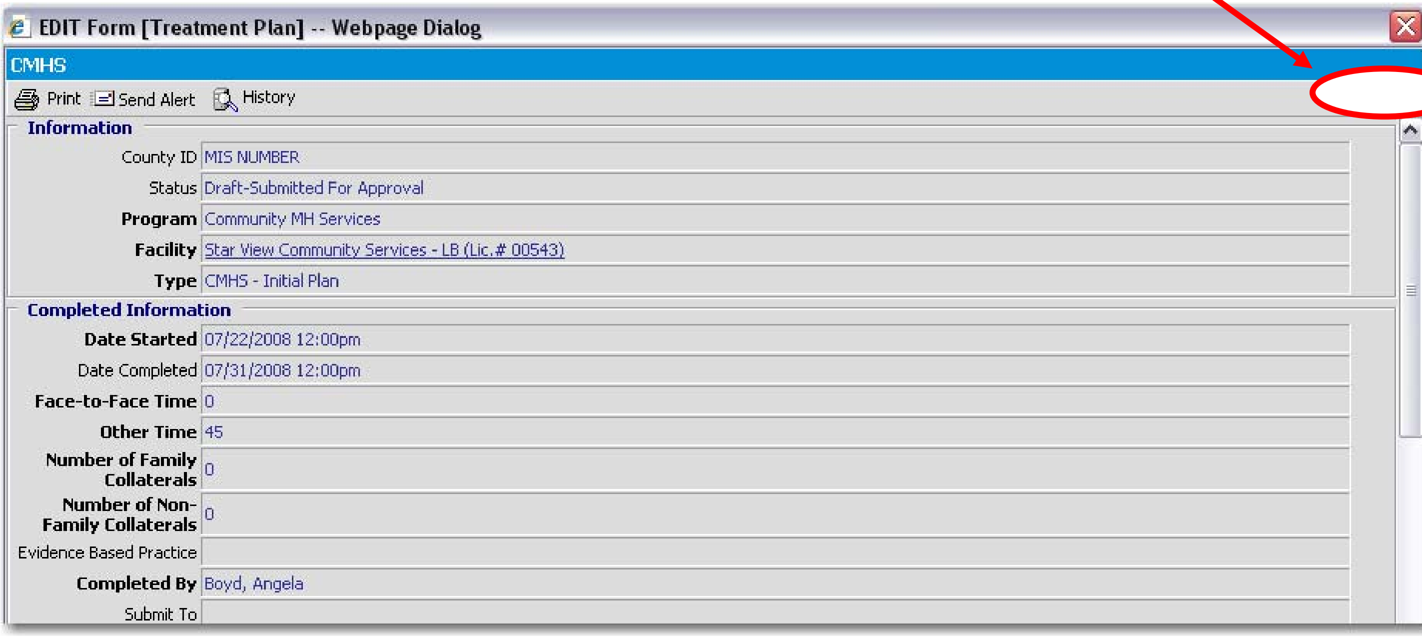
You will receive this message asking you if you are sure you want to proceed with submitting the Care Plan. Click 

.

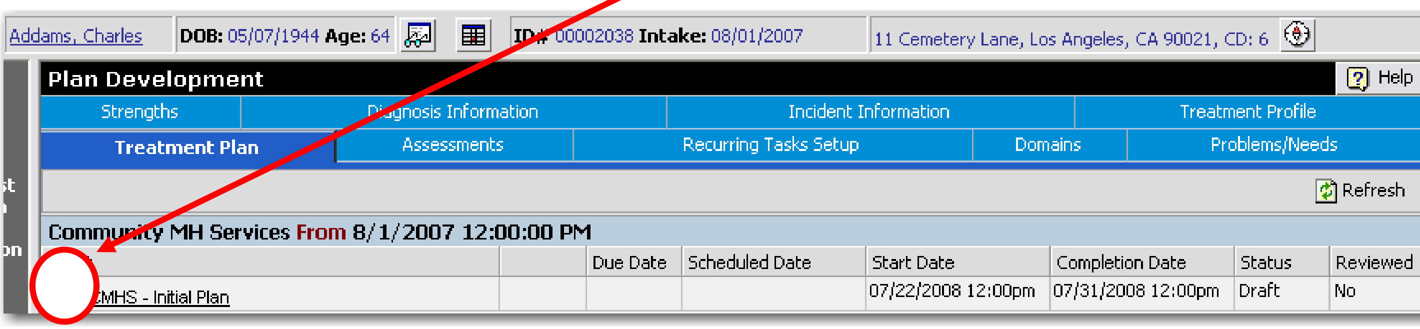


The Care Plan will now show in a format that is not editable. Click the 

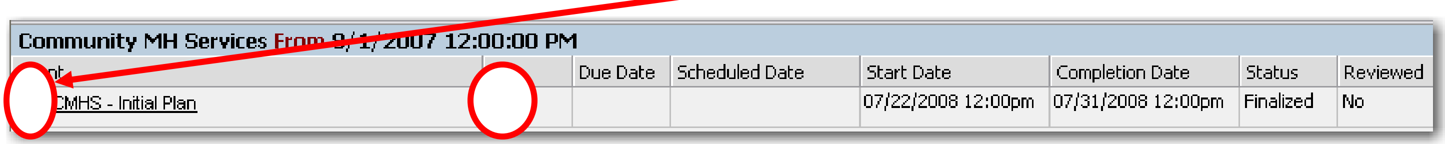
button to return to the Treatment Plan screen.



You will now see the Care Plan listed with an envelope  to the left of the service in the Treatment Plan screen.



When your supervisor or designee APPROVES the Care Plan you will see a green check mark  to the left of the service.



Also notice the eyeglass icon  to the right of the service. The eyeglass icon indicates the Care Plan can be updated.

Repeat the Update process for each subsequent Care Plan update.

Completing the Discharge Care Plan

When discharging a client you **MUST** update the Care Plan and complete the outcome for each objective on file for the client. In the EMR the outcome is a combination of the status date, status and review remarks for the objective and intervention AND ending the Problems / Needs on file for the client.

Ending Problems / Needs at the time of Discharge: follow the instructions on pages 39 – 40.

Updating the Care Plan at the time of Discharge: follow the instructions on pages 42 – 51 and 76 – 80 of this manual.

- Exception to the **Date Started** in the Updated Care Plan
    - If you are completing an *Administrative D/C* you ***need*** to use the Last Billable Date of Service as the **Date Started** AND **enter 0 (zero) minutes in both Face-to-Face AND Other Time** (doing this will prevent a problem with discharging the client in the EMR and prevent the service from being billed)
    - If you are NOT completing an Administrative D/C refer to page 15 of this manual for a definition of Date Started
- Under **Status**, select either Discontinued OR Achieved and then follow the instructions on pages 49 – 51 of this manual

Un-approving / Un-sumbitting the Care Plan / Treatment Plan

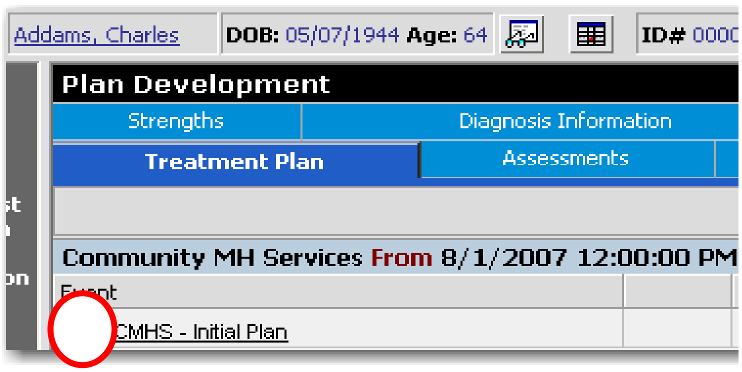
IF you make a mistake on the Care Plan, depending on the status of the Care Plan, you need to do the following:

Draft status (indicated by the pencil icon to the left of the service):

- You are able to click into the Care Plan and change the information at anytime.

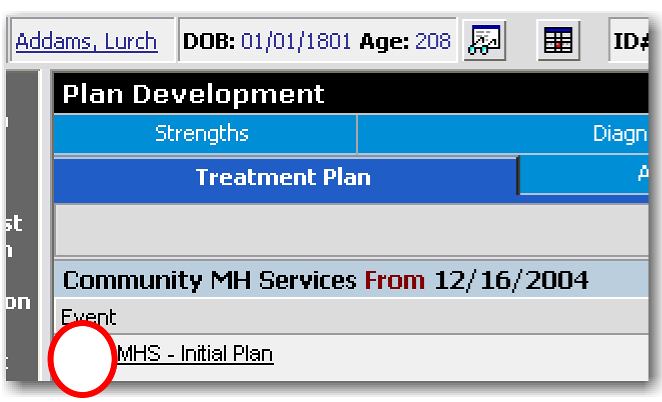
Submitted status (indicated by the envelope icon to the left of the service):

- Contact your supervisor and request they UN-SUBMIT the Care Plan back to you to make the needed corrections. Once the Care Plan is un-submitted it will show in draft status.



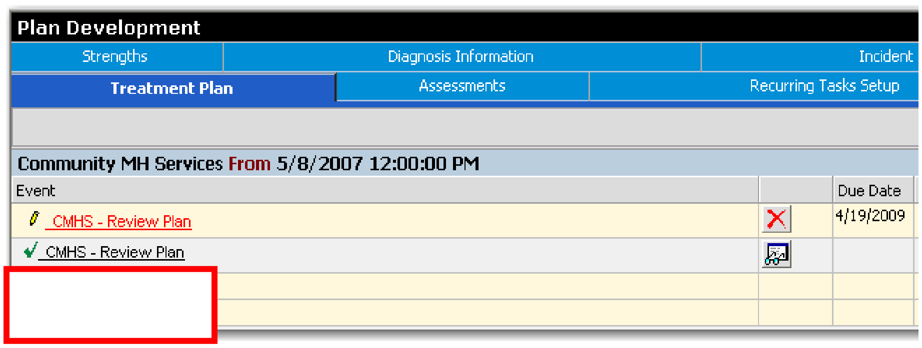
Approved status – single Care Plan (indicated by the green check mark to the left of the service):

- Contact your supervisor and request them to UN-APPROVE and UN-SUBMT the Care Plan back to you to make the needed corrections.
- Once the Care Plan is un-approved AND un-submitted it will show in draft status.



<u>Approved</u> status – multiple Care Plans (indicated by the green check mark to the left of the service):

- Once a Care Plan (either the Initial or Review Plan) has been approved AND you started the next Review Plan, the previous Care Plan(s) - either the Initial or Review Plan - are a PERMANENT part of the client's record and CAN NOT be changed. Your supervisor will not have the option to un-approve / un-submit the care plan.
- The ONLY way to correct mistakes on an approved Care Plan in this situation is to Discontinue the Objective or Intervention on the next Review Plan and add a new Area of Treatment, Goal or Method with the correct information.



If you have any questions about the Care Plan, contact your QA Manager/Coordinator.