



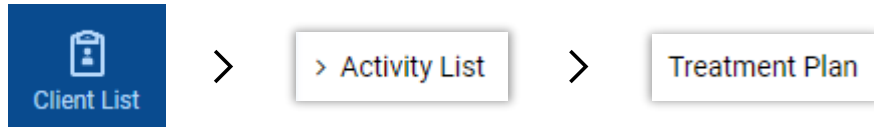
UWITS Treatment Plan Guide

This is a visual guide to the functionality available in the EA Treatment Plan. Creation of a Treatment Plan allows for tracking diagnosis, assessments, and status of Problems, Goals, Objectives and Interventions.

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EA Treatment Plan Guide –



Overview: The EA Treatment Plan will be used primarily for Mental Health and co-occurring MH/SUD clients. This structure allows for the creation of a Treatment Plan with association to active Assessments, current Diagnosis and association of Goals, Objectives, and Interventions in the Mental Health Encounter notes.

Caveat: Once a Treatment Plan has been signed, it can no longer be deleted. A new plan would have to be created.

Navigation: Once in a client’s Open Episode, navigate to the new module, “Treatment Plan”. The Treatment Plan main screen displays the **active plan** at the top and the plan history at the bottom.

Requirements:

1. To create a Treatment Plan the client must be **enrolled in a program**.
2. Rights must be granted to Treatment Team members to “Sign” or “Sign and Finalize” the Treatment Plan module.
3. At least one staff must be added to client’s Treatment Team. A Treatment Team member must sign and finalize to make the plan active.
4. All plans must include at least one Problem with a Goal, Objective and associated Intervention.

MAIN DISPLAY

Treatment Plan + Add Treatment Plan

Treatment Plan: 2.0
Status: Active
Active Timespan: 04/23/2021 -
Next Review: 10/20/2021

Need: Living environment is not supportive of recovery
Goal: Move to a more supportive environment
Objective: Surround myself with people who will support my recovery
Interventions:
Find a new apartment

Start Review View

ADD a “NEW” Treatment Plan, OR VIEW the displayed plan

History
Review of any Treatment Plan or Pending Review.
Status of each version of a plan is displayed.

Main Screen Navigation Tips
Arrows allow for segments to be expanded or collapsed.
History
Selecting a plan from the HISTORY section will show an overview in the Main Display section.

Treatment Plan Status
Pending: An unsigned Treatment Plan. Only a Pending plan can be deleted. All required elements must be completed for the plan to be signed.
Active: The current signed Treatment Plan.
Retired: Treatment Plan that is superseded by a newer signed version.

2.0
2.0 Pending 04/23/2021 -

1.0
1.0 Retired 04/22/2019 - 10/19/2019 → 1.1 Retired 10/20/2019 - 04/19/2020 → 1.2 Retired 04/20/2020 - 04/21/2021 → 1.3 Active 04/22/2021 -

Treatment Plan Workspace –

From within the Treatment plan the workspace is set up as follows:

Client information

View History of activity

Prints all expanded panels

Back to Main

Jump to a specific panel

Tip! The Profile, Diagnosis and Assessments panels can be completed in advance.

PANELS

- Profile (required):** Version number, Status, Active Timespan for plan, Next Review Date, Review Period (# of Days)
- Diagnosis (required):** Either carried over from most current on Diagnosis list or newly entered Diagnosis
- Assessment:** Options to associate ASAM from Outcome Measure, Behavioral Health Assessment (BHA), Mental Health Assessment (MHA), Multi-Dimensional Assessment.
- Outline (required):** List of Problems, Goals, Objectives, and Interventions
- Client Participation (required):** 3 Questions regarding client's participation in the formulation of Treatment Plan
- Treatment Team (required):** All persons listed on Treatment Team. All clients must have at least one Treatment Team member to complete a Treatment Plan.
- Sign Off:** **Required** to have Treatment Team members sign off to activate the plan. **Once a signature has been added all modification is disabled.**

Completion Requirements-
All listed requirements must be completed prior to any Treatment Team member signature.
Each item will stop being displayed when the element is completed.

The plan is Active only when "Signed and Finalized".

Adding a New Treatment Plan

+ Add Treatment Plan

Add Treatment Plan

Active Timespan
 - Has end date

Review Period (Days)

Next Review Date

Copy values from Active Plan if available.

After clicking on **+ Add Treatment Plan**, you will be presented with a window to enter dates for the new Plan. Information populated here will appear in the PROFILE panel.

Active Timespan requires a start date.

*Any field with a vertical colored or striped bar on the end is **required**.* →

Active Timespan

Has End Date is optional.

Review Period (Days) is optional. If entered the "Next Review Date" will be automatically calculated.

Next Review Date is optional. If entered the "Review Period (Days)" will be automatically calculated.

If neither the "Review Period (Days)" or the "Next Review Date" are populated a default of thirty (30) days will automatically be calculated from the Active Date for the Next Review Date.

Upon **SAVE** the Treatment Plan Workspace will be opened in EDIT mode.

RUNNER, Road

R9R052704M
UNIQUE CLIENT ID

16

1
CASE #

5/27/2004
DOB

Male
GENDER

road.runner@beepbeep.org

PREFERRED METHOD OF CONTACT

Home Page

Agency

Clinical Dashboard

Client List

System Administration

← Treatment Plan Workspace

Profile

Version: 1.0	Status: Pending	Active Timespan: 04/19/2021 -
Next Review Date: 10/16/2021	Review Period (Days): 180	<input type="button" value="Edit"/>

Notes: No Items

Completion Requirements

- Associate Diagnosis
- Add Problem
- Add Intervention
- Complete Client Participation

Arrows expand or collapse section

In Edit Mode, Mouse over data will display option to EDIT.

Notes can be added to the Profile section
Note Type:
"Clinician Comments" OR
"My comments are"
 All Notes are Time and Date Stamped.

Expand all/
Collapse all panels

Completion Requirements will update as elements are added.

Diagnosis

Diagnosis

Effective Date: 04/19/2021 Diagnosing Clinician:

Primary Diagnosis: F15.10-Other stimulant abuse, uncomplicated Secondary Diagnosis: Tertiary Diagnosis:

Behavioral Diagnosis: F15.10-Other stimulant abuse, uncomplicated (ICD)

Medical Diagnosis: None

Psychosocial Diagnosis: None

GAF Score:

Associate ▼

Use Current:
04/19/2021
Other stimulant abuse, uncomplicated

Create New

Tips

Clicking on **ASSOCIATE** will give 2 Options for adding a Diagnosis to a Treatment Plan.

1. **Use Current** – This will list the “current” Diagnosis listed for the client from the Diagnosis List.

OR

2. **Create New** – This will allow the user to enter Diagnoses under the Diagnosis list.

WARNING- This option will move you completely out of the Treatment Plan. It will save your work but you will have to navigate back manually.

Neither of these options enters the Diagnosis in the Outcome Measure.

Assessments

Optional. Multiple assessments of any type will be listed from which to choose.

Only **completed** assessments are available to be added.

ASAM

Source Outcome Measure
Criteria Completed and signed ASAM
Results -Summary of each Dimension, -Recommend LOC, -Actual LOC, -Clinical Override, -Comments
-Signed by Staff name and Date signed

Behavioral Health Assessment

Source BHA module
Criteria Completed and signed
Results Includes Assessment Date, Created by Staff name, Summary

Mental Health Assessment

Source MHA Module
Criteria Completed and signed
Results Includes Assessment Date, Created by Staff name, Summary from the Clinical formulation section

Multi-Dimensional Assessment

Source MDA module
Criteria Completed and signed
Results Includes Assessment Date, Created by Staff name, and all recommendations added

OUTLINE

Add Problem, Add Goal, Add Objective

Workflow: At least one Problem must be added to the Plan. Each problem must contain:
-At least one Goal which must contain:
-At least one Objective which must have:
-At least one Intervention associated.
Goals, Objectives and Interventions can be associated to services in the Encounter notes.

Multiple Problems can be added.

Multiple Goals can be added under a single Problem.

Multiple Objectives can be added under a single Goal.

WORKFLOW:
1) **Add** Interventions first and then
2) **Associate** to an existing Objective.

Add Problem

Problem Type
Category:
Substance Abuse/Dependency

Type:
Other

Client's problem

Is Deferred
No

Is Referred
No

Save Cancel

Category and Type are required. If Type = OTHER, enter text description of the Problem.

Deferred and Referred are not required. If left blank these will default to "No".

Add Goal

Name
Goal Name Here

Projected

Is Deferred
No

Save Cancel

Add Objective

Name
Object Name Here

Projected

Is Deferred
No

Save Cancel

Tip! When writing a Mental Health Encounter, there is the option to associate the Goals/Objectives to the Encounter.

Add Intervention

WORKFLOW: Add Interventions first and then **Associate** to an existing Objective.

Notes can be added to any section in Outline. Notes are based in the client's voice or the clinician's. Notes will be added with username, credentials, and date/time stamp.

Problem, Objective and Intervention Note Types:

- Clinician Comments
- My comments are

Goal Note Types:

- Clinician Comments
- My comments are
- My possible barriers are
- My strengths are

Tip! In Edit Mode, Mouse over data will display option to EDIT.

Hover over a Problem, Goal, Objective or Intervention to edit or delete.

After Interventions are added they must then be Associated to an Objective.
Tip! One Intervention can be associated to more than one Goal.

Name and Responsible Party are required for all Interventions.

If a Service is entered additional elements are available.

Completion Requirements
Complete Client Participation
Associate intervention for Running away doesn't solve problems
Associate objective for 90804 - Individual Psychotherapy 20 to 30 min.

Outline
Profile
Diagnosis
Assessments
Outline
Client Participation
Treatment Team
Sign Off

Problems
+ Add Problem
Category: Emotional/Behavioral
Problem Type: Enter Problem here
Review Comments: No Items
+ Add Review Comments
Notes: No Items
+ Add Notes
+ Add Goal
Stop running away from problems
Progress: [Progress indicator] Select...
Notes: No Items
+ Add Notes
+ Add Objective

Objectives
Enter Objective here
Review: Achieved
Progress: [Progress indicator] Select...
Notes: No Items
+ Add Review Comments
+ Add Notes
Associated Interventions: Enter Intervention here
+ Associate Intervention
+ Add Intervention

Interventions
Learn to find solutions to problems
Effectiveness: [Effectiveness indicator] Select...
Notes: No Items
+ Add Review Comments
Responsible Party: Client
+ Add Responsible Party
Planned Date Range:
Notes: No Items
+ Add Notes
Associated Objectives: Enter Objective here

Add Intervention
Name
Responsible Party Type:
Program Enrollment
Service Location
Service
Is Deferred: No
Save Cancel

Client Participation

All Treatment Plans require client participation be documented.

▼ **Client Participation**

Did the client participate in the planning process?:
-

Did the client sign the plan?:
-

Was the client offered a copy of the plan?:
-

Hover over the Client Participation section to edit.

Did the client participate in the planning process?
No
If no, what is the reason?

Did the client sign the plan?
No
If no, what is the reason?

Was the client offered a copy of the plan?
No
If no, what is the reason?

Questions require YES or NO answer. If answering NO it is required to provide a reason as to why.

Save Cancel

Tip! You can upload the client-signed Treatment Plan document into the Document Management module of UWITS.

Client Participation

Did the client participate in the planning process?

Did the client sign the plan?

Was the client offered a copy of the plan?

Signature of participant: _____ Date: _____

Mason, Perry

Using **Generate Report** to print out the Treatment Plan, the client will be able to sign.

Treatment Team

Active Treatment Team members at the time of creating the Treatment Plan will automatically be listed in this section. Treatment Team members can be added or modified at any time during a client's episode.

▼ **Treatment Team**

Name: Charlton, Emily	Primary Care: Yes	Role/Relation: Case Manager	Active: 04/23/2021 -
Name: Priestly, Miranda	Primary Care: No	Role/Relation: Clinical Supervisor	Active: 04/23/2021 -

Go To Treatment Team

Navigating to the Treatment Team using the button will allow you to **edit** the Team list but requires that you navigate back to the plan manually.

Click on **+ Add Team Member** to add a staff member or click on **Assign Group** to add a Treatment Team Group.

At least one staff must be listed on the client's Treatment Team in order to sign the Treatment Plan. Staff must have the proper rights to "Sign and Finalize" the plan.

Sign Off - Staff must be granted user rights to sign a pending plan. Signatures are Time and Date stamped.

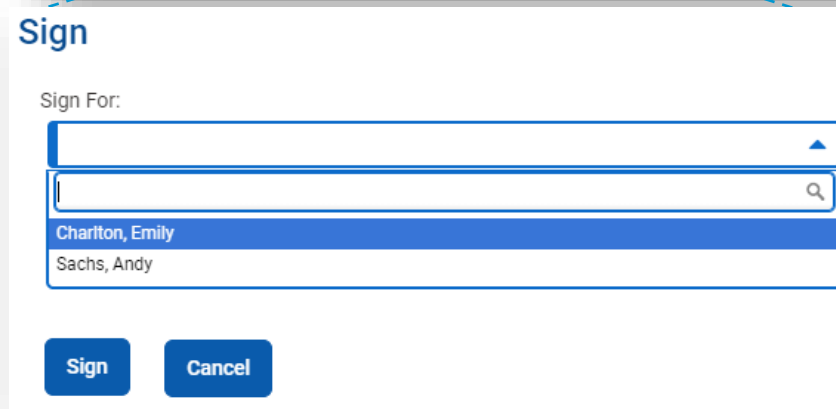
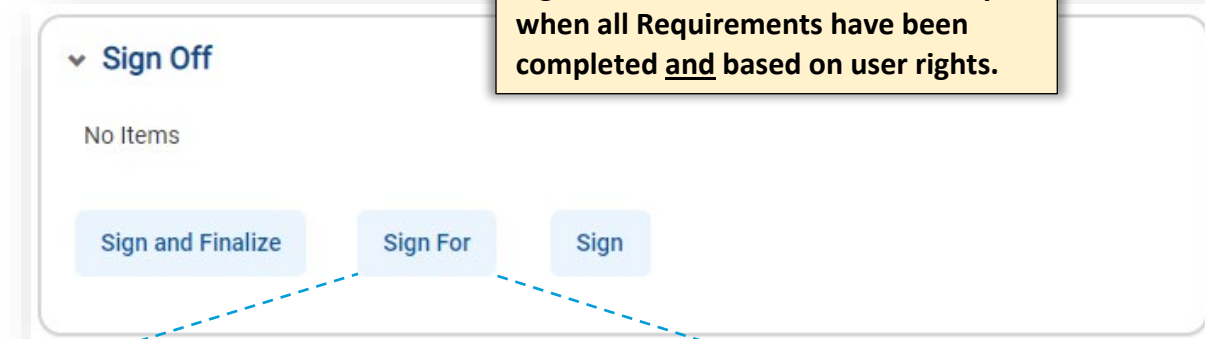
WARNING: Signatures cannot be removed or deleted.

Sign: Any Treatment Team Members can sign a Treatment Plan before it is finalized. (*User right is inherited by Clinical Full*). Licensed clinicians will not need to have this right if they will be signing off and finalizing the plan.

Sign for: Clinical supervisors can sign for their staff who are members of the team **OR** Staff members with a license to sign for other team members with the same credentials. Selecting “Sign for” will give you options of staff for which you have ability to sign.

Sign and Finalize: Users with this right can finalize the plan with or without any other TX Team member signatures. The plan is considered

Signature Buttons are available only when all Requirements have been completed and based on user rights.



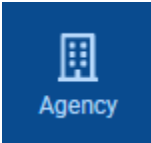
Tip! After sign-off by any team member, the plan becomes **read-only** and must be reviewed to be edited.

“Final” once member with these rights signs. Plan status changes to “Active”. Prior active plan status changes to “Retired”. With this right additional Treatment Team members do not need to have signed.



Tip! If a Treatment Team Member clicks on the Sign button to sign the plan (rather than the Sign and Finalize button) then that Treatment Team Member can no longer Sign and Finalize the Treatment Plan.

If there is only one Treatment Team Member for this client then another will need to be added before the Treatment Plan can be Finalized.



Treatment Team Groups

Add multiple Treatment Team members to a Treatment Plan in one step by using Treatment Team Groups. Begin by creating the Treatment Team Group in advance.

*The **Manage Treatment Team Groups** right is required.*

Navigation: Select **Agency** then **Tx Team Groups** from the Navigation bar. Click on the **+ Add Treatment Team Group Record** link to add a new group.

Name the group and add a Start Date.
Click on the **+ Add Staff to Group** link to add a new staff member to the group.

Treatment Team Group Profile

Group Name Group Start Date Group End Date

Save **Save and Finish**

Treatment Team Staff List

+ Add Staff To Group

Currently, there are no results to display for the Treatment Team Staff List.

Treatment Team Group Staff Profile

Name

Save **Save and Finish**

Role


- Brother
- Case Manager
- Clinical Supervisor**
- Counselor
- DCFS
- Direct Service Provider
- DJJ (Dept of Juvenile Justice)
- DOC (Dept of Corrections)

Select a Staff Member from the **Name** dropdown and select a role from the **Role** dropdown.

Adding a Treatment Team Group to a Client's Treatment Team

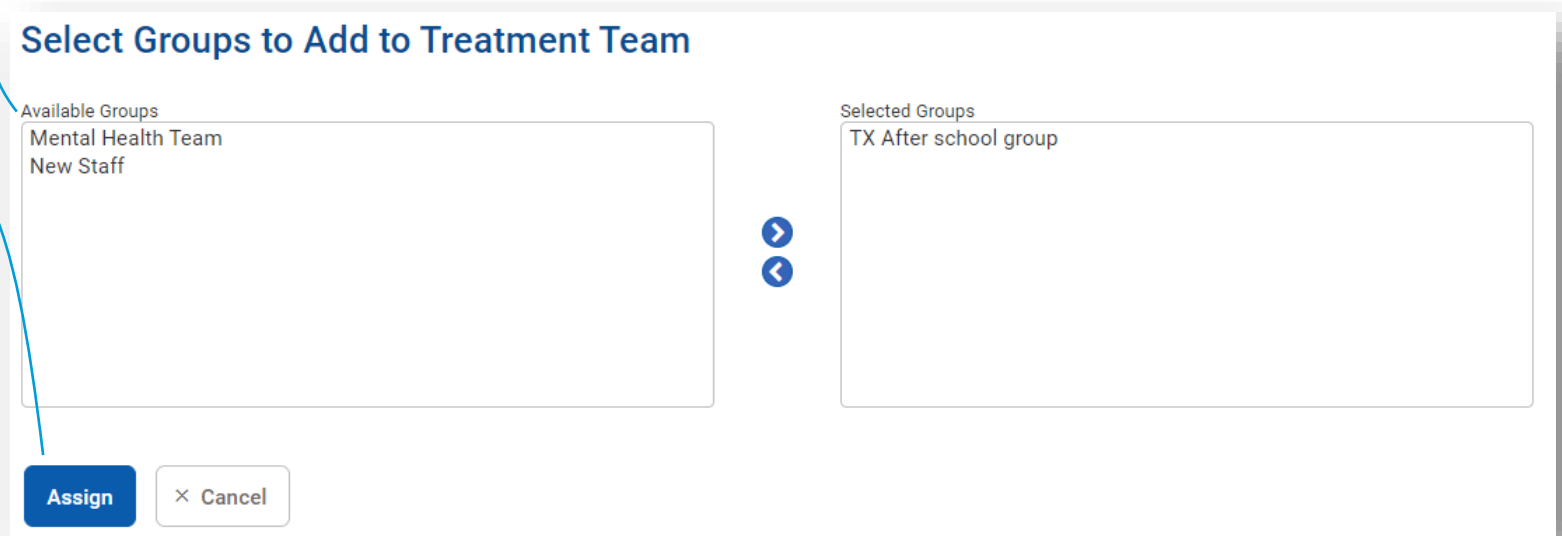


From the Treatment Plan Review screen, click on the **Go To Treatment Team** button and then click on the **Assign Group** button.

Click on one of the listings in the **Available Groups** box then click on the  button to move to the **Selected Groups** box.

To add the members of the selected group to the Treatment Team, click on the **Assign** button.

At this point, all members of the selected group will be added to the client's Treatment Team.



To mark a member of the Treatment Team as a Review Member, hover over the action button (⋮) then click on the **Review** option.

Treatment Team

+ [Add Team Member](#) Assign Group

Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date	
Sachs, Andy	Yes	Yes	Case Manager	6/27/2022		⋮
Priestly, Miranda	No	Yes	Clinical Supervisor	6/27/2022		⋮
Charlton, Emily	No	No	Therapist	6/27/2022		⋮

Profile

Staff Name: Charlton, Emily Non Staff Name: [Add Collateral Contact](#)

Role/Relation: Therapist Start Date: 6/27/2022 End Date:

Review Member: Yes No

Primary Care Staff: Yes No

Deny Access to Client Records: Yes No

Treatment Sub-Teams: Recovery Selected Sub-Teams:

Notes:

Treatment Plan

To return to the Treatment Plan Review, click on the **Treatment Plan** option on the Navigation bar to the left.

Relevant UWITS Roles

Treatment Team members must have the necessary UWITS Roles added to their account. Here is a summary:

SignOff Treatment Plan	Allows staff member to sign but not finalize a Treatment Plan.
SignOffAndFinalizeTreatmentPlan	Allows staff member to both sign <i>and</i> finalize a Treatment Plan.
View Treatment Plan	View Treatment Plan
Treatment Plan Full Access	Treatment Plan (Full Access)
Manage Treatment Team Groups	This role gives the user access to the Tx Team Groups Menu item under Agency. It allows the user to create treatment team groups and add staff members to them.
SignOff Treatment Plan	Sign Off on a Treatment Plan
SignOffAndFinalizeTreatmentPlan	Sign off and finalize a treatment plan

Required to Sign and Finalize a Treatment Plan:

1. Treatment Plan Outline must include all required elements.
2. Client Participation must be completed.
3. Staff Member user account must have the correct UWITS Roles.
4. Staff Member must be listed on the Treatment Team as a Review Member.