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Ohio Administrative Code

Rule 5122-2-12 Individual treatment plan for clients receiving intensive and specialized services and forensic inpatient services in the integrated behavioral healthcare system.

Effective: September 18, 2010

(A) The purpose of this rule is to establish department policy and guidelines governing the development and implementaton of assessments, treatment plans and discharge plans.

(B) The following definitions shall apply to this rule in addition to or in place of those appearing in rule 5122-1-01 of the Administrative Code.

(1) "Basic neurological exam" means an examination of cranial nerves, sensory and motor functions, coordination, and deep tendon reflexes.

(2) "CPST" means community psychiatric supportive treatment service which provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed toward adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST service is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

(3) "Day" means a calendar day, unless otherwise indicated.

(4) "Direct care nursing staff" means, but is not limited to, registered nurses, licensed practical nurses, mental health technicians, and therapeutic program workers.

(5) "Goal" means an expected result or condition that takes time to achieve, that is specified in a statement that provides guidance in establishing intermediate objectives directed towards its attainment.

(6) "Long-term view" means the life situation the patient would like to attain in the next three to five years. Usually described in the patient's own words, the long-term view includes all elements that are important to the patient. This may include living arrangements, vocational/educational activities, relationships, and other factors that are important to the quality of life desired by the patient.

(7) "Objective" means an expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement, and is related to the attainment of a goal.

(8) "Physical disabilities" means conditions such as deaf/hard-of-hearing, visual impairment, and/or other physical limitations in what would be considered normal physical functioning that may affect an individual's access to treatment, and that needs to be considered in the overall assessment process, and in the development of an individual's treatment plan.

(9) "Physical examination" means an examination of a patient by a physician including, but not limited to, all the items indicated on "History of Physical Illness" and "Physical Examination" forms designated by the department.

(10) "Physician" means a person licensed under the laws of this state to practice medicine.

(11) "Psychiatric examination" means an examination of a patient by a psychiatrist, or a physician privileged by the facility to conduct such examinations, including, but not limited to, all the items indicated on the "Psychiatric Examination" form designated by the department.

(12) "Psychiatrist" means a licensed physician who has satisfactorily completed a residency training program in psychiatry, as approved by the residency review vommittee of the American council on graduate medical education, the committee on graduate education of the American osteopathic association, or the American osteopathic board of neurology and psychiatry, or who, as of July 1, 1989, has been recognized as a psychiatrist by the Ohio state medical association or the Ohio osteopathic association on the basis of formal training and five or more years of medical practice limited to psychiatry.

(13) "Psychologist" means an individual who holds a current license under Chapter 4732. of the Revised Code which authorizes the practice of psychology.

(14) "Recovery" means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence.

(15) "Registered nurse" means an individual who holds a current license issued under Chapter 4723. of the Revised Code which authorizes the practice of nursing as a registered nurse.

(16) "Social worker" means a person who uses the application of specialized knowledge of human development and behavior, and social, economic and cultural systems in directly assisting individuals, families, and groups to improve or restore their capacity of social functioning, including assessment, counseling, and the use of social work interventions and social psychotherapy.

(17) "Treatment plan" (also known as "plan of care") means a written statement of specific, reasonable and measurable goals and objectives for an individual established by the treatment team, in conjunction with the patient, with specific criteria to evaluate progress towards achieving those objectives.

(18) "Treatment team" means a team comprised of the patient, patient's family as defined and authorized by the patient, psychiatrist, or physician so privileged by the facility, registered nurse, social worker, and other appropriate personnel (such as activity therapist, CPST worker, interpreter, readers, dietitian, occupational therapist, pharmacist, psychologist, and others as appropriate) based on patient needs and standard-setting agency requirements.

(C) Assessments

The RPH shall be responsible for conducting a complete assessment of each patient, including a consideration of the patient's abilities, strengths, stage in the recovery process, problems, and needs, and the types of services required to meet those needs in the least restrictive setting. Assessments shall contain a statement of individual strengths, and anticipated treatment interventions and recommendations. The assessment process shall pay careful attention to the uniqueness of individual patients, such as the presence of any physical disabilities, cultural differences, and/or religious

preferences. To the fullest extent possible, each assessment shall be conducted in the patient's preferred method of communication; for deaf/hard of hearing patients, an interpreter shall be used to communicate unless the patient has expressed a preference for an alternative form of communication. See ODMH policy MD-10 "Providing Services to Deaf and Hard-of-Hearing (Deaf/HOH) Patients in ODMH Hospitals." The assessments shall include, but not be limited to, the following areas: physical, mental, behavioral, social, recreational, financial, housing, vocational, recovery stage, and when appropriate, educational, legal, risk, nutritional, cultural, and spirituality. Information from relevant community agencies with whom the patient has been involved in treatment should be used as appropriate in the assessment process. It is understood that, due to a patient's condition, and/or unwillingness to cooperate with an assessment or with certain portions of it, the time frames indicated for assessments may not be met in every instance.

(1) A complete history and physical examination shall be completed on all patients within twenty-four hours of admission. This history and physical examination shall include a medical, alcohol and drug history, and a vision and hearing screening. It shall also include appropriate information about past and current physical disorders, and a basic neurological examination. Phrases like, "gross neurological examination within normal limits", "intact", and "no abnormalities", without any indication of tests performed and their result, are not acceptable.

(2) A psychiatric examination shall be completed and in the patient's medical record within sixty hours of admission.

(3) A nursing assessment by a registered nurse shall be completed, and in the patient's medical record within twenty-four hours of admission.

(4) A social work assessment, including a social history, shall be completed, and in the patient's medical record prior to the development of the comprehensive individual treatment plan.

(5) A psychological assessment shall be provided as appropriate to patient need.

(6) Other patient assessments shall be completed as appropriate, depending on the patient's needs, and standard-setting agency requirements.

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(7) The physical and psychiatric examinations and the nursing and social service assessments shall be updated as often as indicated by the patient's changing condition, but in no case less frequently than annually. Other assessments shall be reviewed and updated as appropriate, based on patient need.

(8) Comprehensive physical examinations performed within thirty days prior to admission by a privileged member of the medical staff may be accepted, provided they are reviewed by the physician and are authenticated as still current, or are updated as needed; and provided a legible copy of the examination as authenticated or updated is placed in the patient's medical record within twenty-four hours of admission.

(9) Each RPH shall have a policy relating to needed assessments, or portions thereof, that are refused by the patient or that are deferred for some reason. The policy shall state the manner in which these deferrals or refusals are to be dealt with, and time frames for doing so.

(D) Treatment plan

Each patient shall have developed with the treatment team a treatment plan which is responsive to the treatment needs and recovery process of the patient, based on information provided by the patient, the patient's family/significant others, and assessments by the treatment team. The plan shall include services to be provided to the patient during the inpatient stay and needed services after discharge. Services to be planned for all patients after discharge shall include medication, housing, financial, and when appropriate, vocational and peer support services. This plan shall be developed with the involvement of the patient, and, when appropriate, the patient's family/significant others, and the CPST worker. The active involvement of the patient, any significant others, and the CPST worker, shall be documented. Each treatment plan shall pay careful attention to the uniqueness of individual patients, such as the presence of any physical disabilities, cultural differences, and/or religious preferences. In treatment plan development and implementation, the patient's preferred method of communication shall, to the fullest extent possible, be utilized. The treatment plan shall be developed and implemented as follows:

(1) An admitting/initial treatment plan, based on the intake assessments, shall be developed at the time of admission. This plan may be documented in the physician's admission note, and/or admitting

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orders. It shall give adequate direction to all relevant staff regarding the treatment regimen to be followed pending the development of the comprehensive treatment plan. This plan shall be reviewed and updated as indicated.

(2) Each patient shall have a comprehensive treatment plan developed by the treatment team. This plan shall be developed no later than five calendar days from admission, counting the day of admission as day one. This plan shall be based on the assessments referred to in paragraphs (C)(1) to (C)(7) of this rule, and upon identified patient abilities, strengths, stage in recovery process, problems, and needs. In most instances this plan will be a further evolution of the plan begun at the time of admission, but based now on more comprehensive assessment information.

(3) Each patient's comprehensive treatment plan shall be reviewed and updated by the treatment team as often as is indicated by the patient's condition, and his/her progress, or lack thereof, in achieving the goals of treatment. It is to be emphasized that the patient's changing condition, and his/her progress, or lack thereof, in moving towards recovery and the achievement of established treatment goals, is the primary determinant of the need for a review and update of the individual treatment plan. However, in no case shall the interval between reviews and updates exceed the following:

(a) Thirty days from the date of the comprehensive treatment plan;

(b) Every thirty days for the next two months of receiving RPH services;

(c) Every sixty days thereafter during the first year of receiving RPH services; and

(d) For patients who are in the RPH beyond one year, at least every ninety days for the duration of receiving RPH services.

(4) Each review and update of the treatment plan shall include a reassessment of the individual's diagnosis, and principal behaviors necessitating inpatient care. Changes shall be made in the treatment regimen, as appropriate, based on the patient's changing condition. The active participation in this entire process of the patient, any significant others, and the CPST worker, shall be encouraged and documented.

(E) Treatment plan contents

Each individual treatment plan and reviews or updates shall contain:

(1) A substantiated diagnosis;

(2) Clearly identified patient abilities, strengths, problems, needs, and stage of recovery drawn from the assessments, and any updates, thereof, that will be addressed in treatment;

(3) Clearly stated and measurable goals and objectives relative to the identified abilities, strengths, problems and needs, including recovery-related issues;

(4) Estimated time frames for the achievement of each goal and objective;

(5) Specific treatment methodologies, with their frequencies, focus, and duration, that will be used in an effort to achieve each stated objective;

(6) Individual names of staff responsible for carrying out, or assuring the carrying out, of each treatment method referenced in paragraph (E)(5) of this rule. The professional discipline shall be clearly indicated;

(7) Criteria for transition to the community, that is, clearly stated patient mental and behavioral status sufficient to allow continued treatment as needed in a community setting;

(8) Specific plans, or recommendations, for post-discharge services;

(9) The patient's involvement in and expressed concerns about the treatment plan; and

(10) The patient's long-term view.

(F) Discharge planning

Discharge planning should start the day of admission. Upon admission, or linkage to a provider organization, the CPST worker, if applicable, and the community provider organization shall be notified, and invited to participate in, and kept fully apprised of plans, including the discharge date.

Appropriate levels of supervision, housing, and peer support services, if appropriate, shall be identified by the treatment team and communicated to the provider staff. If the patient is not able to be discharged within one week after he/she is ready for discharge due to placement problems, the RPH social worker shall inform the RPH social work director/designee. The RPH social work director/designee shall contact the community provider organization to facilitate the discharge. These cases are reviewed by the RPH utilization review committee. Regular meetings between the RPH chief clinical officer and the mental health center chief clinical officers and their staffs need to be held to address cases that cannot be resolved by the social work directors.

(G) Patient access to medical records

(1) Pursuant to division (A)(5) of section 5122.31 of the Revised Code, a patient shall, upon request, be granted access to his/her medical record unless clear treatment reasons, i.e., likely to endanger the life or physical safety of the patient or others, are documented in the individual treatment plan and physician progress notes restrict such access. Examples of clear treatment reasons include:

(a) The information is about another person and the RPH determines that patient review would cause sufficient harm to another individual to warrant withholding; or

(b) Review by the patient could be reasonably likely to endanger the life or physical safety of the patient or anyone else.

(2) If restricted, the areas in the record from which the patient is restricted to view shall be noted; the non-restricted areas are still accessible to the patient. The patient's written treatment plan shall specify the treatment designed to eliminate the restriction.

(H) Authorization of individual treatment plans

The names of all team members actually participating in the development and/or review and update

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of the treatment plan shall appear on the treatment plan. The individual treatment plan and each review and update thereof shall be signed by a psychiatrist, or a physician so privileged by the RPH. A psychiatrist, or a physician so privileged by the RPH, shall assume primary responsibility for supervision and evaluation of each patient's ongoing care and treatment. The patient shall participate in the development of his/her treatment plan and shall be asked to sign it.

(I) Implementation of treatment plans

Treatment plan progress notes shall be completed for patients. The frequency of the notes is determined by the condition of the patient. Progress notes are written at least weekly or more frequently if clinically indicated. Such notes shall indicate the treatment interventions carried out in relation to a specific problem or goal on the treatment plan, and shall contain a careful assessment of the patient's progress in accordance with the stated goals and objectives on the treatment plan, and subsequent updates thereof. They shall also contain any recommendations for the continuation of or modifications in the patient's treatment regimen. All such entries shall be signed and dated by the staff member and the professional discipline shall be clearly indicated. In addition, direct care nursing staff shall complete regular notes. These notes shall be daily for the first week of admission. After the first week, while no required frequency is given, the notes shall be frequent enough to give a clear picture of the patient's clinical status and his/her response to the active treatment interventions.

(J) Treatment plan monitoring

Individual treatment plans governed by this policy shall be monitored by the RPH quality assurance/ improvement program. Results of the monitoring activity shall be distributed as appropriate both to inform staff persons with a need to know, and in order to assure prompt and effective corrective action on all identified deficiencies.