Vermont Psychiatric Care Hospital Procedure	
Treatment Planning	
Revised: X	Date: 04/07/14

A. Interdisciplinary Teams

Each patient shall be served by an interdisciplinary treatment team which shall be responsible for developing the patient's treatment plan. The interdisciplinary team's membership shall be dictated by the particular needs, strengths, and preferences of the individual in the team's care.

The interdisciplinary team for each individual shall:

1. Have as its primary objective the provision of individualized, integrated treatment that optimizes the patient's opportunity for recovery and ability to sustain him or herself in the most appropriate, least restrictive setting, and supports the patient's interests of self determination and independence.

2. Be led by a treating psychiatrist who shall:

    a. assume primary responsibility for the individual's treatment;

    b. require that each member of the team participates appropriately in assessing the individual on an ongoing basis and in developing, monitoring, and, as necessary, revising treatments;

    c. require that the treatment team functions in an interdisciplinary fashion; and

    d. require that the scheduling and coordination of assessments and team meetings, the drafting of integrated treatment plans, and the scheduling and coordination of necessary progress reviews and plan updates occur in a timely fashion.

3. Have its composition dictated by the individual's particular needs, strengths, and preferences, but shall consist of a stable core of members, including the individual, the treating psychiatrist, registered nurse, and the social worker and, as the core team determines is clinically appropriate, other team members, who may include the individual's family, guardian, advocates, and the pharmacist and other clinical staff.

B. Integrated Treatment Plans

1. Treatment plans shall provide that:

    a. where possible, individuals have substantive, identifiable input into their treatment plans;

    b. timely attention is paid to the needs of each individual, in particular:

(i) initial treatment plans by MD and RN are completed within 24 hours of admission;
(ii) comprehensive treatment plans are completed within 7 business days of admission; and
(iii) treatment plan reviews are performed every 14 calendar days during the first 60 days of hospitalization and every 30 calendar days thereafter, or more frequently as clinically indicated; and
(iv) between treatment plan meetings, individual progress notes serve as treatment plan updates.

c. the interventions by which the treatment goals for the particular individual shall be addressed, monitored, reported, and documented are specifically identified in each treatment plan;

d. treatment and medication regimens are modified, as appropriate, considering factors such as the individual's response to treatment, significant developments in the individual's condition, and the individual's changing needs; and

e. in instances where emergency involuntary procedures are utilized, the treatment plan revision is incorporated into the Certificate of Need documentation.

2. Treatment planning shall be based on a comprehensive case formulation for each individual that emanates from an integration of the discipline-specific assessments of the individual. Specifically, the case formulation shall:

a. be derived from analyses of the information gathered from discipline-specific assessments, including diagnosis and differential diagnosis;

b. include a review of pertinent history, predisposing, precipitating and perpetuating factors, present status, and previous treatment history;

c. consider such factors as age, gender, culture, treatment adherence, history of substance abuse, and medication issues that may affect the outcomes of treatment interventions;

d. enable the treatment team to reach sound determinations about each individual's treatment and habilitation needs; and

e. make preliminary determinations as to the least restrictive setting to which the individual should be discharged, and the changes that will be necessary to achieve discharge.

3. Treatment planning shall be driven by individualized needs, build on an individual's current strengths, and that provide an opportunity to improve each individual's health and well being. Specifically, the treatment team shall:

a. develop and prioritize reasonable and attainable goals/objectives (e.g., relevant to each individual's level of functioning) that build on the individual's strengths and

address the individual's identified needs and, if any identified needs are not to be addressed, provide a rationale for not addressing the need;

b. provide that the goals/objectives address treatment (e.g., for a disease or disorder) and rehabilitation (e.g., skills/supports/quality of life activities);

c. write the objectives in behavioral and measurable terms;

d. provide that there are interventions that relate to each objective, specifying who will do what, within what time frame, to assist the individual to meet his/her goals as specified in the objective;

e. design a program of interventions throughout the individual's day with a minimum of 20 hours of clinically appropriate treatment/rehabilitation/therapeutic support per week; and

f. provide that each treatment plan integrates and coordinates all selected services, supports, and treatments provided by or through the Vermont Psychiatric Care Hospital for the individual in a manner specifically responsive to the plan's treatment and rehabilitative goals.

4. Treatment planning shall be outcome-driven and based on the individual's progress, or lack thereof, as determined by the scheduled monitoring of identified treatment objectives. Specifically, the treatment team shall:

a. revise the objectives, as appropriate, to reflect the individual's changing needs;

b. monitor, at least every 30 days, the goals, objectives, and interventions identified in the plan for effectiveness in producing the desired outcomes;

c. review the goals, objectives, and interventions more frequently than monthly if there are clinically relevant changes in the individual's functional status or risk factors;

d. provide that the review process includes an assessment of progress related to discharge; and

e. base progress reviews and revision recommendations on data collected as specified in the treatment plan.

Approved by	**Signature**	**Date**
Frank Reed, Commissioner of DMH	Frank Reed	11/29/16