Life Areas Treatment Plans

AWARDS INSTRUCTION SHEET

AWARDS makes available to programs a variety of service plan formats, including a life areas treatment plan. This type of plan was developed specifically for substance abuse and OASAS programs. Once a program is configured to use the life areas treatment plan, the AWARDS Services module Service Plans feature is used to enter and update each of the following life area individual treatment plan components:

- **Initial Treatment/Service Plans**
  Preliminary short-term plans that identify immediate needs.
- **Comprehensive Treatment/Service Plans**
  Plans that identify life area goals and short-term objectives.
- **Comprehensive Treatment/Service Plan Reviews**
  Treatment plan updates on a regularly scheduled basis, typically quarterly (every 90 days).

This feature can also be used to view read-only treatment plan reports.

REQUIRED PERMISSIONS

Permissions required to work with treatment plan records are:

- Chart Access – You must have chart access permission for each program for which treatment plan records are to be entered, updated, and/or viewed.
- Data Entry / Access – You must have the "Display Any Chart Records Buttons," and "Display Chart Records Services Button" permissions in order to access the Services module in which treatment plans are located.

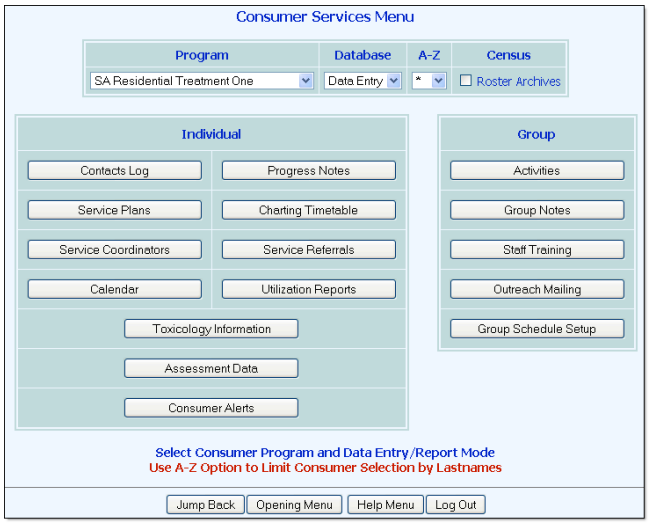
ABOUT THIS DOCUMENT

This document is intended to guide you through the process of working with life area treatment plans. Specific topics covered are:

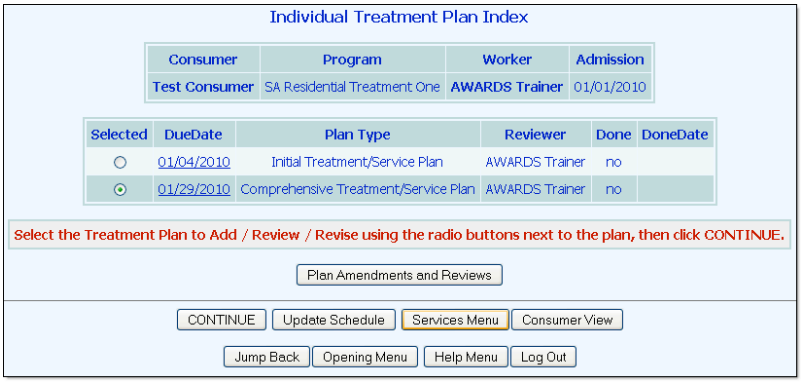
ENTERING OR UPDATING AN INITIAL TREATMENT/ SERVICE PLAN

Not all programs will require the initial treatment/service plan be completed. Typically, only residential programs utilize this tool. Check the guidelines set within your program to determine if one is necessary.

To enter or update a life area initial plan, complete the following steps:



1. From the *AWARDS Opening Menu* page, click **Services**. The *Consumer Services Menu* page is displayed.
2. Click the **Program** drop-down arrow and select the program associated with the consumer for whom the plan is to be entered or updated.
3. Click the **Database** drop-down arrow and select "Data Entry."
4. To limit consumer selection by name, click the **A-Z** drop-down arrow and select the initial of the consumer's last name. An asterisk (*) in this field will include all consumers in the selection process.
5. If the plan to be updated is for a former (discharged) consumer, click the **Roster Archives** check box.
6. Click **Service Plans**. The *Service Plan Consumer Selection* page is displayed.
7. Click the **Consumer** drop-down arrow and select the consumer for whom the plan is being entered or updated.
8. Click **CONTINUE**. The *Individual Treatment Plan Index* page is displayed. This page contains a list of existing plans scheduled for the selected consumer.



   If an Initial Treatment/Service Plan schedule record must be entered or updated, continue with step **9**.

   If an existing Initial Treatment/Service Plan is to be worked on and it is not necessary to enter or update a schedule record, continue with step **12**.

   In most cases, an initial plan will have been scheduled for the consumer during the intake/admission process.

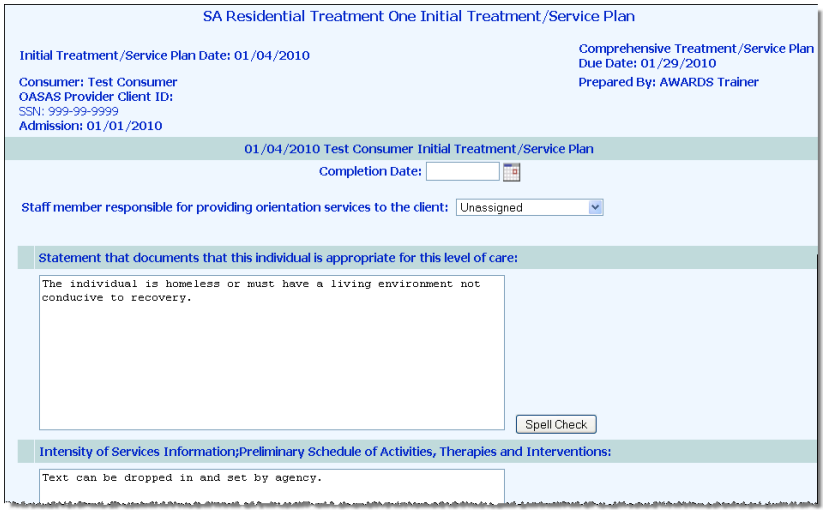
9. Click **Update Schedule**. The *Individual Comprehensive Treatment/Service Plan Review Schedule* page is displayed.
10. To *update* an existing schedule record, make changes to the review schedule fields/options as necessary. To *enter* a new schedule record, configure the blank **NEXT** or **BACK FILL** review schedule fields/options:

- **Due Date –** In this field, type the date on which the initial treatment/service plan development must be done (in **mm/dd/yy** format).
- **Plan Type –** Click the drop-down arrow and select "Initial Treatment/Service Plan."
- **Reviewer –** Click the drop-down arrow and select the worker responsible for working on the initial treatment/service plan.
- **Done –** Click the drop-down arrow and select "Yes" or "No" to indicate whether the plan has been completed.
- **Done Date –** If "Yes" was selected for the **Done** option, in this field type the date on which the plan was completed (in **mm/dd/yy** format).

11. Click **CONTINUE**. The schedule record is saved and the updated *Individual Comprehensive Treatment/Service Plan Index* page is displayed.

12. Click the **Selected** radio button next to the initial treatment/service plan.

13. Click **CONTINUE**. The *Initial Treatment/ Service Plan* page is displayed. →



14. If applicable, in the **Completion Date** field, type the date on which the plan was completed.

15. Click the **Staff member responsible for providing orientation services** to the client drop-down arrow and select the correct staff member.

16. Enter or make changes to the information in the following text boxes: **Statement that documents that this individual is appropriate for this level of care**, and **Preliminary Schedule of Activities, Therapies, and Interventions**.

    These text boxes may be labeled differently, depending on the program's settings. Fill in the text boxes that appear for the program you are working in, as appropriate.

17. Click **UPDATE**. The *Initial Treatment/ Service Plan* page is displayed in report mode and includes signature lines.

    *To make additional changes to the plan at this time, click **Return to Data Entry** to return to the* Initial Treatment/ Service Plan update *page.*

The process of entering/updating an initial treatment/service plan is now complete.

ENTERING OR UPDATING A COMPREHENSIVE TREATMENT/SERVICE PLAN

A comprehensive treatment/service plan is typically due within 30 days following a client's admission, and outlines goals and objectives for specific life areas. To enter or update a comprehensive treatment/service plan, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Services**. The *Consumer Services Menu* page is displayed.

2. Click the **Program** drop-down arrow and select the program associated with the consumer for whom the comprehensive treatment/service plan is to be entered or updated.

3. Click the **Database** drop-down arrow and select "Data Entry."

4. To limit consumer selection by name, click the **A-Z** drop-down arrow and select the initial of the consumer's last name. An asterisk (*) in this field will include all consumers in the selection process.

5. If the comprehensive treatment/service plan to be updated is for a former (discharged) consumer, click the **Roster Archives** check box.

6. Click **Service Plans**. The *Treatment Plan Consumer Selection* page is displayed.

7. Click the **Consumer** drop-down arrow and select the consumer for whom the comprehensive treatment/service plan is being entered or updated.

8. Click **CONTINUE**. The *Individual Treatment Plan Index* page is displayed. This page contains a list of existing plans scheduled for the selected consumer.

   If a Comprehensive Treatment/Service Plan schedule record must be entered or updated, continue with step **9**.

   If an existing Comprehensive Treatment/Service Plan is to be worked on and it is not necessary to enter or update a schedule record, continue with step **12**.

9. Click **Update Schedule**. The *Individual Comprehensive Treatment/Service Plan Review Schedule* page is displayed.

10. To *update* an existing schedule record, make changes to the review schedule fields/options as necessary. To *enter* a new schedule record, configure the blank **NEXT** or **BACK FILL** review schedule fields/options:

    - **Due Date –** In this field, type the date on which the comprehensive treatment/service plan development must be done (in **mm/dd/yy** format).

    - **Plan Type –** Click the drop-down arrow and select "Comprehensive Treatment/Service Plan."

    - **Reviewer –** Click the drop-down arrow and select the worker responsible for working on the comprehensive treatment/service plan.

    - **Done –** Click the drop-down arrow and select "Yes" or "No" to indicate whether the plan has been completed.

    - **Done Date –** If "Yes" was selected for the **Done** option, in this field type the date on which the plan was completed (in **mm/dd/yy** format).

11. Click **CONTINUE**. The schedule record is saved and the updated *Individual Comprehensive Treatment/ Service Plan Index* page is displayed.

12. Click the **Selected** radio button next to the comprehensive treatment/service plan to be worked on.

13. Click **CONTINUE**. The *Comprehensive Treatment / Service Plan* page is displayed.

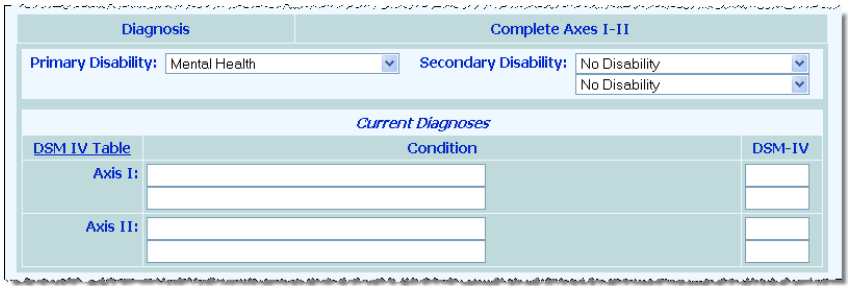
14. If necessary, in the **First Review Due Date** field, make changes to the date on which the first comprehensive treatment/service plan review must be done for this consumer.

This field will only be editable the first time the plan is opened/completed.

15. In the "Multi-Disciplinary Team Consultants Approval" portion of the plan, enter or make changes to the information in the **Staff Signature/Title/Credential** and **Reviewing Supervisor Signature (w/in 7 days)/Title/Credential** fields as necessary.

The signature blocks presented in this section will vary based on program type.

16. In the "Current Diagnoses" portion of the plan, configure the fields and options for the following diagnoses axes:



- **Primary Disability –** Click this drop-down arrow and select the primary disability of the client as necessary.

- **Secondary Disability –** Two drop-down selection lists are available for documenting secondary disabilities of the client. Click the drop-down arrow(s) and select any secondary disability conditions as necessary.

- **Axis I –** In each Axis I **Condition** field, type the condition diagnosis description(s) as necessary. In the corresponding **DSM-IV** fields, type the DSM-IV codes.

- **Axis II –** In each Axis II **Condition** field, type the condition diagnosis description(s) as necessary. In the corresponding **DSM-IV** fields, type the DSM-IV codes.

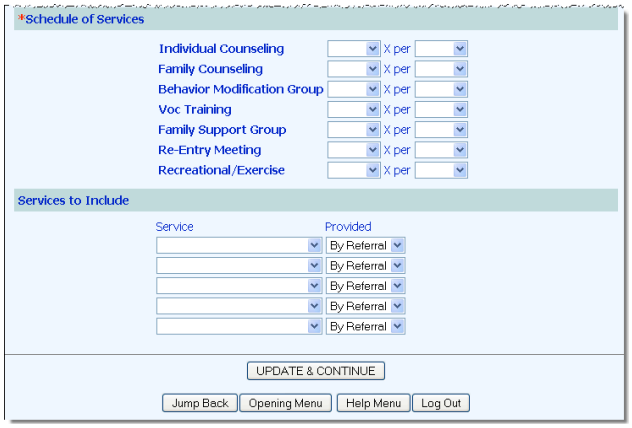
If current diagnosis information has already been entered for the client via his or her face sheet or the Medical module Diagnoses Information feature, that information will pre-populate this portion of the plan.

17. In the "Life Areas to be Addressed" portion of the plan, each life area is listed with a drop-down list containing the choices "N/A," "Addressed in Plan," and "Deferred." Select the appropriate choice for each life area.

18. Where applicable, enter the reason for deferral in the corresponding **Reason for Deferral** text box for any deferred life areas.

This is a required field for any life area set to "Deferred" in step 18.

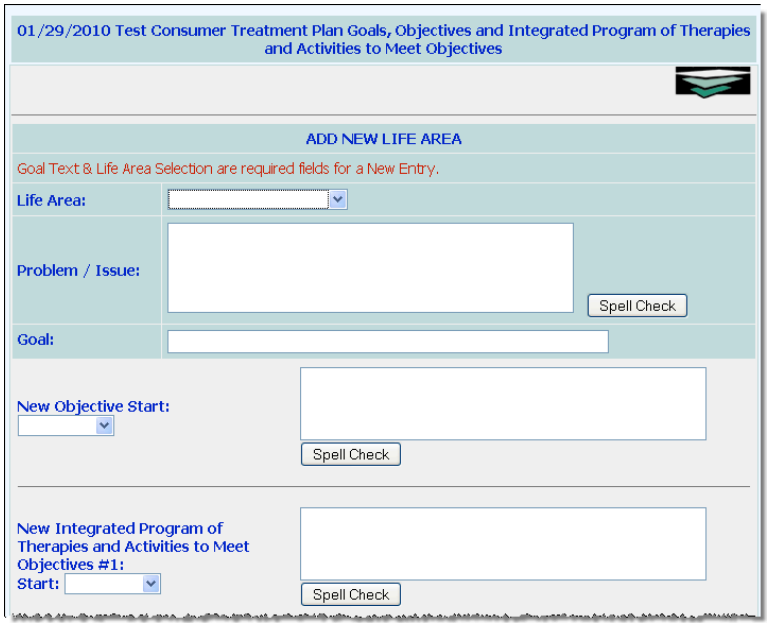
19. In the "Schedule of Services" portion of the plan, enter or update the frequency for any applicable services the consumer will be receiving, by selecting a number from the first drop-down list and a timeframe from the second drop-down list.



For example: "1 x per Week" or "Two x per Month"

20. In the "Services to Include" portion of the plan, select any applicable service from the **Service** drop-down list, and select a corresponding **Provided** item. Available options on the Provided list are "Directly," and "By Referral."

21. Click **UPDATE & CONTINUE**. The *Treatment Plan Goals, Objectives and Integrated Program of Therapies and Activities to Meet Objectives* page is displayed.



22. Add or update a life area goal/objective on this page as needed. When working with a new plan, an "Add New Life Area" section is available automatically. When updating an existing plan, click **Add Additional Life Area** to add a new one, or **Update Life Area** to make changes to the corresponding existing life area. For each life area you add or update, you'll need to configure the following fields/options:

    - **Life Area –** Click this drop-down arrow and select the applicable life area for the goal being added or updated.
    - **Problem/Issue –** In the text box provided type or making changes to the problem/issue being addressed.
    - **Goal –** in the text box provided, type or make changes to the goal that corresponds to the life area selected.
    - **Target Date for Achievement –** When updating an existing life area, this date field will be available for a target date of goal achievement.

      This field will not display when adding a new life area.

    - **New Objective Start –** Click the drop-down arrow and select the date on which the corresponding service objective began. The default value is the plan date.

      This field will only be editable the first time the plan is opened/completed.

    - In the text box that appears next to the start date, type or making changes to the objective.

      *Up to three objectives can initially be entered for each new goal, after which additional objectives can be added. To add more objectives, complete steps 24 through 27, click **Return to Data Entry**, and then repeat the process beginning with step 23.*

- **Target Date –** In the date field provided beneath each objective, enter a target date for the objective to be reached.

- **Delete Objective –** When updating an existing life area, check this check box to remove the corresponding objective from the plan.

- **Integrated Program of Therapies and Activities to Meet Objectives** or **New Integrated Program of Therapies and Activities to Meet Objectives** or **Add Integrated Program of Therapies and Activities to Meet Objectives –** Each objective can have up to four therapies/activities added to them initially. In the text box provided, type or make changes to a description of each therapy/activity that corresponds to the objective being added/edited. Each therapy/activity being added also requires a start date in the **Start** field, and a **Target Date** in the date field provided.

  *To add more therapies and activities if more than four are needed, complete steps 24 through 27, click **Return to Data Entry**, and then repeat the process beginning with step 23.*

23. If an existing life area is being updated, or a new additional life area is being entered on an existing plan, click **UPDATE** to save the updated/new information and view the plan in report mode. If further updates are needed, including work on the plan Coordination or Discharge Planning information referred to in steps 25 and 26 below, click **Return to Data Entry**.

    *When working with a new plan, **UPDATE** cannot be clicked until steps 25 and 26 are completed.*

24. In the "Coordination of off-site services" portion of the plan, if any off-site services will be referred to the client, configure the following fields/options:

    - **Date of Referral –** In the date field provided, enter the date the referral to the off-site service was made.

    - **Describe the Nature of Service/Name of Provider –** In the text box provided, type or make changes to the description of the off-site service and provider information.

    - **Result of Referral –** In the text box provided type or make changes to information on the referral result.

    - **Procedure for Ongoing Coordination of Care –** In the text box provided, type or make changes to the procedure for any ongoing coordination of care needed.

25. In the "Discharge Planning" portion of the plan, fill in or make changes to the information in the following text boxes: **Relapse Prevention Plan (be specific)**, **Assessment of Home Environment**, **Vocational / Educational / Employment Status**, **Relationship with Significant Others, including need for services to significant others**, **Assessment of Housing Suitability**, **Clients / Families Need for Continued Services and Self Help**, and **Other Needs**.

26. Click **UPDATE**. The comprehensive treatment/ service plan information is saved, any goals or objectives marked for deletion are removed, and a read-only report version of the treatment plan is displayed on the *Comprehensive Treatment/ Service Plan* page.

    *To make additional changes to the treatment plan at this time, click **Return to Data Entry** to return to the* Treatment Plan Goals, Objective and Integrated Program of Therapies and Activities to meet Objectives *update page. On that page you will have the option of adding a new life area using the add new life area button, updating an existing life area (including its goals/objectives) by clicking the corresponding update button, or editing existing Coordination and Discharge Planning information.*

The process of entering/updating a comprehensive treatment/service plan is now complete.

ENTERING OR UPDATING A COMPREHENSIVE TREATMENT/SERVICE PLAN REVIEW

A comprehensive treatment/service plan review is typically due quarterly, or every 90 days, and outlines any progress made on goals and objectives addressed in the plan. To enter or update a comprehensive treatment/service plan review, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Services**. The *Consumer Services Menu* page is displayed.

2. Click the **Program** drop-down arrow and select the program associated with the consumer for whom the comprehensive treatment/service plan review is to be entered or updated.

3. Click the **Database** drop-down arrow and select "Data Entry."

4. To limit consumer selection by name, click the **A-Z** drop-down arrow and select the initial of the consumer's last name. An asterisk (*) in this field will include all consumers in the selection process.

5. If the comprehensive treatment/service plan review to be updated is for a former (discharged) consumer, click the **Roster Archives** check box.

6. Click **Service Plans**. The *Treatment Plan Consumer Selection* page is displayed.

7. Click the **Consumer** drop-down arrow and select the consumer for whom the comprehensive treatment/service plan review is being entered or updated.

8. Click **CONTINUE**. The *Individual Treatment Plan Index* page is displayed. This page contains a list of existing plans scheduled for the selected consumer.

   If a Comprehensive Treatment/Service Plan Review schedule record must be entered or updated, continue with step **9**.

   If an existing Comprehensive Treatment/Service Plan Review is to be worked on and it is not necessary to enter or update a schedule record, continue with step **12**.

   Typically, the first comprehensive treatment/service plan review is automatically scheduled for the consumer when his or her comprehensive treatment/service plan is opened and updated for the first time. Subsequent comprehensive treatment/ service plan reviews are automatically scheduled for a consumer when the previous review for that consumer is opened and updated for the first time.

9. Click **Update Schedule**. The *Individual Comprehensive Treatment/Service Plan Review Schedule* page is displayed.

10. To *update* an existing schedule record, make changes to the review schedule fields/options as necessary. To *enter* a new schedule record, configure the blank **NEXT** or **BACK FILL** review schedule fields/options:

    - **Due Date –** In this field, type the date on which the comprehensive treatment/service plan review must be done (in **mm/dd/yy** format).

    - **Plan Type –** Click the drop-down arrow and select "Comprehensive Treatment/Service Plan Review."

    - **Reviewer –** Click the drop-down arrow and select the worker responsible for working on the comprehensive treatment/service plan review.

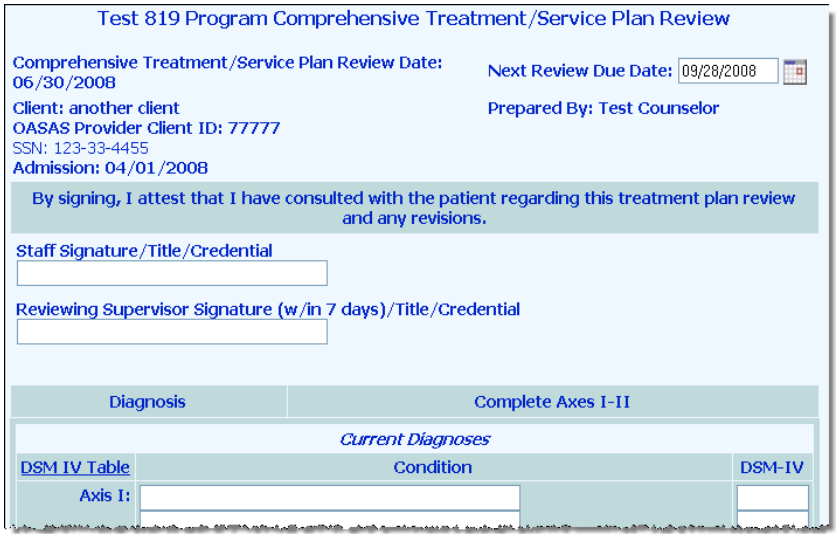
- **Done –** Click the drop-down arrow and select "Yes" or "No" to indicate whether the review has been completed.

- **Done Date –** If "Yes" was selected for the **Done** option, in this field type the date on which the review was completed (in **mm/dd/yy** format).

11. Click **CONTINUE**. The schedule record is saved and the updated *Individual Comprehensive Treatment/Service Plan Index* page is displayed.

12. Click the **Selected** radio button next to the comprehensive treatment/service plan review to be worked on.

13. Click **CONTINUE**. The *Comprehensive Treatment/Service Plan Review* page is displayed.



14. If necessary, in the **Next Review Due Date** field, make changes to the date on which the next comprehensive treatment/service plan review must be done for this consumer.

    This field will only be editable the first time the plan is opened/completed.

15. In the "By signing, I attest that I have consulted with the patient regarding this treatment plan review and any revisions" portion of the plan, enter or make changes to the information in the following fields as necessary: **Staff Signature/Title/Credential**, and **Reviewing Supervisor Signature (w/in 7 days)/Title/Credential**.

    The signature blocks presented in this section will vary based on program type.

16. In the "Current Diagnoses" portion of the review, configure the fields and options for the following diagnoses axes:

    - **Primary Disability –** Click this drop-down arrow and select the primary disability of the client as necessary.

    - **Secondary Disability –** Two drop-down selection lists are available for documenting secondary disabilities of the client. Click the drop-down arrow(s) and select any secondary disability conditions as necessary.

    - **Axis I –** In each Axis I **Condition** field, type the condition diagnosis description(s) as necessary. In the corresponding **DSM-IV** fields, type the DSM-IV codes.

    - **Axis II –** In each Axis II **Condition** field, type the condition diagnosis description(s) as necessary. In the corresponding **DSM-IV** fields, type the DSM-IV codes.

17. In the "Life Areas to be Addressed" portion of the plan, each life area is listed with a drop-down list containing the choices "N/A," "Addressed in Plan," and "Deferred." Any selections made in the previous plan/review will have carried over to this plan. Make changes to the selection for each life area as needed.

18. Where applicable, enter or update the reason for deferral in the corresponding **Reason for Deferral** text box for any deferred life areas.

    This is a required field for any life area set to "Deferred" in step 18.

19. In the "Schedule of Services" portion of the plan, enter or update the frequency for any applicable services the consumer will be receiving, by selecting a number from the first drop-down list and a timeframe from the second drop-down list. Any selections made in the previous plan/review will be displayed.

    For example: "1 x per Week" or "Two x per Month"

20. In the "Services to Include" portion of the plan, select any applicable service from the **Service** drop-down list, and select a corresponding **Provided** item. Available options on the Provided list are "Directly," and "By Referral." Any selections made in the previous plan/review will have carried over to this plan.

21. Click **UPDATE & CONTINUE**. The *Treatment Plan Goals, Objectives and Integrated Program of Therapies and Activities to Meet Objectives* page is displayed.

22. Each life area is listed in report mode, along with the corresponding goals, objectives and integrated program of therapies and activities. To add additional life areas to a review, continue with step **30**. To enter review information for an existing life area, click the corresponding **Update Life Area** button and continue with step **24**.

23. Review the progress on all existing goals/objectives/therapies by configuring the following fields/options:

    Treatment plan changes such as the addition of new goals cannot be made until this step is complete.

    - **Completion Date –** In the date field provided, enter a date on which this life area review is complete.
    - **Life Area –** Click this drop-down arrow and select the applicable life area for the goal being reviewed.
    - **Problem/Issue –** In the text box provided type or making changes to the problem/issue being addressed.
    - **Goal –** in the text box provided, type or make changes to the goal that corresponds to the life area selected.
    - **Target Date for Achievement –** In this field type or make changes to the target date for achievement of this goal.
    - **Target Date –** In the date field provided beneath each objective, enter or make changes to the target date for the objective to be reached.
    - **Review of Progress/Objective Achievement –** In the text box provided, describe the progress toward achievement of the objective.
    - **Objective Outcome** or **Integrated Program of Therapies and Activities to Meet Objectives Outcome –** Click this drop-down arrow and select one of the following objective or therapy/activity outcome options for each objective and therapy/activity: "Attained," "Progress," "No Progress," "Reconsidered," or "Not Worked On."

24. Click **UPDATE**. The comprehensive treatment/service plan review information is saved, and a read-only report version of the review is displayed on the *Comprehensive Treatment/Service Plan Review* page.

25. To add new life areas/objectives and/or to continue to review the plan, click **Return to Data Entry**. The *Treatment Plan Goals, Objectives and Integrated Program of Therapies and Activities to Meet Objectives* update page is re-displayed.

26. To complete the review of existing life areas/objectives, click the corresponding **Update Life Area** button and configure the following fields/options:

    - **Objective Outcome –** Click the second **Objective Outcome** drop-down arrow and select one of the following outcome options: "Objective Continued," "Objective Revised (Below)," or "Objective Discontinued." If "Objective Revised" is selected, enter the text of the revised objective in the text box that displays below.

    - **Integrated Program of Therapies and Activities to Meet Objectives Outcome –** Click the second **Integrated Program of Therapies and Activities to Meet Objectives Outcome** drop-down arrow and select one of the following outcome options: "Integrated Program of Therapies and Activities to Meet Objectives Continued," "Integrated Program of Therapies and Activities to Meet Objectives Revised," or "Integrated Program of Therapies and Activities to Meet Objectives Discontinued." If "Integrated Program of Therapies and Activities to Meet Objectives Revised" is selected, enter the text of the revised therapy/activity in the text box that displays below.

27. Once all objectives within a life area have been reviewed using steps 24 through 16, you have the opportunity to add new objectives to the life area, if necessary. To add new objectives/therapies/activities follow the same steps necessary to add a new objective/therapy/activity in a comprehensive treatment/service plan. This includes the configuration of the following fields/options: "New Objective Start," the new objective, "Target Date," "New Integrated Program of Therapies and Activities to Meet Objectives," "Start" date for new therapies/activities, and "Target Date" for new therapies/activities.

28. Click **UPDATE**. The periodic review information is saved and a read-only report version of the comprehensive treatment/service plan review is displayed. To make additional changes to the review at this time, click **Return to Data Entry** to return to the *Treatment Plan Goals, Objectives and Integrated Program of Therapies and Activities to Meet Objectives* update page. On that page you will have the option of adding a new life area using the Add Additional Life Area button detailed in step 30, updating an existing life area (including its goals/objectives) by clicking the corresponding update button, or editing existing Coordination and Discharge Planning information.

29. To add a new life area to the plan, click the **Add Additional Life Area** button, and complete the necessary fields as done when adding a new life area to the comprehensive treatment/service plan.

30. Click **UPDATE** to save the new life area information and view the review in report mode. If further updates are needed, click **Return to Data Entry**.

31. In the "Coordination of off-site services" portion of the plan, enter or make changes to any off-site services that have been referred to the client by configuring the following fields/options:

    - **Date of Referral –** In the date field provided, enter the date the referral to the off-site service was made.

    - **Describe the Nature of Service/Name of Provider –** In the text box provided, type or make changes to the description of the off-site service and provider information.

    - **Result of Referral –** In the text box provided type or make changes to information on the referral result.

    - **Procedure for Ongoing Coordination of Care –** In the text box provided, type or make changes to the procedure for any ongoing coordination of care needed.

32. In the "Discharge Planning" portion of the plan, make changes to the information in the following text boxes as needed: **Relapse Prevention Plan (be specific)**, **Assessment of Home Environment**, **Vocational / Educational / Employment Status**, **Relationship with Significant Others, including need for services to significant others**, **Assessment of Housing Suitability**, **Clients / Families Need for Continued Services and Self Help**, and **Other Needs**.

33. Click **UPDATE**. The comprehensive treatment/ service plan review information is saved and a read-only report version of the treatment plan is displayed on the *Comprehensive Treatment/ Service Plan Review* page.

    *To make additional changes to the review at this time, click **Return to Data Entry** to return to the* Treatment Plan Goals, Objective and Integrated Program of Therapies and Activities to meet Objectives *update page*

The process of entering/updating a comprehensive treatment/service plan review is now complete.

VIEWING PLAN REPORTS

There are two types of reports that can be viewed for life areas treatment plans: a Treatment Plan History report and a Service Plan report:

- **Treatment Plan History Report** - A Treatment Plan History report displays the history of any goals, start dates, objectives and therapies/activities entered for specific life areas. It will also display review or amendment information, if entered.

- **Service Plan Report** - A Service Plan report displays a client's entire plan in read-only mode, and is typically suitable for printing and placing in a client's file.

VIEWING A TREATMENT PLAN HISTORY REPORT

To view a read-only treatment plan history report, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Services**. The *Consumer Services Menu* page is displayed.

2. Click the **Program** drop-down arrow and select the program associated with the consumer for whom the treatment plan history report is to be viewed.

3. Click the **Database** drop-down arrow and select "Reports."

4. To limit consumer selection by name, click the **A-Z** drop-down arrow and select the initial of the consumer's last name. An asterisk (*) in this field will include all consumers in the selection process.

5. To view the treatment plan history report of former (discharged) consumers only, click the **Roster Archives** check box.

6. Click **Service Plans**. The *Treatment Plan Consumer Selection* page is displayed.

7. Click the **Consumer** drop-down arrow and select the consumer for whom the Treatment Plan History report is to be viewed.

8. Click **CONTINUE**. The *Individual Treatment Plan Index* page is displayed.

9. Click **Plan Amendments and Reviews**. The *Plan Amendments & Reviews Preliminary Selections* page is displayed.

10. Click the **Life Areas** drop-down arrow and select the life area to be viewed on the report. The default selection is "All Life Areas."

11. Click **CONTINUE**. The Treatment Plan History report is displayed. This report displays goals, start dates, objectives and therapies/activities entered for the life areas selected. If review or amendment information is entered for the client, this information will also display on the report.

The process of viewing a Treatment Plan History report is now complete.

VIEWING A SERVICE PLAN REPORT

To view a read-only Service Plan report, complete the following steps:

1. From the *AWARDS Opening Menu* page, click **Services**. The *Consumer Services Menu* page is displayed.

2. Click the **Program** drop-down arrow and select the program associated with the consumer for whom the Service Plan report is to be viewed.

3. Click the **Database** drop-down arrow and select "Reports."

4. To limit consumer selection by name, click the **A-Z** drop-down arrow and select the initial of the consumer's last name. An asterisk (*) in this field will include all consumers in the selection process.

5. To view the Service Plan reports of former (discharged) consumers only, click the **Roster Archives** check box.

6. Click **Service Plans**. The *Treatment Plan Consumer Selection* page is displayed.

7. Click the **Consumer** drop-down arrow and select the consumer for whom the report is to be viewed.

8. Click **CONTINUE**. The *Individual Treatment Plan Index* page is displayed.

9. Click the **Selected** radio button next to the service plan item to be viewed.

10. Click one of the following **Treatment Plan to Display** radio buttons to indicate how report information is to be viewed:

    - **Complete Plan –** Displays the plan/review report in its entirety on a single page.

    - **One Goal At A Time –** Displays the Service Plan report one section at a time with each life area on a separate page.

11. Click **CONTINUE**. The Service Plan report is displayed.

12. If the **One Goal At A Time** option was selected, scroll down to the bottom of the report page and click **NEXT** to view the next service plan goal/objective.

The process of viewing a Service Plan report is now complete.

FREQUENTLY ASKED QUESTIONS

The following frequently asked questions regarding the treatment plan feature can be a useful reference when you have your own questions about the functionality.

A CLIENT WAS DISCHARGED BEFORE DATA ENTRY ON HIS/HER TREATMENT PLAN WAS COMPLETED. HOW CAN WE COMPLETE THAT DATA ENTRY?

To update treatment plan data for a discharged client, select the roster archives option on the Services module menu page before accessing the Service Plan feature. When that option is used, the consumer selection list will be comprised of former clients instead of active clients.

A STRANGE SYMBOL (Â) APPEARS IN A TEXT BOX ON A CLIENT'S TREATMENT PLAN. HOW DID IT GET THERE?

When text that is cut and paste from a Word document into AWARDS is spell checked using the AWARDS spell checker, it may result in the insertion of an Â character in the text. This is a known issue which can usually be prevented by doing one or more of the following:

- Save the Word document from which the text will be pasted as plain text.
- Delete any blank spaces before or after the text once it has been pasted into AWARDS.
- Use the Word spell check feature prior to pasting the text into AWARDS.

In the event that the Â does appear in a client's plan, the user can manually delete it from the text box and save the plan.

HOW DO I CHANGE WHO A TREATMENT PLAN IS ASSIGNED TO?

To change the staff person a treatment plan is assigned to, use the Update Schedule feature located beneath the treatment plan index. Within update schedule make changes to the "Reviewer" selections as necessary, then click CONTINUE to save your changes.

HOW DO I CORRECT / ADD A TREATMENT PLAN DATE?

To correct the date of a treatment plan, use the Update Schedule feature located beneath the treatment plan index. Within update schedule make changes to the "DueDate" values as necessary, then click CONTINUE to save your changes.

To add a treatment plan date, use the NEXT line within update schedule to enter the information for that date, and then click CONTINUE to save it. Keep in mind that within update schedule dates must be entered in order from top to bottom. If it is necessary to insert a new date between two existing dates, use the BACK FILL line instead of NEXT.

To update the schedules for all clients using the autmatic scheduling feature, contact the Foothold Help Desk.

HOW DO I DELETE A PLAN?

If no data has been entered in a plan, it can be deleted using the Update Schedule feature located beneath the treatment plan index. Plans available for deletion will have a delete check box next to them.

HOW DO I INDICATE A PARAGRAPH SEPARATION WITHIN A TREATMENT PLAN DATA ENTRY BOX?

Use a double return to create a paragraph separation where needed. (A single return is removed.)

I ENTERED A DONE DATE FOR A REVIEW USING UPDATE SCHEDULE, BUT AM BEING TOLD THAT THE REVIEW IS OVERDUE WHEN TRYING TO WRITE A PLAN LINKED NOTE. WHY?

Treatment plan done dates control whether or not charting timetable reminder notices are sent for the plans - they do not determine whether or not a review has been completed for progress note data entry purposes. In such cases, AWARDS looks in the plan to see whether there is actual review data entered. If not, you will be prevented from writing plan linked notes against that plan if the last review was not completed within the last 90 days.

I RECEIVED A "NO PLAN DATA" ERROR WHEN I CLICKED ON THE DATE LINK FOR A PLAN IN THE TREATMENT PLAN INDEX. WHY?

The date links on the treatment plan index can only open a report version of the plan if there is data in that plan. Information entered on the first page of a treatment plan is not considered data, so it is possible that you will have completed that page of the plan and still receive the "no plan data" error.

I WANT TO REVISE A GOAL BUT IT IS READ-ONLY AND UNDERNEATH IT SAYS "GOAL TEXT LOCKED BY SUBSEQUENT REVISION." WHAT DOES THAT MEAN?

The bold red "goal text locked by subsequent revision" notice beneath a goal indicates that the goal cannot be changed because one or more of its objectives have already been revised. In the event that it is necessary to update both a goal and its objectives, you must first revise the goal, the objectives will then be restarted, and you can make any necessary changes to those objectives. In order to revise a goal after one of its objectives has already been revised, you must undo the revision, schedule a plan amendment and revise the goal within that amendment, or wait until the next review and make the changes at that time.

IF A CLIENT IS DISCHARGED FROM A PROGRAM AND LATER RE-ADMITTED TO THAT SAME PROGRAM, SHOULD HIS/HER ORIGINAL PLAN BE AVAILABLE FOR THE NEW PROGRAM STAY?

No. When a client is discharged from a program the data from the treatment plan entered during the original program stay does not transfer over to the plan for the new program stay when the client is re-admitted.

IN AN OASAS/LIFE AREA TREATMENT PLAN, SHOULD THE DISCHARGE PLANNING PORTION CARRY FORWARD TO SUBSEQUENT PLANS?

Yes, the discharge planning information will carry forward to the next plan. In order to have it do so, you must click the UPDATE button at the bottom of the second page of the plan to which the information should be carried. (The second page is the one on which all of the life areas and objectives are displayed and where the Update Life Area buttons are located.)

THERE IS A RED "LOCKED BY SUBSEQUENT NOTES" MESSAGE BENEATH PART OF A PLAN AND I CANNOT MAKE CHANGES TO THAT PART OF THE PLAN. WHY?

When a goal or objective is locked by "subsequent notes" it is an indication that there are notes written against that part of the plan that have dates that are on or after the plan date. If the locked portion of the plan needs to be revised, you can either complete a plan amendment using a date after the plan linked note date(s), or you can temporarily unlink the notes. To do so, view the progress notes report and make note of the dates of those notes linked to the part of the plan to be changed. Next, go into the Progress Notes feature in report mode and open

the first of the notes in question. (Keep in mind that you must be the note writer or have the "Surrogate Data Entry" permission in order to do this, and that it is possible that you will need the "Backdated Progress Notes Data Entry" permission depending on the note dates.) Once the note is open, change the note type from treatment plan linked to general chart note and save. Repeat as needed until all relevant notes are unlinked, then go into the treatment plan and make the necessary changes. Once those changes are complete, go back into the Progress Notes feature and relink all of the notes to the correct plan components.

THERE IS A SCHEDULED TREATMENT PLAN ON A CLIENT'S TREATMENT PLAN INDEX THAT CANNOT BE SELECTED AND OPENED IN DATA ENTRY MODE. WHY?

By default, AWARDS prevents users from opening and working on treatment plan reviews whose due dates are more than a month in the future. In the event that you need to work on a plan that is not available for selection on the treatment plan index for this reason, you will need the "Service Plan Early Review" permission. That permission enables users who have it to open and work on any scheduled reviews, regardless of their due dates.

WHAT IS A PLAN AMENDMENT?

Amendments are typically used when a treatment plan or part of one needs to be reviewed before its scheduled due date. Within amendments, only the part of the plan to be changed needs to be reviewed unlike regular reviews where the entire plan must be reviewed before changes can be made.

Amendments are scheduled using the Update Schedule feature located beneath the treatment plan index; however, not all programs are set up to schedule amendments. If you do not see an amendment plan type within update schedule and would like more information on whether amendments are right for your program, please contact your Client Services representative.

WHEN USING UPDATE SCHEDULE TO CHANGE A PLAN DATE I RECEIVED A "DUPLICATE DATE" ERROR AND COULD NOT PROCEED. WHAT DO I DO?

AWARDS does not allow for duplicate treatment plan dates; however, in rare instances (for example, due to problems with automatic plan scheduling) a duplicate date may be created. In the event that this happens, please contact the Help Desk for assistance. Be sure to provide them with the client name, program, existing plan date, and what new date you were entering. They will assist you in making the correction.