Treatment Plan Tool User Guide

Summary

The Treatment Plan Tool enables the user to create, update, and review treatment plans. This document walks through the process of setting up and starting a new treatment plan, updating it, and reviewing it. Also included is a labeling guide that explains each of the fields and controls of the feature.

Requirements

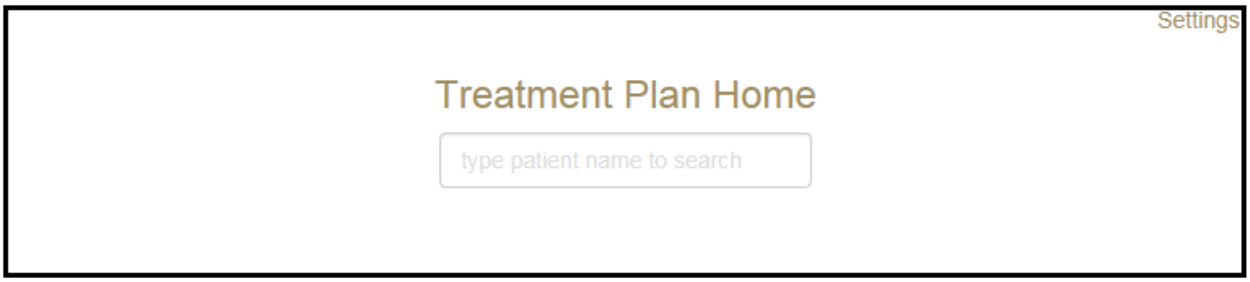
The user must be using the Vālant ICD-10 diagnostic tool for the Treatment Plan Tool to function properly. In addition, the user will also need to have the Mobile Notes™, Mobile App, and Treatment Plan Clinical modules enabled.

Contents

Accessing the Treatment Plan Tool

EHR Access

To access the Treatment Plan Tool through the EHR, hover the mouse cursor over Tools in the side navigation bar and click Treatment Plan Tool. The Treatment Plan Tool will display in a new browser tab or window, depending on local settings.



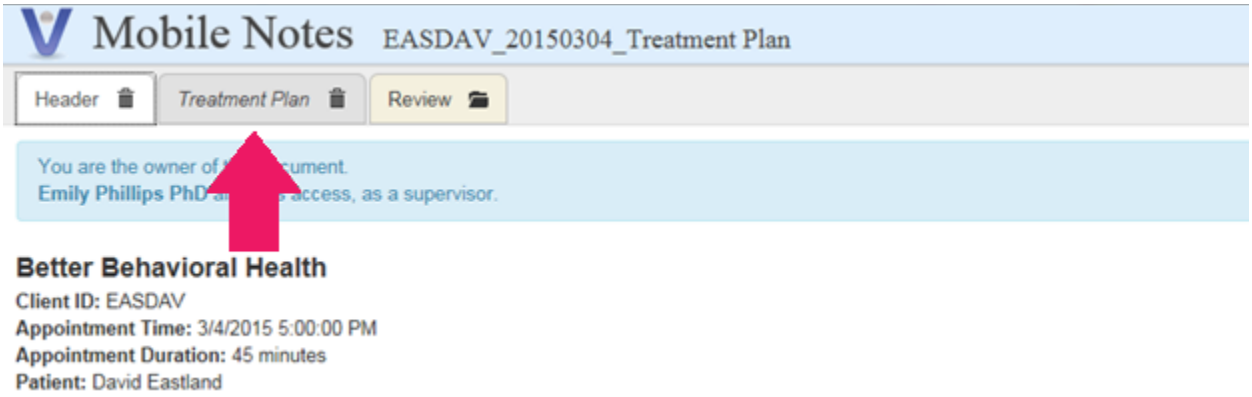
The Home Page

Mobile Site Access

Providers can access Treatment Plan Tool through the mobile site by following the link at the bottom of the schedule page.

Mobile Notes™ Access

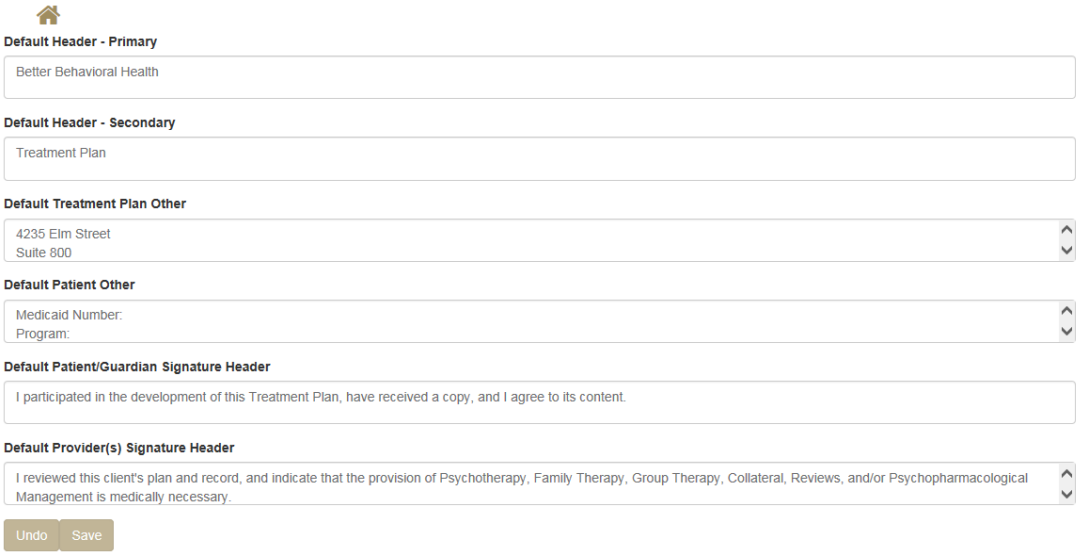
If a Mobile Notes™ template has the Treatment Plan section included in it, there will be a link to the Treatment Plan Tool there as well.



Settings

Throughout the treatment plan various headers exist for fields and text boxes. Rather than having to fill out each of the headers every time, the user can arrange for the headers to be automatically populated with desired text from within the Treatment Plan Tool Settings Page. The provider can alter the text in these fields within individual treatment plans if desired.

From the Home Screen, click Settings. The Settings interface will display.



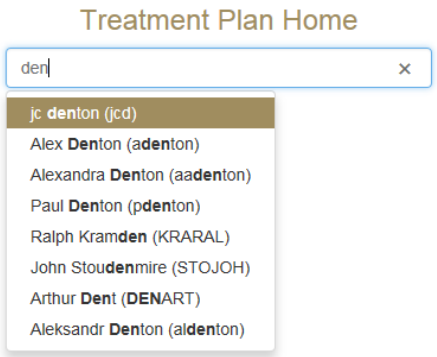
Each of the treatment plan headers are represented in the settings interface by text boxes. The text entered into the text boxes will automatically populate those areas of the treatment plan. There are no strict requirements for usage; ultimately, it is up to the providers to come up with headers that best suit their needs.

> Note: a future version of Treatment Plan Builder will allow customers to set this default text for all providers.

Click the Save Button at the bottom of the interface to commit the changes. Click the Undo Button to delete any changes since the last Save. Click to return to the Home Screen.

Creating a New Treatment Plan

From the Home Screen, enter at least the first 3 letters of a patient's first or last name into the search box. The system will run a search query and provide a list of potential matches from the database to choose from. Click on the patient's name to access that patient. Once the patient's profile is pulled up, click Create New Treatment Plan.

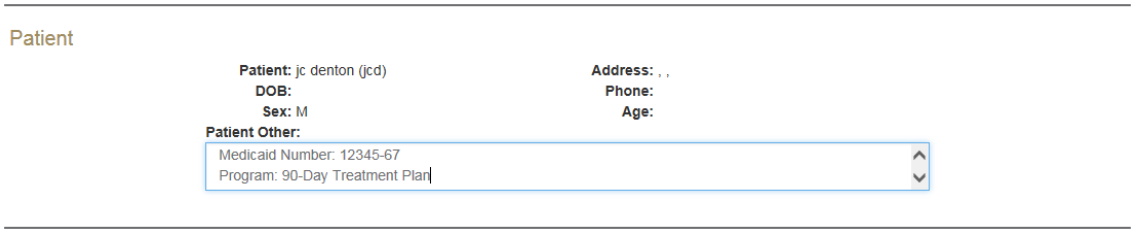


Note: A new treatment plan cannot be created if the patient already has an active or draft treatment plan in progress, or if the patient does not have at least one up-coded ICD-10 diagnosis in the system.

Note: Only a provider is allowed to create, update, or review treatment plans. Staff can only view, print, and have a patient sign off on them.

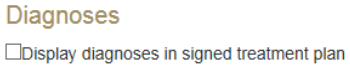
1. Patient

Enter any additional patient information into the Patient Other Textbox as needed. If this header was customized on the Settings Screen, it will be automatically populated by the text you specified.



2. Diagnoses

Choose whether or not to display patient diagnoses in the signed version of the treatment plan. In the Diagnoses Section, check the Display Diagnoses Checkbox to display them, or leave the checkbox unchecked to hide them.



3. Header

Customize the header of the treatment plan under the Header Section. Enter header content into the Primary, Secondary, and TxPlan Other Textboxes as needed. If these headers were customized on the Settings Screen, they will be automatically populated by the text you specified.

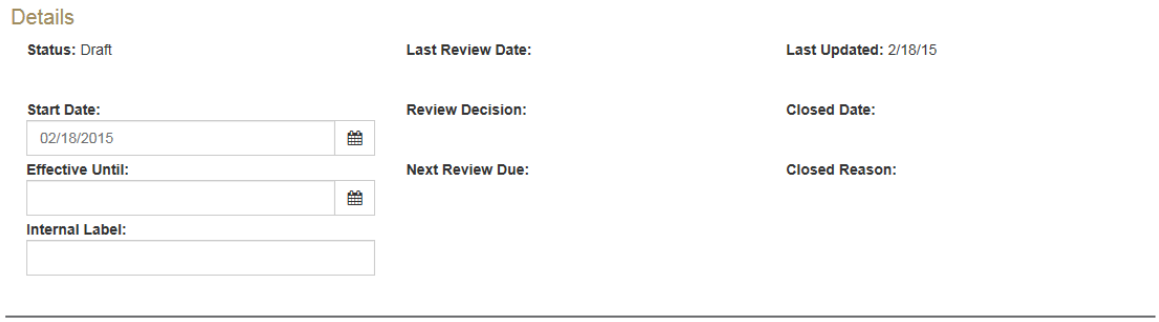
4. Reviews

Add reviews to the treatment plan by checking the checkboxes in the Review Section. Some typical multi-day review increments are provided, though the user can also add a custom review by clicking the Add Custom Review Button.

Clicking a Review Checkbox will display the projected review date in a textbox, based on the chosen increment and the Start Date (see below). The user can adjust the date as needed, either by revising the date manually or using the attached calendar tool.

5. Details

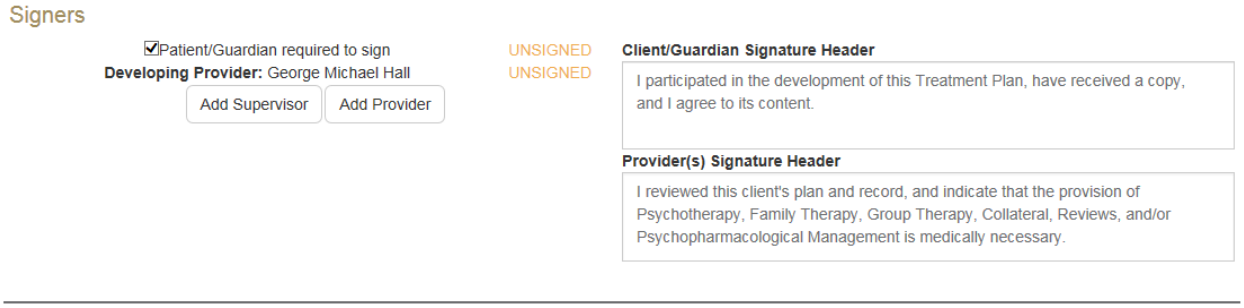
Specify the treatment plan's beginning and end date, using the Start Date (required) and Effective Until fields. The user can either enter the dates manually or use the attached calendar tool.



Enter any pertinent information into the Internal Label Field. This field is optional, and will not display on the printed version. It can be used to improve the clarity of the treatment plan's intended use to the clinician user.

6. Signers

Choose whether or not the patient or guardian is required to sign the treatment plan. In the Signers Section, click the Patient/Guardian Checkbox to make it required, or leave the checkbox unchecked to make it not required.

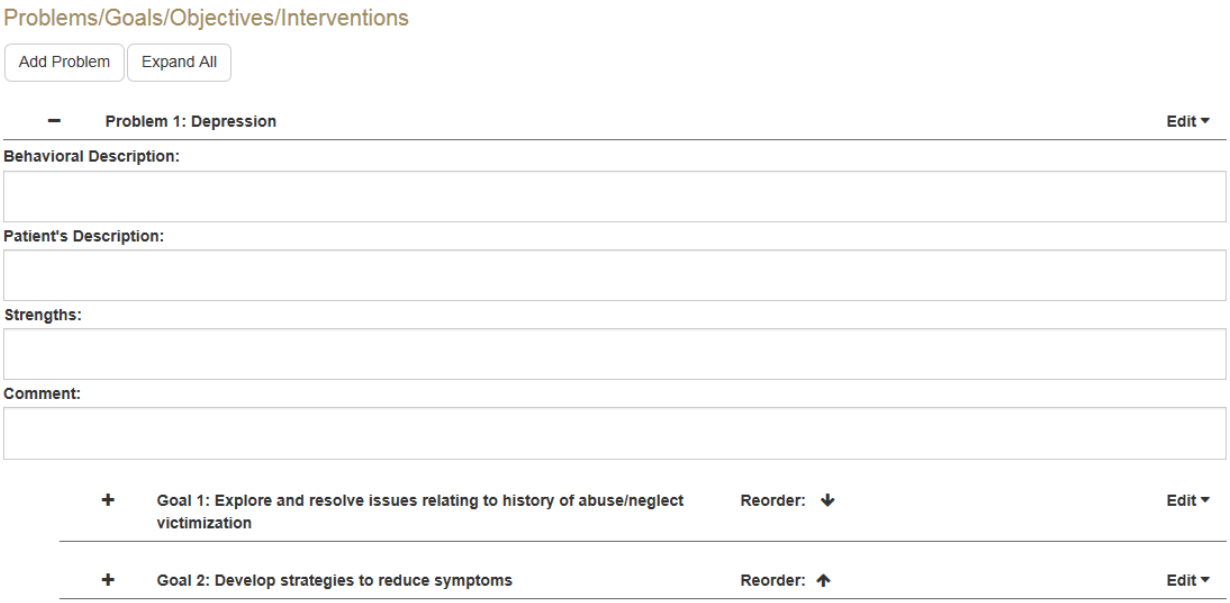


Add any additional supervisor or provider names to the list of required signatures by clicking the respective buttons and selecting names from the drop-down. You can add multiple other providers, but only one supervisor.. To appear on the supervisor list, the provider must have permissions to be a Supervisor for Mobile Notes.

Customize the signature headers as needed. If these headers were customized on the Settings Screen, they will be automatically populated by the text indicated there.

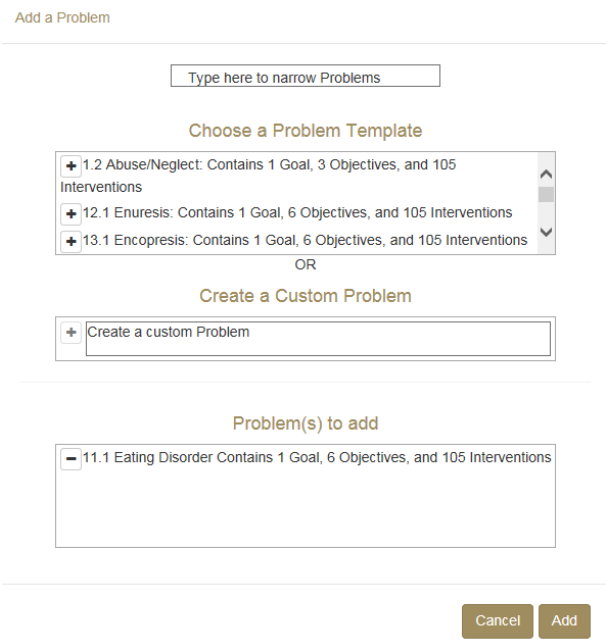
7. Problems/Goals/Objectives/Interventions

Problems, goals, objectives, and interventions are arranged in a hierarchy of levels and sub-levels in the treatment plan. Beginning at the top, problems can have one or several goals under it, and each goal can have a set of objectives, and so on.



Problems

Add problems to the treatment plan by clicking the Add Problem Button. The Add a Problem Window will display.



The user can select from a list of problem templates that share at least one diagnosis with the patient by clicking the accompanying Add Icon  . The user can also create custom problems by entering a brief description or title into the Create a Custom Problem Text Box and clicking the attached Add Icon. Any chosen problems will display in the Problem(s) to add List Box, located near the bottom of the window. Click the Add Button to add the selected problems to the treatment plan and close the window.

Problems that have been added to the treatment plan will be listed in the Problems/Goals/Objectives/Interventions Section. Click the Plus Icon ✚ beside a listed problem to expand the problem and display its header information. The fields will be blank for new problems, and the user will need to fill them out to provide clarity. If the problem

came from a template, a description of the template and provider instructions (*which will not appear in the printed version of the treatment plan*), will be displayed.

Goals, Objectives, and Interventions

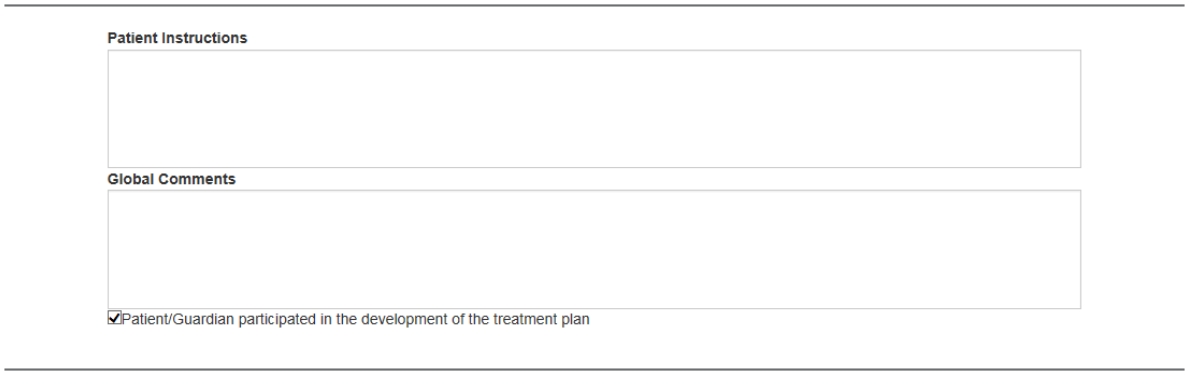
Add goals, objectives, and interventions by clicking on the Edit Drop-Down and selecting Add goal/objective/intervention. Adding a sub-level (sub-level) item works similarly to adding a problem to the treatment plan. An Add Window will display, allowing the user to select from a list of available template items (i.e., items built into the template), choose from available library items (i.e., items not built into the template, but that share a diagnosis with the template or the patient), or create custom sub-level items. Click the Add Button to commit the selected items to the problem.

Any sub-level items that have been added will be listed under their corresponding parent problem. Click the Plus Icon beside a listed sub-level item to expand it to display its header information. If the item is new, all of the header fields will be blank. The user will need to fill them out to provide clarity.

> Note: Problem templates, depending on how they were set up in the Treatment Plan Builder feature, may prepopulate sub-level items, and may prohibit the user from adding custom items or removing required items in the problem.

8. Patient Instructions and Global Comments

Fill out the text boxes for Patient Instructions and Global Comments as needed. The Patient/Guardian Participated Checkbox will be displayed on the active version of the treatment plan.

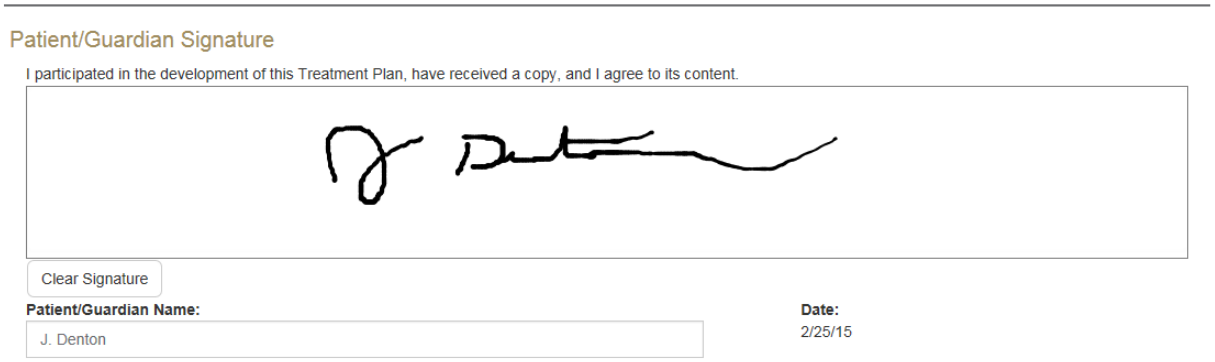


9. Finalizing the Treatment Plan

Click the Save and Sign Button to capture the changes and sign the treatment plan. Alternatively, if you are not ready to sign, you can click the Save and Continue Button or the Save and Close Button to save your work.

> **Note: It is strongly recommended that you save your work regularly as the tool does not automatically save.**

If the Patient/Guardian Checkbox was checked in the Signers Section, the patient or guardian will also need to sign before the treatment plan goes active. With the treatment plan owner's signature in place, click View Draft from the Home Screen. Scroll to the bottom of the treatment plan and click the Patient Sign Button. This will open a signature box at the bottom of the treatment plan. Have the patient sign the signature box (using a finger or stylus on a touch screen, or a mouse on a non-touch screen), verify their name into the Patient/Guardian Name Field, and click the Sign Button. If desired, two or more individuals could sign in the signature box and type their names in the Patient/Guardian Name Field.



Any providers or supervisors that were added to the signing requirements in the Signers Section will also need to provide their signatures before the treatment plan becomes active. Any unsigned treatment plans that a provider or supervisor needs to sign will appear in his/her Unsigned Documents in the EHR with the status "Ready to Sign". To sign, they can open the Treatment Plan Tool, search for the patient, select "View Draft", click the Edit Button, and click the Save and Sign Button. After he/she signs, the treatment plan will continue to appear in Unsigned Documents with the status "Signed.Pending" until the treatment plan becomes active.

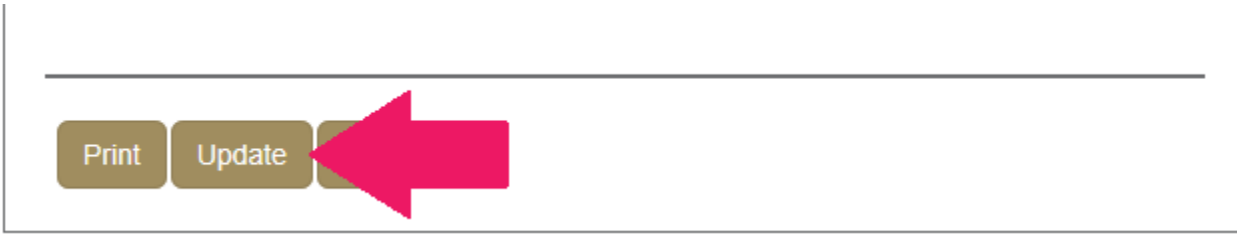
Once the signature criteria for the treatment plan are met, the treatment plan will become active. A PDF snapshot of the signed treatment plan will be saved and will appear in the Documents tab in the patient chart in the EHR.

Updating an Active Treatment Plan

Treatment plans can be revised even after they have already been made active. From the Home Screen, find the active treatment plan in the list and click View Active.

Scroll to the bottom of the plan and click the Update Button. This will bring the plan into update mode and permit the user to make revisions as necessary.

> Note: Only a provider is allowed to create, update, or review treatment plans. Staff can only view, print, and have a patient sign off on them.

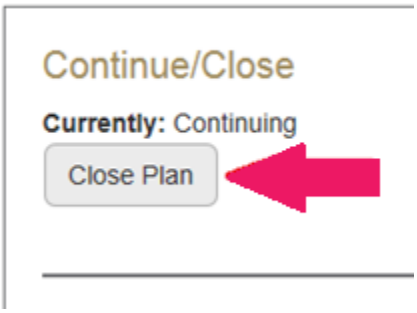


While in update mode, you can edit most of the areas described in the Creating a New Treatment Plan section (above); add new problems, goals, objectives, and interventions; close the plan or individual problems/goals/objectives/interventions; and update progress on goals and objectives.

> Note: Some actions, such as closing the plan or adding problems, goals, objectives, or interventions, will place the treatment plan into a draft status until all the required signatures are collected. The last active version of the treatment plan will remain active in the interim. Other changes, like adding or removing a signer, require only the owner's signature. Finally, some changes, like changing the header or updating progress on a goal or objective (see below), do not require a signature; the plan immediately becomes active upon saving.

Closing a Plan

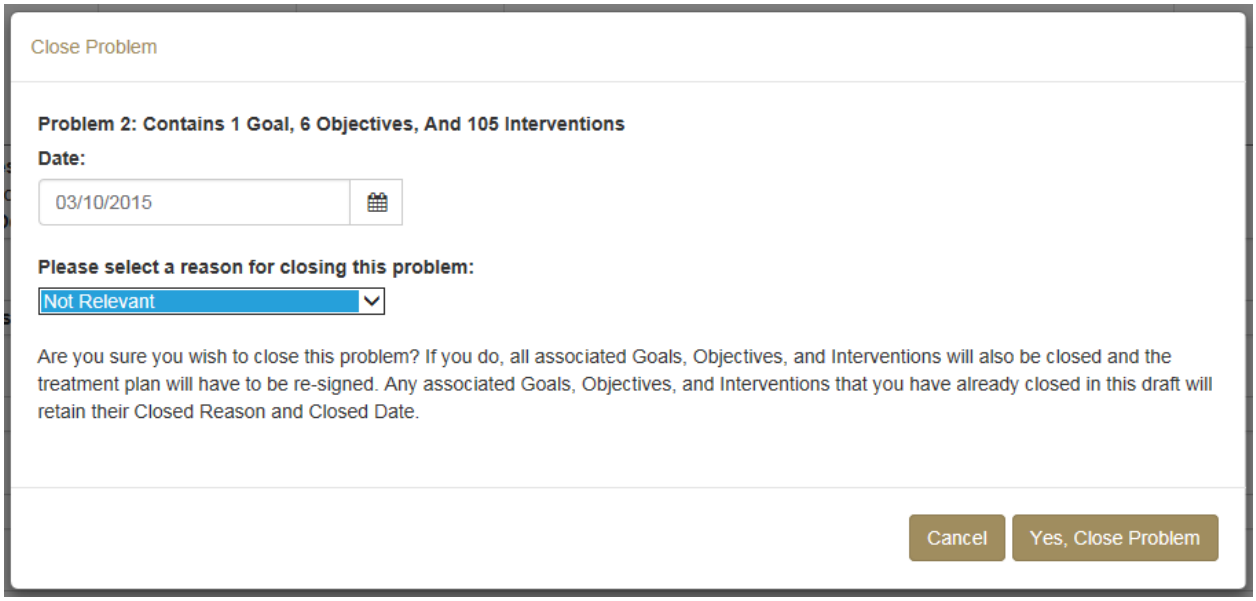
While in update mode, click the Close Plan Button to initiate the closing of a treatment plan. The Close Plan Window will display. Enter the close date into the date field (either manually or by using the attached calendar tool) and select a reason for closing the plan from the drop-down. Finally, click the Yes Button.



Closed plans can be viewed and printed, but they cannot be updated, reviewed or re-opened.

Close Problem/Goal/Objective/Intervention

Problems, goals, objectives, and interventions can be closed on an individual basis. Click the Edit Drop-Down of the corresponding item to close, and click Close problem/goal/objective/intervention. Enter the close date into the date field (either manually or by using the attached calendar tool) and select a reason for closing the item from the drop-down. Finally, click the Yes Button to confirm. If the item has any sub-level items under it, they will all be closed as well.

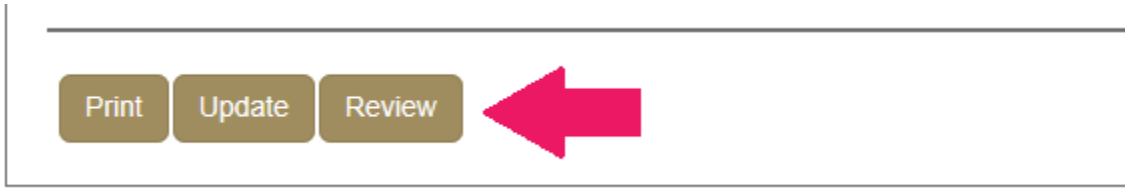


Update Progress

Measure-based goals and objectives provide an opportunity to assess their progress. Click the Edit Drop-Down of the corresponding item to update and click Update Progress. Enter the date of the assessment into the Progress Date field—either manually or by using the attached calendar tool. Click the Progress Drop-Down and select from the list of progress. Provide any pertinent information in the Progress Details Text Box. Finally, click the Update Button to confirm.

Reviewing an Active Treatment Plan

Conduct a scheduled review by accessing the active treatment plan from the Home Screen, scrolling down to the bottom of the plan, and clicking the Review Button.

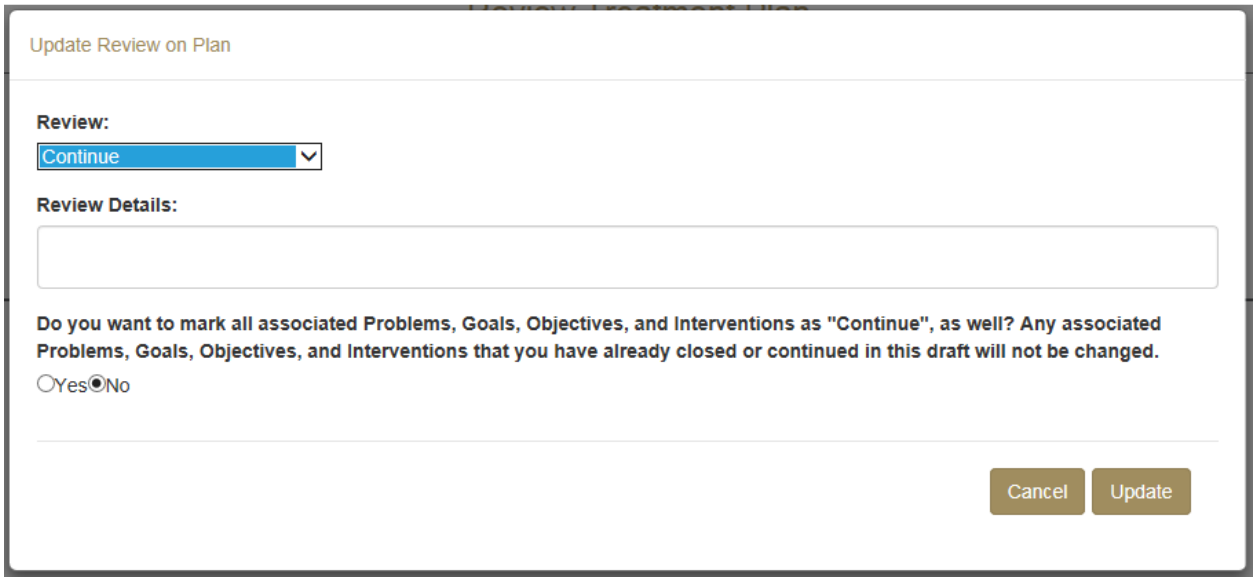


The plan will be brought into review mode, with a set of Review Radio Buttons at the top to choose from—each one representing the reviews that were scheduled when the treatment plan was created. Make the appropriate selection and click the Review Button.

Note: Only a provider is allowed to create, update, or review treatment plans. Staff can only view, print, and have a patient sign off on them.

The Update Review on Plan Window will display. Select to either close or continue the review from the drop-down. Enter any relevant information in the Review Details Text Box.

If “Continue” was chosen from the drop-down, the option to uniformly continue every problem, goal, objective, and intervention in the treatment plan will be presented. Select Yes or No, and click the Update Button. Every item in the treatment plan must eventually be addressed in order to sign off, so this method can be a time-saving feature for a provider that does not wish to make any changes to the plan during a review.



Note: Items that are marked in this way to continue can still be assessed on an individual basis and closed, if need be. Also, any data for items previously continued or closed within this draft will not be overwritten by this process.

If “Close” was chosen from the drop-down, enter the close date into the date field (either manually or by using the attached calendar tool) and select a reason for closing the plan from the drop-down. Finally, click the Update Button.

Note: All items in the plan (e.g., problems, goals, etc.) will also be closed with the same close reason, although the close reason and close date for individual items can be changed, and goals and objectives can still be given Progress Updates. Also, the close reason and close date for items previously closed within this draft will not be overwritten by this process.

Problems, goals, objectives, and interventions can be reviewed on an individual basis. In the Problems/Goals/Objectives/Interventions section, click the Edit Drop-Down next to the item you want to review, and click the Review Option. This will pull up a window that gives the user the choice to continue or close the item, as well as leave any relevant commentary. As it is at the Plan level, *continuing* an item with sub-level items attached to it allows the user to choose whether to propagate the decision to each of the sub-level items; *closing* an item with sub-level items attached to it will automatically close each of the sub-level items. Click the Update Button to capture the changes and close the window.

For Goals and Objectives, you can also Update Progress as a part of doing a Review. Enter the date of the assessment into the Progress Date field—either manually or by using the attached calendar tool. Click the Progress Drop-Down and select from the progress menu. Provide any pertinent information in the Progress Details Text Box. Finally, click the Update Button to confirm.

Once every problem, goal, objective, and intervention, and the treatment plan itself, is reviewed (i.e., either “continued” or “closed”), click the Save and Sign Button at the bottom of the treatment plan to complete the review and return to the Home Screen.

> Note: If you have not reviewed all items, you will not be permitted to sign the treatment plan. Alternatively, if you are not ready to sign, you can click the Save and Continue Button or the Save and Close Button to save your work.
>
> **Note: It is strongly recommended that you save your work regularly as the tool does not automatically save.**

Labeling Guide

This section of the document provides additional information about each of the controls and fields in the feature.

Home Page

- **Settings** – Opens the Settings Screen.
- **Search Box** – Performs a search of the patient database, and returns a list of potential matches based on the first three letters entered. Click on a name to pull the record, or click the (X) icon to clear the search box.
- **Patient Demographics** – The patient's name, date of birth, age, and sex. These fields are initially hidden, but will display and be populated with the appropriate information when a patient is selected from the Search Box.
- **Release Lock** – Unlocks the selected patient's treatment plan.

  Note: The treatment plan will lock when a user is in the middle of an edit, update, review, or patient signing until the record is saved or closed. If the feature is unexpectedly closed, the lock will remain in place until it automatically times out after 20 minutes or the user clicks Release Lock to manually release the lock.

- **Create New Treatment Plan** – Opens a new, blank treatment plan template. A new treatment plan cannot be created if there is already an active plan or draft in place. This hyperlink will be hidden until a patient is selected from the Search Box.

Home Page Grid

- **Status** – The state of the treatment plan. The status can be closed, draft, or active.
- **Start Date** – The beginning date of the treatment plan.
- **Effective Until** – The ending date of the treatment plan.
- **Last Review** – The date that the most recent review was conducted.
- **Next Review** – The date of the next scheduled review.
- **Last Update** – The date that the most recent update to the treatment plan was performed.
- **Owner** – The creator of the treatment plan.
- **View** – Opens the treatment plan.

Settings Page

- **Home Icon** – Returns the user to the Home Screen.
- **Text Boxes** – Each text box represents certain headers in the treatment plan template. Any text entered will automatically populate the template in the area that corresponds with the text box label, but isn't permanent; the user can adjust the text once inside the template itself, if need be.

- **Undo Button** – Reverts all the text boxes to the last saved version.
- **Save Button** – Captures and commits the changes in the text boxes.

Create/View/Update/Review Treatment Plan Page

- **Home Icon** – Returns the user to the Home Screen. Any unsaved changes made during the creation, update, or review of the plan will be lost.

Continue/Close Section (Update Treatment Plan)

- **Close Plan Button** – Opens the Close Plan Window. To initiate the closing of the plan, enter a closing date, select a reason for closing the plan from the drop-down, and click the Yes, Close Plan Button. The plan will need to be signed by all required parties before it closes. Closed plans can be viewed and printed, but they cannot be updated, reviewed or re-opened.

  Note: This will close the entire treatment plan at once without assessing each problem, goal, objective, and intervention individually. If you want individual items to have a different "Close Reason" from the plan, before signing you can update those items before or after closing the plan.

Review Section (Review Treatment Plan)

- **Review Radio Buttons** – Indicate the intended review session. The user will be able to choose from any interval that was specified when the treatment plan was created.
- **Review Button** – Reviews the treatment plan itself, allowing you to "continue" the plan or "close" it. Click the button to open the Update Review Window, select a review decision from the drop-down, provide any pertinent information in the Review Details text box, and click the Update Button to complete the review and close the window.

  If you choose to close the plan, all problems/goals/objectives/interventions will also be closed. If you want individual items to have a different "Close Reason" from the plan, before signing you can update those items before or after closing the plan.

  If you choose to continue the plan, you are given the option to continue all problems/goals/objectives/interventions as well. However, any items already marked "close" or "continue" in this draft will retain their own content and not be overwritten. You can also choose to close or continue individual items after continuing the whole plan.

Patient Section

- **Patient Demographics** – The patient's name, date of birth, age, and sex.
- **Patient Other** – Additional information pertaining to the patient. The content in this field is automatically populated with whatever was specified on the settings screen, but can be edited in individual treatment plans.

Header Section

- **Primary** – The customizable main header for the treatment plan. The content in this field is automatically populated with whatever was specified on the settings screen, but can be edited in individual treatment plans.
- **Secondary** – The customizable sub-header for the treatment plan. The content in this field is automatically populated with whatever was specified on the settings screen, but can be edited in individual treatment plans.
- **TxPlan Other** – The customizable, tertiary header for the treatment plan. The content in this field is automatically populated with whatever was specified on the settings screen, but can be edited in individual treatment plans.

Diagnoses Section

- **Display Diagnoses Checkbox** – Toggles the display of the patient diagnoses on the printed version of the treatment plan. Only the treatment plan owner's signature is required to make changes to this field.
- **DSM-5 Diagnoses** – The diagnoses under the DSM-5 guidelines that are listed for the patient.
- **DSM-5 Other Conditions** – Non-diagnostic DSM-5 conditions listed for the patient, such as V Codes.
- **General Medical & Non-DSM-5 Diagnoses** – Any other diagnostic codes listed for the patient outside of DSM-5 guidelines. This includes ICD-9 and ICD-10, among other formats.

Reviews Section (Review Mode)

- **Add Custom Review Button** – Adds an additional review date that the user can specify. Enter a day amount into the textbox and click the adjoining checkbox to create a custom review. The system will calculate the review date based on the amount of days from the starting date. This date can be adjusted by the user manually, or by using the attached calendar tool.
- **Review Checkboxes** – Adds a review to the treatment plan that correlates with the checkbox's label. The system will calculate the review date based on the amount of days from the Start Date. This date can be adjusted by the user manually, or by using the attached calendar tool.

Details Section

- **Status** – The state of the treatment plan. The status can be closed, draft, or active.
- **Start Date** – The beginning date of the treatment plan.
- **Effective Until** – The ending date of the treatment plan.
- **Internal Label** – An additional field of information available to the user. The information in this field will not be displayed on the printed version of the treatment plan.

- **Last Review Date** – The date that the most recent review was conducted.
- **Review Decision** – The outcome of the review – whether to close or continue.
- **Next Review Due** – The date of the next scheduled review.
- **Last Updated** – The date that the most recent update to the treatment plan was performed.
- **Closed Date** – The date the plan was closed, if applicable.
- **Closed Reason** – The stated reason for closing the treatment plan.

Signers Section

- **Patient/Guardian Checkbox** – Determines whether or not the patient/guardian signature is required to create, update, review, or close the treatment plan. Check the checkbox to make the patient/guardian signature required. Only the treatment plan owner's signature is required to make updates to this field.
- **Add Supervisor Button** – Adds a supervisor to the list of required signatures for the treatment plan. Click the button to pull up the Add Supervisor Window. Make a selection from the drop-down and click the Ok Button to add the selected supervisor to the list of required signatures. Only the treatment plan owner is allowed to add or remove a supervisor from the list of required signatures.
- **Add Provider Button** – Adds a provider to the list of required signatures for the treatment plan. Click the button to pull up the Add Provider Window. Make a selection from the drop-down and click the Ok Button to add the selected provider to the list of required signatures. Only the treatment plan owner is allowed to add or remove a provider from the list of required signatures.
- **Client/Guardian Signature Header** – The customizable header for client or guardian's signature box. The content in this field is automatically populated with whatever was specified on the settings screen, but can be edited in individual treatment plans.
- **Provider(s) Signature Header** – The customizable header for the provider's signature box. The content in this field is automatically populated with whatever was specified on the settings screen, but can be edited in individual treatment plans.

Problems/Goals/Objectives/Interventions Section

- **Add Problem Button** – Adds problems to the treatment plan.
  Click the button to open the Add a Problem Window. Available problem templates may be chosen from the database by clicking the (+) next to the corresponding list item. Add custom problems by entering the desired title of the problem into the Create a custom Problem text box and clicking the corresponding (+).
  Selected items will be transferred to the Problem(s) to add list box. Click the Add button to commit the problem(s) to the template and close the window.

Note: problem templates will only be available if the template has at least one diagnosis in common with the patient.

- **Expand All / Collapse All Button** – Displays or hides all of the problem, goal, objective, and intervention details.
- **(+/-)** – Collapses or expands the corresponding problem/goal/objective/intervention, displaying or hiding the item details and any of the item's immediate sub-levelren.
- **Reorder** – Changes the display order of the corresponding problem/goal/objective/intervention, if multiple items in the tier exist.
- **Edit Drop-Down** – Displays editing options for the problem/goal/objective/intervention.
    - **Add goal/objective/intervention** – Adds a new sub-level (sub-level) item under the selected item. Sub-level items are added the same way problems are added. The Add a goal/objective/intervention Window will display, allowing the user to select available template items from the database, other items not associated with the template but that share a diagnosis with the template or the patient, or create custom sub-level items. Template items will not be available under a custom parent.
    - **Close problem/goal/objective/intervention (Update Mode)** – Opens the Close Window for the item. Select a close date and choose a reason for closing from the drop-down. Click the Yes Button to confirm and close the window. Any sub-level items of this item will also be closed.
    - **Review (Review Mode)** – Opens the Update Review Window. Select a review decision, record any pertinent information in the Review Details text box, and click the Update Button to complete the review of the item and close the window. If reviewing a goal or objective, the user will also be able to provide an assessment of the item's progress. Make a selection from the Progress Drop-Down and record any pertinent information in the Progress Details Text Box.
- **Template Description (Problem)** – The attached description of the problem template. This field will not be displayed in a custom problem.
- **Behavioral Description (Problem)** – The description of the problem as exhibited by this patient. This field is considered optional by the system.
- **Patient's Description** – The patient's own words regarding the problem/goal/objective. This field is considered optional by the system.
- **Strengths (Problem)** – Any skill or characteristic of a patient that will assist the patient in solving the problem. This field is considered optional by the system.

- **Comment** – Any additional information pertaining to the problem/goal/objective/intervention. This field is considered optional by the system.
- **Changes** – A record of updates to the problem/goal/objective/intervention. This table describes the action taken and the date of the action. If a review was performed, any recorded review details and a review decision will also be logged.
- **Responsible Party (Goal)** – The person or institution pledged to the completion of the objective. The responsible party can take many forms, such as a parent, practitioner, or organization. This field is considered optional by the system.
- **Target Date (Goal/Objective)** – The projected date for accomplishing the goal or objective. This field is considered optional by the system.
- **Target # of Sessions (Goal/Objective)** – The intended number of sessions pertaining to the goal or objective. This field is considered optional by the system.

Patient Instructions and Global Comments Section

- **Patient Instructions** –Guidance for the patient based upon the treatment plan. This field is considered optional by the system.
- **Global Comments** – Any additional field of information for any details that weren't previously covered. This field is considered optional by the system.
- **Patient/Guardian Participation Checkbox** – Indicates whether or not the patient or guardian assisted in developing the treatment plan.

Bottom Section

- **Print Button (View Mode)** – Prints the treatment plan.
- **Update Button (View Mode)** – Brings the treatment plan into update mode, allowing the user to make changes to the plan.
- **Review Button (View Mode)** – Brings the treatment plan into review mode, allowing the user to perform reviews.
- **Save and Continue Button (Update/Review Mode)** – Captures any changes made during an update or a review and saves the treatment plan as a draft. The treatment plan stays open, allowing the user to continue working.
- **Save and Close Button (Update/Review Mode)** – Captures any changes made during an update or a review and saves the treatment plan as a draft. The treatment plan will close and return the user to the Home Screen.
- **Save and Sign Button (Update/Review Mode)** – Captures any changes made during an update or a review and adds the user's signature to the treatment plan, after which the user will be returned to the Home Screen. If all of the signature requirements have been met, the plan will become active. If additional signatures are still pending, the treatment plan will be saved as a draft. In Review mode,

signing is not allowed until the plan and all problems, goals, objectives, and interventions have been reviewed.

- **Delete Draft Button (Update/Review Mode)** – Discards any changes made during an update or a review, and returns the user to the Home Screen. If the user is working on a saved draft of the treatment plan, clicking the button will delete it.
- **Cancel Button (Update/Review Mode)** – Discards any changes made during an update or a review, and returns the user to the Home Screen. If the user is working on a saved draft of the treatment plan, the draft will revert to its last saved version.

Treatment Plan FAQ

1. Can I type my own goals and objectives, or must I use what is provided?

You can create custom problems, goals, objectives, and interventions instead of choosing an item from the library of options. Please note that custom items will not be added to your library, and you will need to type them again if you wish to use custom language in the future.

2. Do I have to start my Treatment Plan from an appointment?

No, you start and continue a Treatment Plan in the Treatment Plan Tool. There are three different ways to navigate to the Treatment Plan Home page:

- In the blue left-hand Navigation menu select Tools, then Treatment Plan Tool
- At the bottom of the Mobile Site click on the Treatment Plan Tool link
- If a Mobile Note template contains a Treatment Plan tab there is a button within the tab called Create/View/Update Treatment Plan

3. Why don't I see my patient when I search by their Patient ID?

You must search for patients in the Treatment Plan Tool by their first or last name.

4. How do I capture electronic patient signatures?

At the bottom of the treatment plan click the Patient Sign button. In the Patient/Guardian Signature field the patient can use their finger or stylus on a touch screen, or a mouse on a non-touch screen, to sign their name. Once they are satisfied with the signature click the Sign button.

5. What is the difference between adding a supervisor to my treatment plan, and adding additional providers?

If a Supervisor is required to sign the treatment plan their name will appear with a Supervisor label in the Signers section towards the top of the treatment plan. The electronic signature of everyone who signed the treatment plan will appear at the end of the last page.

6. Why am I receiving this error message when I try to save my treatment plan?

If you encounter a Plan Errors pop up message, you have likely entered a date in a format that is not compatible with the Treatment Plan Tool. For example, 5.15.2015 and 5/15/3015 are not accepted date formats, but 5/15/2015 and 5/15/15 are accepted formats.

7. Can a patient have more than one active treatment plan at a time?

No, each patient can only have one active and/or draft state treatment plan at a time.

8. Can I reassign a treatment plan to a different provider?

No. The provider who created the treatment plan must review and close the treatment plan to allow a different provider to begin a new treatment plan for the patient.