QI CORNER

Best Practices Series

In this issue:

- Treatment plan

To help ensure your success with following County, State, and Federal guidelines, we highlight some best practices for treatment plans.

Each client record must contain a treatment plan completed within 30 days of the initial assessment session. The treatment plan is updated at least annually or as goals change. It must be developed in partnership with the client or, for children/adolescents, with their legal guardian.

Tips and Links

- **If provider is using an Outpatient Authorization Request form (OAR) as the treatment plan, it must be signed by the client or guardian within 30 days of the initial assessment.**

For Optum's treatment plan template please click HERE

Treatment plan should:

- Include specific, observable and quantifiable goals
- Identify the proposed type(s) of intervention
- Have estimated time frames for goal attainment
- Be updated whenever goals are achieved or new problems are identified
- Be consistent with the diagnosis
- Be reviewed and updated with the client at regular intervals
- Addresses biopsychosocial needs
- Indicate the client's involvement in care and service
- Indicate the family's involvement in the treatment process, including care decisions (when applicable)
- Include documentation (a signed form or in progress note) that the client or legal guardian (based on age of consent) has agreed to the treatment plan within 30 days of initial assessment and updated at each authorization request

Have Questions?

Email us at: SDQI@Optum.com