

*****DRAFT - NOT FOR FILING*****

5122-27-03 **Treatment planning.**

- (A) Each provider required by chapter 5122-27 of the Administrative Code to maintain an individual client record (ICR) for a certified service, shall also develop an individualized treatment plan (ITP) for each client.
- ~~(A)~~ (B) The development of the ITP is a collaborative process between the client and service provider based on a diagnostic assessment, a continuing assessment of needs, and the identification of interventions and services appropriate to the individual's diagnosis and other related needs. An AoD case management plan of care may be based upon the diagnostic assessment or a separate case management assessment.
- ~~(B)~~ (C) The ITP shall document, at minimum, the following:
- (1) A description of the specific mental health or addiction services and supports needs of the client, including the AoD level of care if applicable;
 - (2) Anticipated treatment goals and objectives based upon the needs identified in this rule. Such goals shall be mutually agreed upon by the provider and the client. If these goals are not mutually agreed upon, the reason needs to be fully documented in the ICR;
 - (3) Name or description of all services being provided;
 - (4) Frequency and duration of treatment services;
 - (5) Documentation that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians or custodians or significant others;
 - (6) As relevant, the inability or refusal of the client to participate in service and treatment planning and the reason given;
 - (7) The signature of the agency staff member responsible for developing the ITP, the date on which it was developed, and documented evidence of clinical supervision of staff developing the plan, as applicable. Evidence of clinical supervision may be by supervisor signature on the ITP, or other documentation by the supervisor in the ICR; and,
 - (8) For clients receiving addiction services treatment, the level of care to which client is admitted.
- ~~(C)~~ (D) An initial ITP may be developed within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later. An initial ITP is one which documents the immediate clinical needs of the client, and includes the items required of an ITP in paragraphs (C)(1) and (C)(3) of this rule to meet those immediate needs.
- A provider may develop separate ITP and AoD case management plans or integrate the ITP and case management plan of care into one plan.
- ~~(D)~~ (E) The complete ITP must be completed within five sessions or one month of admission, whichever is longer, excluding crisis intervention mental health service provided in accordance with rule 5122-29-10 of the Administrative Code or pharmacologic management service provided as the least restrictive alternative in an emergency situation in accordance with rule 5122-29-05 of the Administrative Code.
- (F) An AoD case management plan of care for a client receiving addiction services treatment shall be developed

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within seven days of completion of the assessment or at the time of the first face-to-face contact following assessment, whichever is later.

~~(F)~~ (G) The ITP shall be periodically reviewed at the client's request; when clinically indicated; when there is a change in the level of care; or when a recommended service is added, terminated, denied, or no longer available to the client.

(1) Documentation of review of an AoD case management plan of care or integrated plan shall be at least every ninety days, or as clinically indicated, if sooner.

Reviews of a case management plan of care shall be based upon a case management reassessment at least every ninety days.

(2) Documentation of the results of non-case management periodic review shall occur at least annually, and shall include:

(a) Evidence that the plan has been reviewed with the active participation of the client, and, as appropriate, with involvement of family members, parents, legal guardians or custodians or significant others;

(b) As relevant, the inability or refusal of the client to participate and the reason given; and

(c) The signature of the provider staff member responsible for completing the review, the date on which it was completed; and documented evidence of clinical supervision of staff completing the review, as applicable.