

245G.06 INDIVIDUAL TREATMENT PLAN.

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program and within five calendar days on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program. Opioid treatment programs must complete the individual treatment plan within 21 days from the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

Subd. 2. **Plan contents.** An individual treatment plan must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), must address each issue identified in the assessment summary, prioritized according to the client's needs and focus, and must include:

(1) specific goals and methods to address each identified need in the comprehensive assessment summary, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths;

(2) resources to refer the client to when the client's needs are to be addressed concurrently by another provider; and

(3) goals the client must reach to complete treatment and terminate services.

Subd. 2a. **Documentation of treatment services.** The license holder must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of each treatment service provided to a client and the client's response to each treatment service within seven days of providing the treatment service.

Subd. 2b. **Client record documentation requirements.** (a) The license holder must document in the client record any significant event that occurs at the program on the day the event occurs. A significant event is an event that impacts the client's relationship with other clients, staff, or the client's family, or the client's treatment plan.

(b) A residential treatment program must document in the client record the following items on the day that each occurs:

(1) medical and other appointments the client attended;

(2) concerns related to medications that are not documented in the medication administration record; and

(3) concerns related to attendance for treatment services, including the reason for any client absence from a treatment service.

(c) Each entry in a client's record must be accurate, legible, signed, dated, and include the job title or position of the staff person that made the entry. A late entry must be clearly labeled "late entry." A correction to an entry must be made in a way in which the original entry can still be read.

Subd. 3. **Treatment plan review.** A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the alcohol and drug counselor responsible for the client's treatment plan. The review must indicate the span of time covered by the review and each of the six dimensions listed in section 245G.05, subdivision 2, paragraph (c). The review must:

- (1) address each goal in the treatment plan and whether the methods to address the goals are effective;
- (2) include monitoring of any physical and mental health problems;
- (3) document the participation of others;
- (4) document staff recommendations for changes in the methods identified in the treatment plan and whether the client agrees with the change; and
- (5) include a review and evaluation of the individual abuse prevention plan according to section 245A.65.

Subd. 4. **Service discharge summary.** (a) An alcohol and drug counselor must write a service discharge summary for each client. The service discharge summary must be completed within five days of the client's service termination. A copy of the client's service discharge summary must be provided to the client upon the client's request.

(b) The service discharge summary must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), and include the following information:

- (1) the client's issues, strengths, and needs while participating in treatment, including services provided;
- (2) the client's progress toward achieving each goal identified in the individual treatment plan;
- (3) a risk description according to section 245G.05;
- (4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the requirements in section 245G.14, subdivision 3, clause (3);
- (5) the client's living arrangements at service termination;
- (6) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed; and
- (7) service termination diagnosis.

History: *1Sp2017 c 6 art 8 s 19; 1Sp2019 c 9 art 6 s 16-18; 1Sp2021 c 7 art 6 s 6; 2022 c 98 art 12 s 8-10*