2960.0490 INDIVIDUAL TREATMENT PLAN.

Subpart 1. **Treatment plan required.** The certificate holder must meet the treatment plan requirements of subparts 2 and 3. These treatment plan requirements may be substituted for the requirements of part 2960.0180, subpart 2, item B, if chemical dependency is the only certificate the license holder has been issued. The individual treatment plan may be a continuation of the initial services plan required in part 2960.0485.

Subp. 2. **Plan must reflect resident's current condition.** An individual treatment plan for a resident in a certified chemical dependency program must continually evolve based on new information gathered about the resident's condition and whether planned treatment interventions have had the intended effect. The plan must provide for the involvement of the resident's family at the earliest opportunity consistent with the resident's treatment needs. The plan begins on completion of the comprehensive assessment and is subject to amendment until the resident is discharged.

The resident must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the individual treatment plan. The individual treatment plan must be signed by the resident and a licensed alcohol and drug counselor, and the participation of others must be noted in the plan. The individual treatment plan and documentation related to it must be kept at the facility in the resident's case file and also sent to other professionals as indicated within designated time lines.

Subp. 2a. **Plan format.** An individual treatment plan must be recorded in the six dimensions listed below:

A. acute intoxication and withdrawal potential;

B. biomedical conditions and complications;

C. emotional, behavioral, and cognitive conditions and complications;

D. readiness to change;

E. relapse, continued use, and continued problem potential; and

F. recovery environment.

Subp. 3. **Plan contents.** An individual treatment plan must include:

A. resources to which the resident is being referred for problems to be addressed concurrently outside the program and why the referral was made;

B. treatment goals in each of the dimensions listed in subpart 2a in which a problem has been identified;

C. specific objectives to be used to address the problems in item B, including frequency of intervention, and expected outcomes for each goal. The certificate holder must tell the resident about the objectives in the resident's individual treatment plan in a language

that the resident understands. The certificate holder must consider the resident's cultural background and other strengths and assets when determining the resident's objectives. The resident's objectives must be stated in the treatment plan and must be individualized, time limited, and measurable;

D. specific intervals at which resident progress must be reviewed;

E. minimum outcomes that are to be met before the resident is discharged; and

F. an initial risk description in each dimension, according to part 9530.6622.

Subp. 4. **Progress notes.** Progress notes must be entered in a resident's file at least daily and must indicate the type and amount of each service the resident has received weekly and whether the services have had the desired impact. All entries in resident records must be legible, signed by staff, with title indicated, and dated.

Subp. 5. **Plan reviews.** The individual treatment plan must be reviewed by an alcohol and drug counselor at the intervals identified in subpart 3, item D, and no less frequently than every two weeks, and the specific services changed if expected goals are not being achieved. Plan reviews must be recorded in the six dimensions listed in subpart 2a and include, for each dimension, a narrative and a risk description according to part 9530.6622. A resident must be notified of the right to access a plan review.

Subp. 5a. **Combined plan reviews and progress notes.** Progress notes may be considered plan reviews if they meet the requirements of subparts 4 and 5.

Subp. 6. **Client records.** Client records must be maintained and information released from them only according to Code of Federal Regulations, title 42, subchapter A, sections 2.1 and 2.2.

Statutory Authority: *L 1995 c 226 art 3 s 60; MS s 241.021; 245A.03; 245A.09; 254A.03; 254B.03; 254B.04*

History: *28 SR 211; 32 SR 2268*

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