Name of Policy:	**Individualized Treatment Plan**	THE UNIVERSITY OF TOLEDO 1872
Policy Number:	3364-143-25	
Department:	Lenore W. and Marvin S. Kobacker Center	
Approving Officer:	Vice President & Executive Director	
Responsible Agent:	Clinical Practice Manager & Agency Executive Director	**Effective Date:** October 31, 2008
Scope:	Kobacker Center	Initial Effective Date: October 31, 2008

X	New policy proposal	____	Minor/technical revision of existing policy
____	Major revision of existing policy	____	Reaffirmation of existing policy

(A) Policy Statement

An Individualized Treatment Plan or "ITP" will be developed for each client and will become part of the Medical Record (MR).

(B) Purpose of Policy

The Individualized Treatment Plan is used to monitor progress during the course of treatment.

(C) Procedure

1. The development of the individualized treatment plan is a collaborative process between the client and the interdisciplinary team based on a diagnostic assessment, a continuing assessment of needs, and the successful identification of interventions/services. The individualized treatment plan shall document, at minimum, the following:

   a. A description of the specific mental health need(s) or identified problems of the patient; including strengths and limitations.

   b. The goals identified for the patient focusing on what can be accomplished while in the hospital. Goals should be written in specific terms that are **S**pecific, **M**easureable, **A**chievable, **R**easonable, **T**ime delineated.

   c. All interventions should be discipline specific and contain specifically what each discipline will be doing with the patient.

   d. Review dates should be recorded with follow up as necessary. If a goal is not met, then either a new goal needs to be made and/or additional interventions should be noted.

   e. Evidence that the plan has been developed with the active participation of the patient and/or family members, parents, legal guardians/custodians or significant others shall also be documented; or

   f. As relevant, the inability or refusal of the patient to participate in service planning and the reason(s) given; and

   g. The date of the goal should be entered along with the dates of any changes made on the ITP. The signature of the staff member providing service must be dated and timed.

2. The individual treatment plan must be initiated as soon as possible but within at least 72 hours of admission.

3. The individual treatment plan shall be periodically reviewed and updated as appropriate to patient response to treatment.

Approved by:	Review/Revision Date:
Vickie Geha, BSN, RN, MEd Administrator, Ambulatory Services & Behavioral Health — Date 11/06/09 Theodor Rais, MD Medical Director, Kobacker — Date 11/06/09 Mark Chastang Vice President & Executive Director — 11/17/09 *Review/Revision Completed By:* *Kobacker Administration*	
	Next Review Date: 10/1/2011
Policies Superseded by This Policy: new	

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.