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| INDIVIDUAL TREATMENT PLANNING | | | | NO. 91 | |
| It is the policy of Winning Wheels, Inc. that the care and rehabilitation regimen of residents served is coordinated by an interdisciplinary treatment team that establishes an individualized program plan that incorporates the unique strengths, needs, abilities and preferences of the person served, prevents/minimizes impairment, reduces activity limitations, lessens participation restrictions, achieves predicted outcomes, and is directly related to the services and environment to which the person will be discharged. Individual programs plan will address goals that reflect the persons served informed choice. The purpose of the coordinated, interdisciplinary treatment team is to promote the design and delivery of services in an effective and efficient manner. Twenty-four hours per day, seven days per week, the interdisciplinary team is aware of persons served plan of care, exchanging information (i.e. DON report sheet), and implementing the plan of care for persons served. Decisions are made and communicated. These decisions may be emergent or ongoing issues. Treatments, resource allocations may change. The coordinated team will meet at least on a weekly basis to carry out its decision making responsibilities, and will maintain documentation of its participants. The result of such meetings will be documented on the program plan and in other areas of clinical record, as necessary (e.g. weekly team conference reports).  The size and composition of the interdisciplinary team will vary according to the services and programs delivered to the person served. At a minimum, it will include the person served and their representative and individuals providing services to the person served (support system). This includes personnel with the competencies necessary to treat the pathological processes and to evaluate and facilitate the rehabilitation services to achieve predicted outcomes of the following types:   1. Functional (e.g. Activities of Daily Living) 2. Psychological (e.g. Behavior Mgt; Psychosocial) 3. Medical (evaluate and treat pathophysiologic processes) 4. Social   The composition of the treatment team is determined for persons served through the assessment, individual planning process and predicted outcomes of persons served. Examples of personnel needed to facilitate the established outcomes may include, but are not limited to the following: a case manager, occupational, physical and / or speech therapist, a psychologist or neuropsychologist, a rehabilitation nurse, a physiatrist, a social worker, a therapeutic recreation specialist and / or a dietitian. | | | | | |
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| Other stakeholders may also be included on the interdisciplinary team, as appropriate. The individual served and/or their representative will be invited to attend their care plan conference. If the person served and/or their representative declines same, they will be assisted in completing an input sheet prior to their conference, and such information will be reviewed by the interdisciplinary team during the conference and incorporated, as appropriate, into the development of the individual program plan. The completed program plan will be reviewed with the person served and/or their representative. If it is not possible for personnel who are involved in the delivery of services to the person served to participate in such conferences in person, they are sill required to provide input and have some type of interactive communication with the rest of the interdisciplinary team. The program facilitates ongoing communication regarding the program of the person served toward the predicted outcomes.  The functions of the interdisciplinary team include the following:   1. Reviewing relevant reports to facilitate assessment of persons served. Recognizing, assessing and treating conditions and preventing complications and co-morbidities as indicated. 2. Determination, modification and implementation of the individual treatment plan and the discharge plan of persons served. Obtain appropriate prescriptions. Review and revision of prediction of outcomes as appropriate. 3. Provision of direct services and treatment (medical and rehabilitation) consistent with the needs of persons served. Development of ongoing relationships with the medical community. 4. Active participation in routine formal conferences concerning persons served, identifying resources, and integrating information on program planning and implementation. Maintain ongoing communication and coordination with members of the treatment team to facilitate service delivery. 5. Promotion of interdisciplinary team functions and mutual support among members of the teams. Ensuring team members change based on the needs of the person served. Referral to additional services as needed. 6. Promotion of the program’s evaluation and treatment philosophy, facilitating functional independence and performance, and collaborating to achieve predicted outcomes. 7. Education, training and services for the persons served, their families, and staff, as necessary (e.g. for accessing community resources/systems, prevention of further impairments, risks and complications due to impairments, financial resource management, psychological and social coping skills, prevention of further injury etc.). | | | | | |
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| 1. Communicate with relevant stakeholders regarding costs, when appropriate. 2. Assist individuals with obtaining equipment and supplies (and assistive technology) and education about use of same. Provide referrals to vendors as appropriate. 3. Identify resources. Integrating information on resources into: Program planning/implementation, conducting assessments, predicting outcomes, establishing the treatment plan and discharge plan, providing services, modifying the treatment plan, ensuring the disciplines change based on the needs of persons served, achieving predicted outcomes, transferring person served to most appropriate level of care, providing education/training, making referrals, communicating with relevant stakeholders and participating in performance improvement activities.   Written communication regarding the interdisciplinary team process is designed / delegated in a manner that demonstrates avoidance of duplication of information and efficient movement through the continuum of care.  An interdisciplinary team conference is held at least weekly for persons served unless it is documented that the needs of the person served indicate that once every other week is sufficient. | | | | | |
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