The Written Treatment Plan

As per the CCOA's Standards of Practice, a written treatment plan must be included in all patient charts. In its most basic form, the written treatment plan is the iteration of how, in a clinically relevant way, we are going to resolve the issues our patients present to us as doctors.

Based on the problem history, our physical examination findings, and our working diagnosis, this treatment plan is our proposed method of addressing the patient's presenting complaint. The following discussion will assume that the patient has presented with a complaint that you would choose to manage in your office. If this is not the case, then an appropriate referral or education of the self-limiting factors of their complaint is in order.

The elements of a written treatment plan are:

Frequency of Visits: the most basic element of the treatment plan is how often we would like to see the patient. This component will include all levels of care that we see ourselves involved in executing or supervising. The familiar notations for this type of treatment plan list the frequency of visits per week and the number of weeks we feel are necessary.

Methods and/or Modalities: this is the part of our plan where we outline all methodology that that we deem necessary for this patient. It is the area for noting all treatments that you propose, including chiropractic manipulation, physical modalities, monitored exercise, home exercise, heat, ice, and any other treatment that you are licensed to provide.

Goals: what are our outcome markers, milestones, and goals? How and when are we going to measure these outcomes? What measures are we going to use to determine treatment effectiveness? This is also the area where we schedule our re-examinations and determine how we are going to evaluate the therapeutic performance.

Timeline: the treatment plan should contain the elements of case completion; this would contain the milestones or outcomes that we are trying to achieve in order to demonstrate therapeutic success for the presenting problem. Beware of the bottomless treatment plan.

Examples of Written Treatment Plans

The most basic:	CMT, 3 x / x 2, RE (this is a bare minimum written treatment plan that would meet the current Standard)
More specific:	CMT, U/S, Acu, Home Exercise (plan included), ice at home 10 min per hour x 3 for 5 days, stretching external rotators as shown, 2 x / x 2, 1 x / x 2, RE

Note that a treatment plan is your plan of attack. It is an essential component of clinical record keeping. The best history, with the most comprehensive physical exam and the most descriptive of working diagnosis, ultimately needs a plan of approach.

Reviewing a treatment plan will quickly inform the clinician about their current place in the treatment regime and their relative success in meeting the initial objectives. It is a very effective practice management tool when a patient's confidence is reinforced by a clinician's reference to the success of their therapeutic predictions.