Treatment Plans

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CCSI’S CENTER FOR COLLABORATION IN COMMUNITY HEALTH
Who is MCTAC?
MCTAC Partners

Webinar Series Partners
Representatives from NYS-serving Managed Care Organizations
Overview of this series

- 6 part series: best practices for all types of documentation
  - What MCOs are seeing: tips and what to avoid
  - Foundations and establishing the need for treatment
  - Treatment plans
  - The progress note
  - Supporting high quality documentation as a supervisor
  - Office hours
- Survey feedback
- Questions
  - Chat at any time
  - Email
Overview of this series

- Information provided in this series reflects general best practices, and is based on the experiences of the individuals on the content development team.
- Current to the best of our ability as of today’s date, December 14th, 2016.
- Does not conflict with regulatory requirements, but may not be sufficient to be in full compliance.
- Information presented does not reflect official guidelines specific to any particular Managed Care Organization.
Join us next time

The Progress Note: A Critical Component of Care

January 11, 2017
12- 1 PM
Yvette Kelly
Objectives

- Review documentation leading up to treatment plans
  - Medical Necessity and establishing the need for treatment
  - The “Golden Thread”
  - Link to the Assessment and defined needs
- Describe essential elements of effective Treatment Plans
  - Goals
  - Objectives
  - Interventions
- Illustrate best practices using examples
Previous Webinars in Series

1. Best Practice documentation tips from MCOs
   - Importance of quality clinical documentation
   - Red Flags
   - Do’s and Don’ts

2. Foundations of effective documentation and establishing the need for treatment
   - Medical Necessity
   - Golden Thread
   - Assessment as lead into effective treatment planning
Person-centered practice

- Individual is the expert in their life
- Identify strengths, capabilities, interests, preferences, needs, hopes and dreams
- Are culturally and linguistically competent
- Involves significant others/key collaterals as appropriate
- Provide a systematic way to align what we do with what the person wants and needs
Do’s and don’ts of person-centered practice

- **Do** let the person lead the process and put them in the “driver’s seat”.
- **Don’t** forget to include those that care about them - recovery happens in a social context.

*Supervisors should understand Person-Centered practice and reinforce these expectations as part of all service delivery.*
Medical necessity – broken down

- Appropriately qualified practitioner
- Clinically appropriate services
  - Focus on why this service is needed to address symptoms and impacted daily life functioning
- At appropriate intensity and duration
- As prescribed in individualized treatment plan
- Designed to improve functioning and symptoms or prevent their worsening
- Based on an approved diagnosis and assessed need
Example of Medical Necessity in Documentation

- Assessed by appropriately qualified practitioner: MD, NPP, CASAC, LCSW, LMHC, etc.
- Based on approved diagnosis: Major Depression
- Supported by symptoms: sleep disturbance, lethargy, sadness, memory impairment, lack of enjoyment, etc.
- Assessed need: Depression is causing problems in relationships and client is unable to hold job
- Intensity and duration: Client meets DSM-5 criteria for moderate to severe depression for past 3 months
- Treatment Plan Goal: Reduce symptoms so client can “Feel like myself again and get back to work”
The Golden Thread

- Assessment data
- Diagnoses
  - Strengths
  - Goals
  - Needs
- Service plan
- Goals
  - Objectives
  - Interventions and Services
- Interventions/services – documented in progress notes
Golden Thread: Assessment

- **Diagnosis:** Major Depression
- **Strengths:** Strong work history, supportive spouse and is motivated to work toward recovery
- **Goals:**
  - “I want to feel like myself again and get back to work.”
  - Client will effectively manage symptoms of depression for a period of 3 consecutive months.
- **Needs/Barriers:**
  - Return to work
  - Improve relationship with spouse
  - Improved mood, sleep, memory, energy level, enjoyment, etc.
Assessment Analysis and Formulation

- **Discharge Criteria:**
  - Client will be effectively managing symptoms of depression for 3 consecutive months
  - Client will score a ’16’ or lower on Beck’s Depression Inventory for 3 consecutive months

- **Plan for treatment:**
  - Cognitive Behavioral Therapy to address relationship between thought process, behavior, and mood
  - Medication Evaluation to determine if psychotropic medication may be helpful
  - Couples sessions to enhance emotional support system and reduce conflict at home
Developing Treatment Plans: Goals, Objectives, Interventions
Treatment Plans

- **Required**
  - Fluid and revised as needed

- **Create a recovery roadmap**
  - Alternative routes and unanticipated barriers

- **Identify criteria for transition and discharge**
  - There is an agreed-upon destination

- **Integrate physical and behavioral health, social determinants, natural supports**
  - More complex than “A to B”
Elements of Treatment Plan

- Goals
- Objectives
- Interventions
Treatment Plan Goals

- Directly correlate to a given problem statement or functional deficit and speaks to its reduction and/or resolution
- Can be global, broadly stated in the person’s own words and speak to what about their lives they want to see change
- Strength-based: reflect the individual’s and family’s strengths, resources, motivation
- Long term, indicate the end point of the episode of care
- Need to be prioritized, ordered or sequenced
Treatment Plan Goals

‣ Example
  • I want to be married again (life goal)
  • I want to return to live with my family (treatment goal)
  • I want to get sober so I can be a better parent and spouse (treatment goal in this setting)

‣ Example
  • I want to be rich and famous (life goal)
  • I want to be successful in my career (treatment goal)
  • I want to graduate on time and get into college (treatment goal in this setting)
Treatment Plan Objectives

- Focus on what needs to change to meet goals
  - What barriers and challenges need to be addressed
  - Identify a lack of resources
    - Psychological: fear and anxiety, confused thinking, irritability, poor anger or impulse control
    - Psychosocial: discomfort around others, social isolation, stressful relationships, lack of support, difficulty with daily functioning tasks
    - Physical/Medical: poor nutrition, poor health, continued drug use, lack of housing, inadequate access to transportation
Treatment Plan Objectives

- **RUMBA**
  - Realistic
  - Understandable
  - Measurable
  - Behavioral
  - Achievable
Realistic

- What is being worked on right now?
- Tied to individualized treatment goals, symptoms, functioning
- Reflective of the age, development, and culture of the individual and family

- Young, single mother from a family-centric culture
- Goal: I want to be independent
- Objective A: Establish own apartment
Realistic

‣ What is being worked on right now?
‣ Tied to individualized treatment goals, symptoms, functioning
‣ Reflective of the age, development, and culture of the individual and family

‣ Young, single mother from a family-centric culture
‣ Goal: I want to be independent
‣ Objective A: Establish own apartment
‣ Objective B: Take over child’s evening routine from mother, including bath, bedtime activities, and discipline as needed
Understandable

‣ How can it be stated so everyone knows what is being worked on?
‣ Clear, non-jargon wording
  • Provider, member, key collaterals (e.g., family members), and supervisors should all be able to easily understand and describe treatment objectives
  • If everyone’s not on the same page about what’s being worked on, it’s easier to get distracted by the “crisis of the week”

  ◦ Objective A: Member will restore mood stability most days
Understandable

› How can it be stated so everyone knows what is being worked on?
› Clear, non-jargon wording
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○ **Objective A:** Member will restore mood stability most days
○ **Objective B:** Member will report feeling in control of her emotions at least 4 days per week (scale of 1-10)
Measurable

- How will you know when this objective has been achieved?
- Use concrete data to see where progress is being made, areas to continue working
  - Intended change should be obvious and readily observed
    - Think “fly on the wall”
  - Anecdotes and “feels better” aren’t sufficient
    - Option 1: Member will be less aggressive at home
Measurable

- How will you know when this objective has been achieved?
- Use concrete data to see where progress is being made, areas to continue working
  - Intended change should be obvious and readily observed
    - Think “fly on the wall”
  - Anecdotes and “feels better” aren’t sufficient

  - **Option 1**: Member will be less aggressive at home
  - **Option 2**: Member will reduce instances of yelling at domestic partner 20% in the next 6 weeks (daily average 10 to 8)
Behavioral

What will you see as you work on this objective? What will the individual/family do differently?

Action-oriented language
- NOT: “gain insight”, “better understand”, “come to accept”

External, observable changes are easiest to measure and discuss

- Objective A: Lucy will acclimate to her new role in this program
Behavioral

- What will you see as you work on this objective? What will the individual/family do differently?
- Action-oriented language
  - NOT: “gain insight”, “better understand”, “come to accept”
- External, observable changes are easiest to measure and discuss

- Objective A: Lucy will acclimate to her new role in this program
- Objective B: Lucy will respond appropriately to social interactions at least 20% of the time most days with one or fewer reminders from staff.
Behavioral

- What will you see as you work on this objective? What will the individual/family do differently?
- Action-oriented language
  - NOT: “gain insight”, “better understand”, “come to accept”
- External, observable changes are easiest to measure and discuss

- Objective A: Lucy will acclimate to her new role in this program
- Objective B: Lucy will respond appropriately to social interactions at least 20% of the time most days with one or fewer reminders from staff.
- Objective C: Lucy will participate at least once in 4/5 recreation activities per day
Achievable

‣ What early successes or short term wins are being targeted?
‣ Structured sequentially within a short time frame
  • Early success predicts later success
  • Builds optimism, sense of self-determination, treatment momentum
‣ Example
  • Recently living independently, Ted is hoping to get a job
  • Identified barriers: Lack of transportation, fear of public transportation
  • Objective: Within 30 days, Ted will be able to take the bus from his home to downtown and return by himself
Objective Do’s and Don’ts

- **Do** have Objectives reflect achievable steps
- **Don’t** confuse Objectives with interventions

Job skills training program

Get a great job
Objective Do’s and Don’ts

- **Do** have Objectives reflect achievable steps
- **Don’t** confuse Objectives with interventions

- Job skills training program
  - Inventory skills and past experiences
  - Draft resume
  - Review resume with mentor
  - Identify job openings
  - Practice interviews
  - Apply for jobs
Treatment Interventions

- Activities that help the individual achieve their goals and objectives
  - Treatment, care, services, therapy, support, medications, programs, etc.

- Objectives: desired changes in status, abilities, skills, behavior for the individual

- Interventions: various steps taken by the team, self-directed actions, natural supports that help bring about the changes described in the objectives

- Methods, plan for achieving goals and objectives

- Resources and equipment needed to support the journey
Treatment Plan Documentation

- One available resource: New York State Clinical Records Initiative (NYSCRI)
  - [https://www.omh.ny.gov/omhweb/nyscri/](https://www.omh.ny.gov/omhweb/nyscri/)
  - Forms to support effective documentation provided at no cost to providers through joint effort of OMH and OASAS
  - Provide structure for describing links between goals, objectives, and interventions
Treatment Interventions

› Specify using the 5 Ws
  • What: type of service or activity
  • Who: person responsible for activity (name, role, function/discipline)
  • When: frequency, intensity, duration of the intervention
  • Where: location (as appropriate)
  • Why: purpose, intent, or impact of the intervention in support of the objective
Tying It All Together
Example: Depression

- Who is the person seeking services and what is the relevant history?
  - 52y/o Hispanic female, symptomatic for 2 months and has family history of depression

- What is the problem the person is seeking help for?
  - “I’m not suicidal, but I feel sad most of the time and I don’t really enjoy anything any more.”

- What are the symptoms and how have these symptoms become barriers for the person to overcome?
  - Trouble sleeping, no appetite, low energy, and crying spells, interfering with relationships and causing client to miss work

- What does the person need to successfully overcome these barriers?
  - Supportive care, Cognitive Behavioral Therapy and anti-depressant medication (My agency provides these services.)

- Why would these specific services be most helpful?
  - CBT is an evidence-based protocol and research shows that it can be very effective for depression in combination with medication
  - Goal: “I want to get back to my life again.”
Example: PTSD

‣ Who is the person seeking services and what is the relevant history?
  • 18y/o African American/Caribbean male, symptomatic for 4 months after car accident

‣ What is the problem the person is seeking help for?
  • “Since the car accident I’ve been having nightmares and flashbacks. It’s gotten so bad I can’t go to school anymore.”

‣ What are the symptoms and how have these symptoms become barriers for the person to overcome?
  • Intrusive thoughts/flashbacks, avoidance, excessive fear and anxiety. Client is isolating at home and struggling with concentration and school attendance.

‣ What does the person need to successfully overcome these barriers?
  • Supportive care, Trauma-Focused CBT and possibly medication

‣ Why would these specific services be most helpful?
  • TF-CBT is an evidence-based protocol and research shows that it can be very effective with teens that struggle with PTSD
  • Goal: “I want to graduate with my class this year.”
Example: Heroin Dependence

- Who is the person seeking services and what is the relevant history?
  - 26y/o female, has 2 unsuccessful attempts at outpatient treatment within last 6 months, and has a seizure disorder

- What is the problem the person is seeking help for?
  - “Outpatient isn’t working for me and I need something longer term.”

- What are the symptoms and how have these symptoms become barriers for the person to overcome?
  - Daily use, at severe risk of medical complications due to withdrawal. Client is aware of dangers re. overdosing and how it might affect her medically.

- What does the person need to successfully overcome these barriers?
  - Medically Managed Detoxification followed by residential treatment (stabilization)

- Why would these specific services be most helpful?
  - LOCADTR 3.0 completed and client requires 24-hour medical supervision
  - Goal: “I’m ready to do whatever they tell me to do this time to get clean.”
What can providers and supervisors do today to improve effective documentation practices?
# Takeaways: Treatment Plan Checklist

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<thead>
<tr>
<th>Self-check/supervisor check item</th>
<th>Yes</th>
<th>Not quite there</th>
<th>No</th>
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<tbody>
<tr>
<td>Are treatment objectives clear and easy to find in the documentation?</td>
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<tr>
<td>Would a “fly on the wall” be able to determine whether treatment objectives have been met?</td>
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<td>Are treatment objectives clearly distinct from goals and interventions?</td>
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<td>Are evidence-based interventions tied to specific treatment objectives?</td>
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<td>Where multiple treatment objectives exist, is the rationale for prioritization and sequencing clear?</td>
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References


References contd.
