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Clinical skills: Treatment planning

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Agenda

1. Treatment plan guidelines
2. Strengths
3. Concurrent documentation
4. Treatment plan review
5. Documentation requirements and preparing for an audit
6. Questions and answers

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The Golden Thread

The golden thread connects key pieces of documentation together to justify medical necessity for treatment services.

Psychiatric Diagnostic Evaluation or Assessment

- ❑ Member presenting problem, strengths, needs, abilities, and preferences are assessed.
- ❑ Diagnosis is provided and substantiated with treatment recommendations.

Treatment (Care) plan

- ❑ Links goals with treatment recommendations and member needs.
- ❑ Guide the treatment process (prescribe treatment) using treatment goals.
- ❑ Prescribes frequency and duration, types of interventions, and assigns who is responsible for these interventions.
- ❑ Treatment Plan reviews reflect treatment progress related to member needs and medical necessity.
- ❑ Discharge planning is discussed and accounted for throughout the treatment episode.

Progress notes

- ❑ "Official" record of what occurred during the session. Progress notes need to reasonably connect to the treatment goals in the treatment plan and the diagnosis in the assessment.
- ❑ Progress notes are where the need for ongoing treatment is documented and justified based on medical necessity.

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Treatment plan guidelines

Treatment plan guidelines

Treatment plan:
The Provider agrees that at the time of admission a Licensed Mental Health Therapist (LMHT) will establish a formal, individualized, person-centered treatment plan for every member.

The treatment plan shall:

- Be consistent with standards for individual treatment or recovery plans.
- Incorporate the goals of the member
- Include the involvement of family and natural supports.
- Respect the wishes and needs of the member within funding limitations.
- Follow clinical best practice standards.

Treatment plan guidelines (continued)

The following must be evident:

- The member was included and participated in the treatment planning process.
- The member's voice is clear in the treatment plan goals.
- The plan addresses the member's individual needs.
- The information from the assessment was utilized to individualize treatment services and reflect medical necessity.
- Motivational strategies were utilized to promote engagement with treatment.

Treatment plan guidelines (continued)

The treatment plan is expected to:

- Demonstrate that cultural considerations and cultural barriers were addressed.
- Address safety when active risk issues are identified.
- Consider information from the Psychiatric Diagnostic Interview Examination (PDIE), and any other pertinent documentation.
- Show a LMHT is responsible for any clinical action and will sign off on the treatment plan.
- Demonstrate discharge and continuing care planning is ongoing and occurs throughout the treatment process.
- Incorporate the OQ®/Y-OQ® into the clinical process to inform treatment decisions.

Additionally,

- Evidence in the record the member or legal guardian has agreed to the treatment plan.
- Documentation the treatment plan will be made available to the member.

Note:

- ✓ Cut and paste documentation lends doubt to accuracy and undermines person-centered care.
- ✓ **Obligation to report/duty to warn:** Providers are expected to follow state and federal laws governing the reporting of potential or suspected child or elder neglect/abuse as well as those governing the duty to warn. **Be sure to document the report was made or verified in the clinical record!**

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Treatment plan - Goals

Guidelines	• Goals are statements that summarize the individual's or family's desires for change and resolution to a problem or need, captured in their own words. • Goals are identified throughout the assessment. • Goals are not necessarily measurable but are reasonably attainable or recognized within an episode of continuing care. • Goals are expected to summarize the member's aspirations for the future.
Tips	Consider the following: • Use the member's own words to describe their presenting problem. • Golden thread: What diagnoses and symptoms were identified in the assessment? • What does the OQ®/Y-OQ®/Y-OQ ®-SR tell you are the critical items or subscales? Is the overall score in the clinical range?

Treatment plan - Objectives

Guidelines	• Objectives are expected to address the member's aspirations as stated in the goal statement(s). • Objectives are short term steps that help the individual reach their goal. • Objectives describe desired changes in status, abilities, skills, or behaviors. • Objectives are expected to be clear, behaviorally measurable and describe the progress and desired outcome for the member (i.e., SMART goals). S: Specific M: Measurable A: Attainable R: Realistic T: Time-bound
Tips	Consider the following: • What replacement behavior is the member increasing? What problem or symptom is the member decreasing to impact their mental illness? • What is the baseline? – Frequency (daily, weekly, etc.) – Duration (minutes, hours, days, etc.) – Intensity (Likert scale, OQ®/Y-OQ® measures, etc.) • What is the target? How long will it take to reach this objective? • How will progress be measured? • Is this objective realistic (age appropriate, within the member's skill level, are resources available to assist member in reaching goal, etc.)

Treatment plan - Methods

Guidelines	• Methods are specific activities, strategies, and interventions used for members to reach their goal and objectives. • Methods are short-term, behaviorally measurable and use action verbs and identifiable outcomes such as what, who, when, where, and why.
Tips	Consider the following: • What specific techniques might be used? • What does the member or family need to learn or what support is needed for these changes? • What services are needed to address the identified symptoms, behaviors, problems or incidents? • What interventions have the most impact for the diagnosis or symptoms? • What model is being used in treatment?

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Adult Case Profile

Sue is a 22-year-old female who dreams of finishing school and becoming a teacher someday. Over the past four years, she has received various mental health services due to her diagnosis of Major Depressive Disorder, Recurrent, Moderate. She moved from Texas to Utah four years ago, to attend school. She has family members in Utah who are supportive. Sue was referred to outpatient behavioral health services due to experiencing periods of ongoing crying, sadness, decreased energy, loss of interest, and low self-esteem. Additionally, most days of the last month she has not wanted to get out of bed or to attend classes. Sue expressed a desire to continue with college classes, for she has 1-year left of school to complete and does not want to put her dream of finishing school on hold. Sue stated her strengths are being a leader of several school projects, she loves to write and journal, is spiritual, and responsible. She has a supportive and good relationship with her primary academic advisor who is aware of her mental health history. Sue's mom strongly supports her finishing school. However, her mother believes she is rushing school and should pace herself more. Culturally, Sue's family is very religious and believes that mental illness does not necessarily require treatment services but believes prayer and a stronger relationship with God would help improve her mental state. This cultural variable is a barrier to Sue consistently seeking out treatment and it may impact her ongoing participation in treatment services.

Treatment plan - adult example (edit the treatment plan)

Treatment plan for adult with a mental health diagnosis

Diagnosis: Major depressive disorder, recurrent, moderate (F33.1)
Goal: “I don’t want to cry all day anymore.” Sue cries about feeling hopeless about completing school.
Objective: Sue wants to participate in positive activities each day, to exhibit no crying episodes per day, as reported by Sue and staff in group. (Baseline = 8 crying episodes per day.)
Methods:

- Individual therapy: 1x a week for 60 minutes to help identify triggers for depression related to/connected to/that go with her experiences with friends.
- Case management services: 2x a month for 6 months.
- Group therapy: To learn healthy coping skills related to thoughts and situations that increase feelings of depression.
- Referral to prescriber to be evaluated for possible medication management.

Treatment plan - adult example (suggested corrections)

Treatment plan for an adult with a mental health diagnosis

Diagnosis: Major depressive disorder, recurrent, moderate (F33.1)

Goal: "I don't want to cry all day anymore." Sue is most hopeful when she can create a calendar/schedule to complete homework and assignments.

Objective: Sue wants to participate in 2 positive activities each day to decrease crying to 4 or fewer incidents per day as recorded in Sue's *daily journaling*. (Baseline = 8 crying episodes per day.)

Methods:

- Individual therapy: The individual therapist will meet with Sue for 1-hour, 1x a week for 6-months to help identify triggers for depression related to or connected to Sue's hopelessness.
- Case Management Services: Sue will receive case management services 2x a month for 6-months to help increase organization skills to manage school assignments and navigate college graduation requirements.
- Group therapy: Sue will meet for a 75-minute group therapy session 1x a week for 6-months to learn and implement healthy coping skills (i.e., increase journaling, exercise, *daily devotions*) related to thoughts and situations of depressive symptoms (i.e., crying, sadness, decrease energy, loss of interest, low self-esteem, etc.).
- Within 30 days Sue will receive a referral to prescriber to be evaluated for possible medication management.

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Youth Case Profile

Joe is a 10-year-old boy, who lives with his mother, step-father and 3 siblings. The oldest sibling is an 18-year-old brother who is getting ready to start college. The younger two are both sisters, 7 and 3 years old. Joe has been diagnosed with Oppositional Defiant Disorder. Joe is becoming aggressive at home and school daily (i.e., yelling, slamming doors, throwing things, and hitting). He has been defiant at home (i.e., arguing, refusing to follow directions and rules) daily for the last 1-month. Joe has no history of prior treatment services. He has recently attacked a peer at school who had to be seen in the emergency room. Joe has a good relationship with his siblings, and they have never been the object of his aggression. Joe and his older brother share an interest in baseball and have been to a few minor league baseball games in their city. Joe loves all sports and has played baseball in the past. Joe stated he has strengths in reading, is helpful, and has a good relationship with his sports team. Joe and his family have limited community support, do not believe in a higher power, they have no religious beliefs, and do not attend church. Joe's mom has tried all that she can think of to stop the aggression (i.e., taking away privileges, grounding, and taking away possessions) and she has become overwhelmed due to not seeing any improvement in his behaviors. Joe's mom believes in seeking mental health treatment to reduce behavioral problems. Joe's step-dad would like to be more helpful, but he really doesn't understand Joe's symptoms and behaviors and has expressed that men seeking therapy is a sign of weakness. However, Joe's mother brought him to seek outpatient services.

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Treatment plan - youth example (edit the treatment plan)

Treatment Plan for a youth with a mental health diagnosis

Diagnosis: Oppositional defiant disorder (F91.3)
Goal: Joe talks about wanting to be included in the decisions about his case/his plans for school/his daily expectations.
Objective: Joe and his family will cooperate with each other to create and use family rules/expectations, a family responsibility chart and a reward system to decrease the conflict in the home. Joe will also demonstrate a statistically significant decrease in distress (-17 points or more) on the Y-OQ®-SR. (Baseline = 85)
Methods:

- Individual therapy: 2x a month for 60 minutes to review progress, to identify triggers to argue and to identify other ways to communicate what he wants.
- Family therapy: Create and start plan for Joe and his parents to talk about expectations and consequences.

Treatment plan - youth example (suggested corrections)

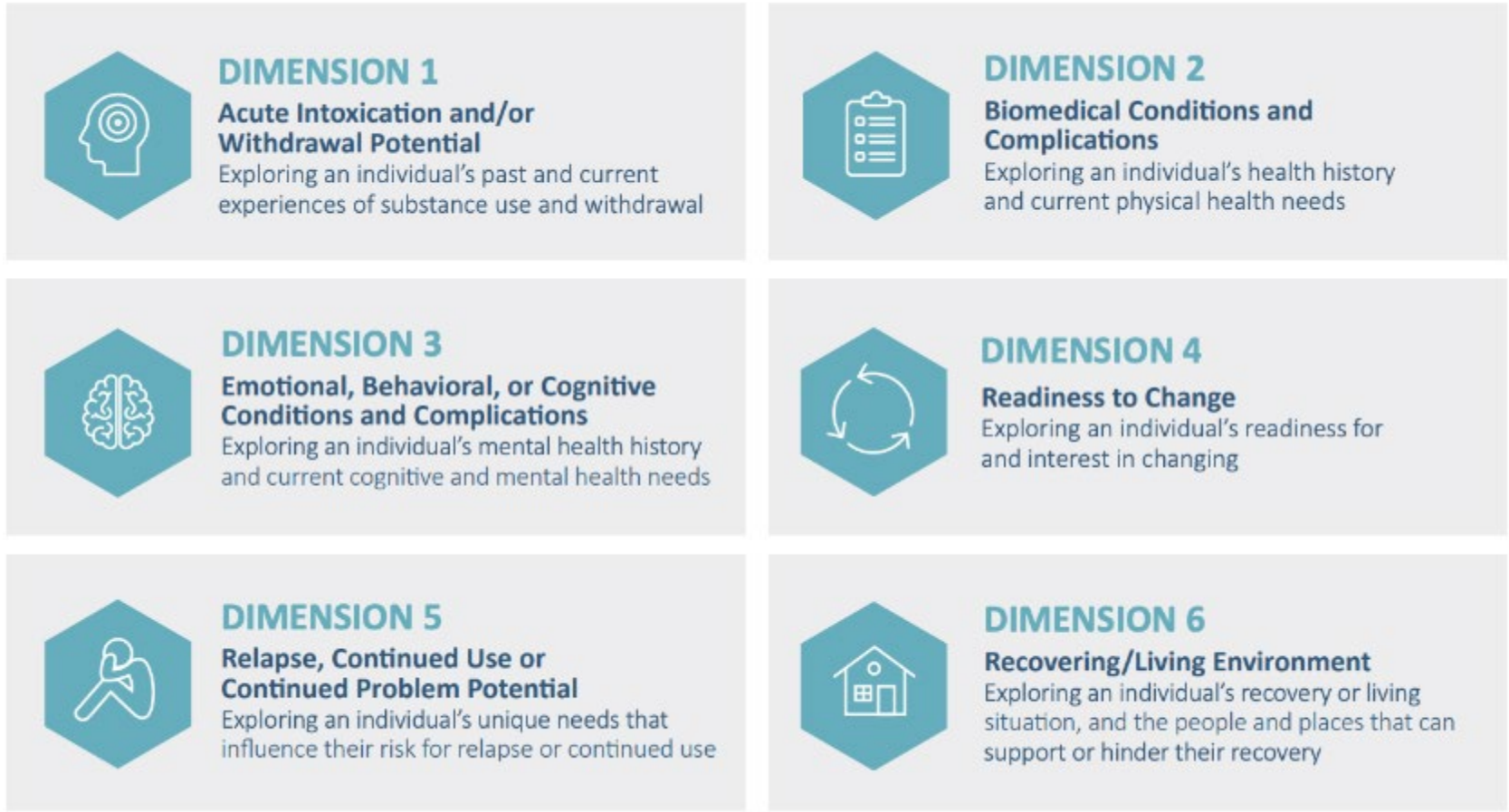
Treatment plan for a youth with a mental health diagnosis

Diagnosis: Oppositional defiant disorder (F91.3)
Goal: "I want to do what I want to do." Joe talks about wanting to be included in the decisions about his case and the treatment services he is receiving for his home and school daily expectations.
Objective: Joe and his family will cooperate with each other to create and use family rules/expectations, a family responsibility chart and a reward system to decrease aggression (i.e., yelling, slamming doors, hitting, etc.), opposition and defiance (i.e., arguing and refusing to follow direction and rules, etc.) in the home as evidence by 5 or more earned activities each week, for the next 30 days. Joe will also demonstrate a statistically significant decrease in distress (-17 points or more) on the Y-OQ®-SR. (Baseline = 85)
Methods:

- Individual therapy: The individual therapist will meet with Joe for 1-hour, 2x a month for 6-months to review progress, to identify at least 2-3 triggers to anger and defiance for Joe to utilize 2-3 behavior management skills (i.e., self- control, communication, etc.) to get what he wants.
- Family therapy: The individual therapist will meet with Joe and his family for 1-hour, 2x a month for 6-months to create and start a behavior-monitoring chart and reward system for Joe and his parents to talk and outline rules, expectations, and consequences and how to reinforce compliance with rules.
- The individual therapist will encourage Joe's family for Joe to participate in independent activities (i.e., *baseball*, basketball, reading, etc.) at least 2-3x weekly over the next 6-months to help in increasing *positive social interactions*.




ASAM Dimensions



ASAM Criteria taken from the American Society of Addiction Medicine website

Treatment plan - Tips for writing SUD treatment plans

- Dimensions with ratings of medium or high, should have a related goal.
  - ⇒ Goals should reference the related dimension (ex. Dimension 4, motivation goal, etc.)

1. Low risk implies full or almost full functioning in this dimension with no immediate services or low intensity of services needed.
2. Medium risk implies support is needed along with skills training and/or therapy. The member may benefit from ASAM 2.1 or 2.5 level of care.
3. High risk implies more immediate and urgent services are needed to address the items in this dimension. The member needs close monitoring and a high intensity of services.

- The treatment plan, including discharge criteria, should reflect the use of ASAM criteria.
  - ⇒ Dimension 6 is an appropriate place to address issues related to housing, employment, childcare, transportation etc.

- Keep the topic in one dimension, although layers may overlap with other dimensions (ex. trauma, mental health dx, medication, relationships etc.,)
  - ⇒ Address medical/medication in the relevant dimension.

- When identified, and with cooperation from the member, the treatment plan includes goals and objectives pertaining to cessation of nicotine use.

Note: SUD treatment plans need to meet the expectations previously discussed and the Optum guidelines.

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Treatment plan - substance use disorder example (edit the treatment plan)

Treatment plan for a substance use disorder

Diagnosis: Alcohol use disorder, severe

D4: Goal: “I want to get my kids back.” Gwen’s children are in foster care because of her drug use.

Objective: Gwen will complete phase 1 and phase 2.

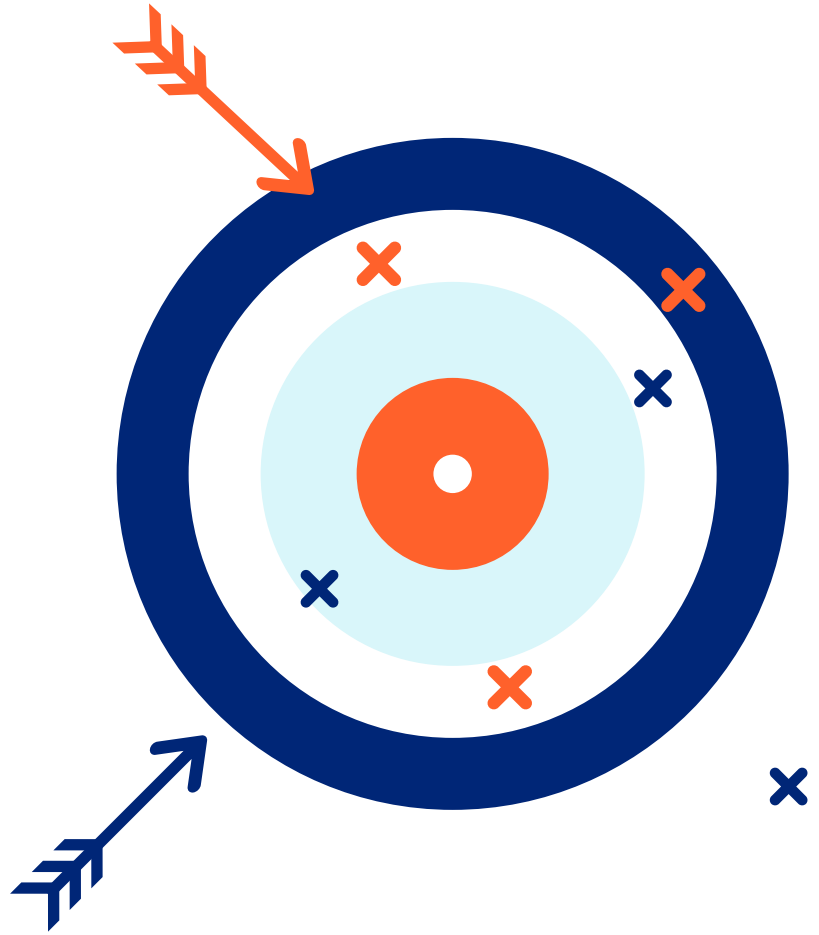
Methods:

Individual therapy: 1x a week for 60 mins to work on Motivational Interviewing techniques.

Family therapy: 1x a month for 60 mins to work on parenting skills.

PRS Group: 1x a day for 90 minutes to learn about healthy relationships and coping skills to better manage her anger toward her partner which is a trigger for her to drink.

Medication management: Gwen is willing to participate in a psychiatric evaluation for further assessment and to clarify her diagnosis.



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Treatment plan - substance use disorder example (suggested)

Treatment plan for a substance use disorder diagnosis

Diagnosis: Alcohol use disorder, severe

D4: Goal: “I want to get my kids back.” Gwen’s children are in foster care because of her substance use.

Objective: Gwen wants to increase her confidence rating for sober living from 3 to 8 to match her motivation for sober living by creating and implementing an action plan to earn unsupervised visits with her children, in the next 90 days.

Methods:

Individual therapy: 1x a week for 60 mins to work on Motivational Interviewing techniques.

Family therapy: 1x a month for 60 mins to teach and observe parenting skills.

PRS Group: 2x a week for 90 minutes to learn about components of sober living.

AA: Gwen will attend morning AA meetings for the next 30 days to help boost her confidence and commitment to sobriety each day.

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Strengths

Why use strengths?

To establish **trust**, build **rapport** and foster a **therapeutic alliance**.

To **validate** their efforts to obtain help.

To discover **motivational** factors.

To help move people from engagement to **activation**.

To identify methods of **survival**.

To **counter** negative cultural messages based in stigma.

To help members understand the relationship between people’s coping skills and behaviors.

To precede a **discussion** about what they'd like to be different or what challenges they are facing..

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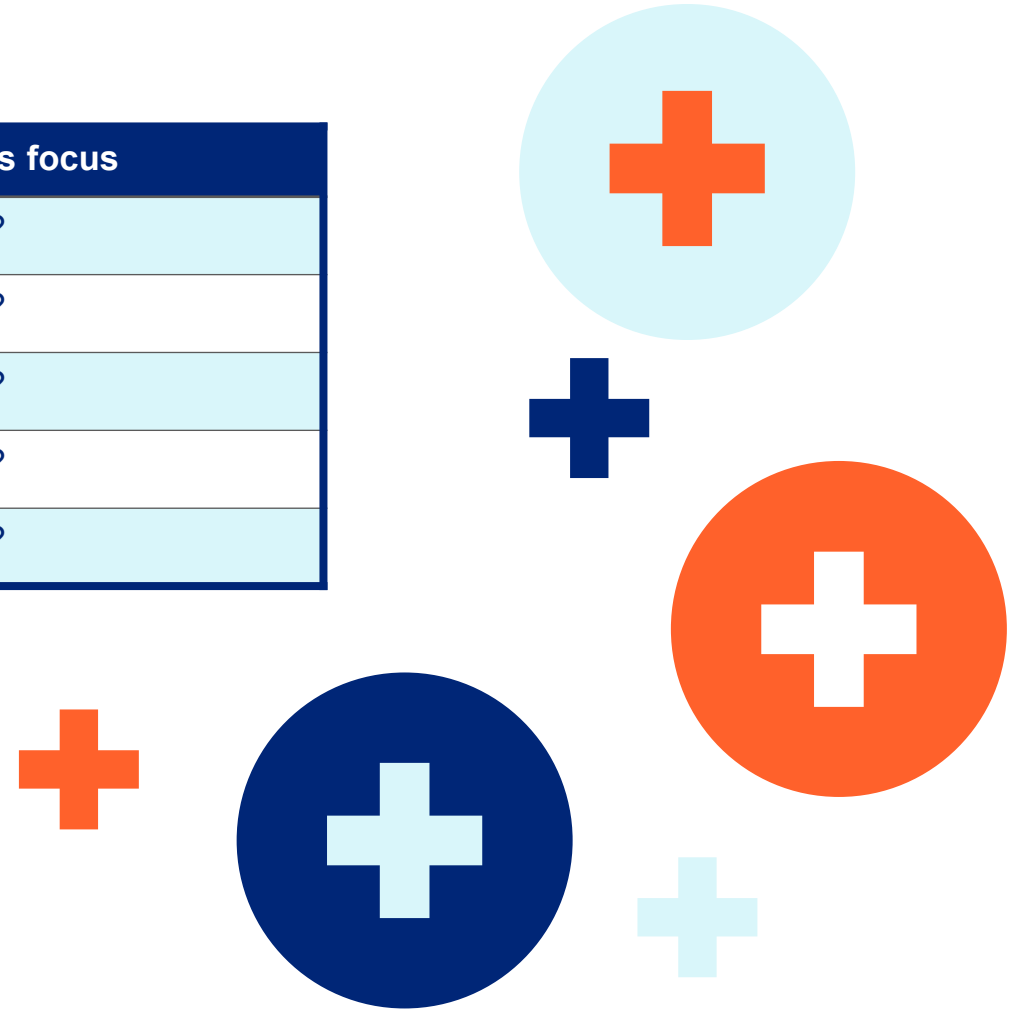
Shifting the focus

Problem focus	Strengths focus
People are viewed as “at risk”	**People are seen as having many strengths**
Language focuses on the problem and the person is a “victim” of the problem	**Language keeps possibilities and strengths in the forefront**
We ask people to help name the problem or deficiency	**We ask people to help us discover who they are beyond their diagnosis**
Experts doubt the person’s stories as “excuses” or “rationalizations”	**The person’s stories or narratives are sought out and believed (as their experience)**
Professionals are the experts and develop the treatment plan	**The person is the expert working collaboratively with their treatment team and driven by the goals of the person**

Reframing exercise

Problem focus	Strengths focus
She's in denial.	??
They have unrealistic expectations.	??
He doesn't follow through.	??
She only cares about herself.	??
I haven't ever been able to stay sober.	??



Strength categories

Attitude and values

- What people have learned from themselves, others and the world around them… in general and in reference to their successes/failures
- Cultural and family beliefs and rituals

Skills and abilities

- Talents
- Interests
- Hobbies
- Capabilities

Attributes and features

- Descriptive statements about the individual or family
- Personal qualities… relationships with other people/entities
- Community and environmental strengths
- Character traits

Preferences

- Likes and dislikes…
  - Entertainment/food/clothes
  - Communication methods
  - Service delivery = methods, location, modalities, etc.

Incorporate positive character traits into the treatment plan

It's important to identify positive character traits to help a member capitalize on them.

Understanding a person's character strengths gives a therapist perspective that reveals the uniqueness of a member, and that can help that person use those traits to improve situations or outcomes.

The VIA Survey is a free, scientific survey of character strengths. It takes about 10 minutes.

viacharacter.org/survey/account/register

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List of positive character strengths

Positive character traits list

The 24 positive character strengths are split into six virtue classes:

- **Wisdom**: Creativity, curiosity, open-mindedness, love of learning, perspective
- **Courage**: Honesty, bravery, persistence, zest
- **Humanity**: Kindness, love, social intelligence
- **Justice**: Fairness, leadership, teamwork
- **Temperance**: Forgiveness, modesty, prudence, self-regulation
- **Transcendence**: Appreciation of beauty, gratitude, hope, humor, religiousness

Activity

Discuss poll question.

Identify a positive character trait that helped a client move through a difficult situation.

What was the situation?

verywellmind.com/what-are-character-strengths

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Questions to elicit strengths from members and supports

What helped you to survive?
How did you get this far?

What did you learn about yourself?

Who helped you?
What did the do that was helpful?

Why did they help you?

Where do you want your life to go?
What are you most proud of about yourself/child/family?

How did things get better last time?

What good things do people say about you?
What things about your life give you the most happiness?

What are your best memories?

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Addressing Mood in the Treatment Plan

- Moods vs Emotions: Both are internal feeling states, but moods last hours or days vs seconds to minutes for emotions. Moods are not associated with recognizable facial expressions. Moods are more nebulous.

- Moods make it more likely that emotions in the same category will be triggered, e.g., if someone is in an irritable mood, they are more likely to express anger. Conversely, if someone is in an optimistic mood, they are more likely to be motivated, try new things, and express positive behaviors.

- Therapeutic interventions include therapist and member understanding the role of moods; promoting mood self-awareness via journaling, meditation, mindfulness, DBT; identifying mood triggers, and promoting positive-mood influences to enhance behavior-change goals.

- Mood disorders: ensure biology is addressed with interventions and collaboration regarding medication, sleep, nutrition.

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Concurrent documentation

Documentation completed with the member at the time of service.

Concurrent documentation - Why?

- Promotes member driven care
- Frames the therapeutic relationship
- Allows for immediate feedback
- Supports efficiency

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Concurrent documentation - How?

Therapeutic relationship	• Build rapport with the member • Include the member in what you are doing • Assign responsibility to the member in treatment • Educate the member about the benefits of engagement
Preparation	• Use of electronic health record (EHR) or Word • Use of formal templates • Use of checklists • Use of SOAP notes for consistency
Service delivery	• Use as a guide through the treatment process • Use as a review to track treatment progress • Use to review at the end of an individual session • Use to promote engagement in group therapy

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Practical suggestions for implementation:

Concurrent documentation

- Complete the full session note with the member.
  - Consider using the last five minutes of the session to summarize the session with the member.
- Complete part of the session note with member.
  - Consider using bullets to highlight important take-aways based on the member's perspective.
- Complete the intake form with the member.
  - Consider having the member complete the intake form initially. Review the intake form with the member afterwards and add information, as necessary.

Note: Inclusivity in note taking allows the therapist to understand how the member is processing sessions. It also helps to ensure the therapist is hearing the member's concerns accurately.

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Treatment plan reviews

Treatment plan reviews- Utah Medicaid requirements

- Treatment plan reviews shall be documented in the clinical record.
- Treatment plan reviews will be conducted by a LMHT meeting in an individual, face-to face interview with the member to review medical necessity, appropriateness of treatment interventions, and to measure progress.
- At a minimum, continuing stay/treatment plan reviews will be conducted every six months for all members who meet criteria for serious mental illness (SMI), and every three months for those who do not meet criteria.
- For members receiving treatment for a substance use disorder, continuing stay/treatment plan reviews will be conducted (at a minimum) every 15 days for ASAM levels 3.5 and 3.3, every 30 days for ASAM levels 3.1 and 2.5, and every 60 days for ASAM level 2.1.
- Reviews will be conducted more frequently if the nature of needed services changes or if there is a change in the member's condition or status.

Note: Documentation should reflect ongoing discharge planning

Treatment plan reviews

When reviewing each goal:

- ✓ Use measurable objectives to track member progress.
- ✓ Identify impacts of progress or lack of progress.
- ✓ Document the member's response to treatment.
- ✓ Consider the member's response to telehealth.
- ✓ Document additional information provided by the family.
- ✓ Assess the appropriateness of each goal.
  - ❑ Should it be modified?
  - ❑ Should it be closed?
  - ❑ Should new goals be established?

Treatment plan reviews

Remember to…

- ✓ Include the member in the treatment plan review process.
- ✓ Consider new information provided by family members/providers.
- ✓ Consider including relevant collateral information
- ✓ Review for medical necessity.
- ✓ Utilize information from the assessment/reassessment .
- ✓ Utilize information from screening tools such as:
  - ❑ OQ®/Y-OQ®
  - ❑ PHQ-9
  - ❑ C-SSRS
  - ❑ ASAM Criteria

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Treatment plan reviews - Troubleshooting

- What if the member is not making progress toward treatment goals?
- What if the member is constantly in crisis?
- What if the member refuses to address a dimension with a rating of medium or high?
- What if there is a lack of parent participation with a child/adolescent member?
- What if a child/adolescent member doesn’t understand the concept of a treatment plan?

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Documentation requirements

Preparing for an audit

Documentation requirements and preparing for an audit

Why is documentation important?

- Clinical documentation is the historical record of what occurs in treatment.
- Documentation is expected to follow a logical path.
- Connecting the documentation gives a logical flow to the treatment process.
- Connecting the documentation allows for staff, clinicians, auditors or those reviewing the record an opportunity to understand and grasp the flow of the process.
- Documentation indicates sessions are focused on member's goals and objectives to address the issues that brought the member to treatment as outlined in the assessment.

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Documentation requirements and preparing for an audit

What is the relevance of the treatment plan and reviews?

- The treatment plan connects the therapeutic process.
- The treatment plan reflects the member's diagnoses and the information gathered in the assessment.
- The treatment plan shows evidence the member was included in the planning process, and the plan addressed the member's individual needs.
- The treatment plan is used as a review during individual sessions for ongoing assessment of medical necessity for the level of care offered, appropriateness of treatment interventions, and progress toward treatment goals and objectives.
- It provides measurable treatment goals including the date each treatment goal was added to the treatment plan to help to establish target dates for completion.

Additionally,

- The treatment plan for the outpatient level of care must have **at least one goal** present in the member's record prior to services being provided.
- The treatment plan review is expected to include an associated encounter note that provides the clinical rationale and medical necessity for ongoing services.

Documentation requirements and preparing for an audit

Audit Checklist

Including, but not limited to:

- ✓ Initial treatment plan/treatment plan review signed or co-signed by an LMHT (including credentials and date).
- ✓ Family involvement in the treatment planning process, when appropriate.
- ✓ Treatment plan reflects discharge planning.
- ✓ Evidence treatment plan or progress is reviewed during individual sessions.
- ✓ Treatment plan is updated whenever goals are achieved, or new problems are identified.
- ✓ Treatment plan addresses safety when active risk issues are identified.
- ✓ Evidence the assessment was used in developing the treatment plan.
- ✓ Treatment plan has estimated time frames for goal attainment.
- ✓ Goals are person-centered and relevant to the assessment and diagnosis.
- ✓ Treatment plan and progress notes for group or individual therapy are in response to identified member needs.
- ✓ Treatment record documents and addresses biopsychosocial needs, as appropriate
- ✓ Treatment plan review indicates the member's involvement in care and service.

Q&A

Resources

medicaid.utah.gov/utah-medicaid-official-publications

asam.org/asam-criteria/about-the-asam-criteria

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