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Purpose of this presentation:

Goal:

To provide a refresher about Treatment Plan Development for providers that will decrease anxiety surrounding writing treatment plans.

Objectives:

1. Identify Magellan's requirements for treatment plans
2. Identify common elements covered in treatment plans
3. Identify elements of SMART Goals/Objectives
4. Identify when treatment plan updates are warranted

What is the treatment plan?

A written document that:

- Identifies the member's most important goals for treatment
- Describes measurable, time-sensitive steps toward achieving those goals
- Reflects an agreement between the provider and the member

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Expectations for Treatment Plans

Treatment Record Review Overview

Treatment Record Review Process

http://magellanoflouisiana.com/media/747977/trr_provider_training_2.28.2014.pdf

Magellan's Requirements for Treatment Plans

- Individualized strengths based treatment plan is current
- Measurable goals/objectives documented
- Goals/objectives have timeframes for achievement
- Goals/objectives align w/consumer identified areas for improvement/outcomes
- Use of preventive/ancillary services incl. community & peer supports considered

Common findings from Treatment Record Reviews

- Treatment plans do not contain required signatures
- Goals and objectives are not measurable
- Lack of treatment plan updates when the member’s needs change
- Treatment plan does not address identified needs of the member including health and safety issues
- No treatment plan included

Treatment Planning Elements Simplified

Treatment Plan should include:

- **Individualized and Strengths Based**
  - *Plan relates to member's initial reason for seeking services and diagnosis*
  - *Member's strengths are utilized i.e. writing, drawing, assertiveness*
  - *Updated at least annually and when other changes occur i.e. hospitalization*
  - *Includes signatures of participants*
- **Measurable goals and/or objectives**
  - *The member's progress can be measured*
- **Time frames for achievement**
  - *July 1, 2014-December 31, 2014*
- **Goals align with member's/family's desired outcome**
  - *What improvements does the member want? Social desires, vocational dreams, independent living*
- **Use Community and Peer Supports**
  - *Support groups, YMCA, Tutoring, Church groups, School clubs*

Writing SMART Goals and Objectives:

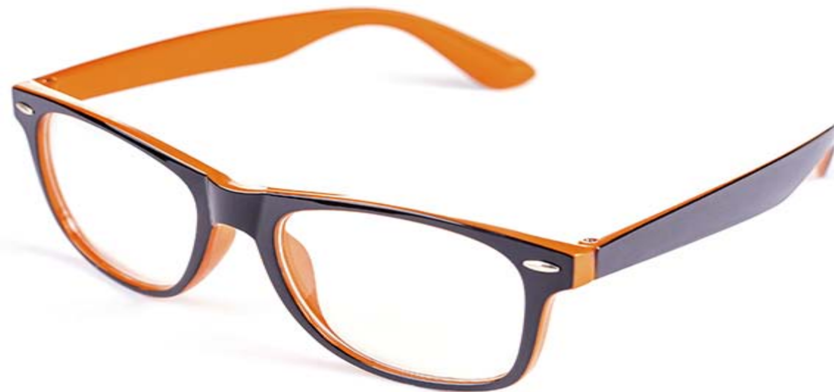
Specific-Who, what, where, when, which, why?

Measurable-How will change be measured? CANS, 1-10 Scales of self report, Child behavior checklists, Burns or Beck Depression and Anxiety Inventories

Attainable-Within reach for the member? Can it be achieved?

Realistic-What is the member willing and able to do?

Time-Limited-What is the time frame for the goal? Two months? Six months?

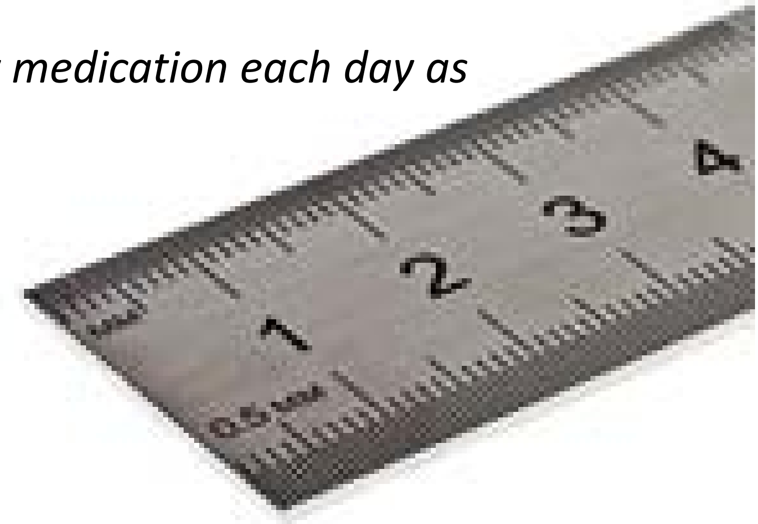


Examples of SMART Goals and Objectives

Two commonly used methods

- **Goal:** *"Improve my sad feelings."*
  - ***Objective***: *"I will exercise at least 20 minutes per day."*
  - ***Objective***: *"I will take my medication twice per day."*
  - ***Objective:*** ***"****I will identify 3 triggers of my depression."*

- **Goal:** *"I will decrease my depression by taking my medication each day as prescribed."*



Who participates in the Treatment Planning Process?

Process should be an individualized collaboration including:

- Member
- Provider
- Participating supporters- family, friend, guardian

Increase the chance of success

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Common elements to include

Treatment Plan contains:

- Information from the assessment
  - *The assessment should guide treatment*
- Date completed
  - *Clearly noted*
- Member’s name on each page
- Member language
  - *Quote the member when possible*

Additional sections:

- Crisis Plan
- Discharge Plan

Acceptable Treatment Plans

Can be:

- Format that you choose
- A template previously used
- Electronic provided the member can sign

Are NOT:

- Plan of Care (POC)
- Community Based Services Authorization Request forms

Updates may be warranted when:

- Plan of Care (POC) is updated
- New behaviors develop
- Health or safety risks become apparent
- Higher intensity care is required following:
  - *Hospitalization*
  - *ER visits*
  - *Crisis Intervention*

What should be noted on updates:

- If the member accomplishes a goal
- If a goal is discontinued
- If barriers exist for accomplishing goals

Remember: Signatures are required on updates and new treatment plans

Treatment Progress

Ongoing Documentation

- Progress notes should reflect the treatment plan goals/objectives
- Progress notes should document progress and barriers related to goals/objectives
- Progress notes should substantiate the need for continued treatment if applicable

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Questions

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Thanks