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Quality Management Department

Goals and Objectives

Goals:

- Enhance providers' understanding of the requirements for writing treatment plans.
- Improve member and family involvement in the treatment planning process.
- Improve understanding of what a Plan of Care is and what treating providers are responsible for.

Objectives:

1. Review treatment plan requirements.
2. Review how Magellan **monitors** treatment plans.
3. Identify ways to improve **member and family involvement** in treatment planning.
4. Differentiate **a treatment plan from a plan of care**.
5. Review **Plan of Care** requirements.
6. Explain **monitoring requirements** related to the Plan of Care.

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Treatment Plans

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 for treatment.
- Should reference all services being provided.
- Required document for everyone receiving services.

What Levels of Care require a Treatment Plan?

The **LBHP Service Definition Manual (SDM)** and **Service Authorization Criteria (SAC)** requires the following service types have an individualized treatment plan:

- CPST
- PSR
- TGH/TFC
- NMGH
- Inpatient , outpatient, intensive outpatient and residential addiction services
- Outpatient Therapy Psychiatric
- PRTF
- MST
- FFT
- Homebuilders
- ACT
- Inpatient, Psychiatric

Requirements for Treatment Plans

Magellan's Requirements for Treatment Plans include:

- **Measurable** goals/objectives documented.
- Goals/objectives have **timeframes** for achievement.
- Goals/objectives **align with member** identified areas for improvement and outcomes.
- Use of preventive/ancillary services includes community & peer supports considered.

Treatment Planning Elements Simplified

Treatment Plan should include:

- **Individualized and Strengths Based Information**
  - *Plan relates to member's initial reason for seeking services and diagnosis*
  - *Member's strengths are utilized (e.g., writing, drawing, assertiveness)*
  - *Updated at least annually and when other changes occur (e.g., hospitalization)*
  - *Includes signatures of participants (at a minimum the provider and member)*
- **Measurable goals and/or objectives**
  - *The member's progress can be measured, quantitative when possible*
- **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*
- **Consumer-run and community programs**
  - *Support groups, YMCA, Tutoring, Church groups, School clubs, drop-in centers, crisis phone line, etc.*
- **Cultural preferences and race/ethnic background**

Other Common Elements of Treatment Plans

Treatment Plan contains:

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

Additional sections:

- Crisis Plan
- Discharge Plan

Writing SMART Goals

Writing goals can often be a difficult part of writing a treatment plan.

- **The SMART technique** can help guide clinicians to writing quantifiable, objective goals.
  - ***Specific****: Who, What, Where, When, Which, and 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."*

Acceptable Forms for Treatment Plans

Magellan does not require a specific form; however, here is some guidance to assist you in documenting your treatment plan.

Treatment Plans can be:

- Format that you choose
- A template previously used
- Electronic version that includes the member signature

Treatment Plans are NOT:

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

Plans of Care will be discussed in more detail later in the training.

Treatment Plan Updates

- The **SDM** and **SAC** require timeframes for updates for some levels of care:
  - *PRTF: Monthly*
  - *ACT: Every six months*
- Although most LOCs do not have specific standards for when treatment plan, treatment plans should be updated under certain circumstances.
- **Circumstances** can include but are not limited to:
  - *New behaviors develop.*
  - *Health or safety risks become apparent.*
  - *Plan of Care (POC) is updated.*
    - POCs are discussed later in the training
  - *Higher intensity care is required, such as the following:*
    - Hospitalization
    - ER visits
    - Crisis Intervention

Treatment Plan Updates

- What should be documented when updating a treatment plan:
  - *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.*

Documentation of the Treatment Plan in Progress Notes

- Treatment plans are not just documented on a singular form.
- Ongoing documentation of progress towards treatment plan goals and objectives should be reflected in the record.
  - *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.*

Monitoring Treatment Plans: Treatment Record Review

- Magellan monitors compliance with requirements by conducting **treatment record reviews.**
  - *Check out the link to trainings and tip sheets related to the TRR process: http://magellanoflouisiana.com/for-providers-la-en/quality-improvement-and-outcomes.aspx*
- Magellan's Clinical Reviewers have identified common **opportunities for improvement** across the network related to treatment planning.
  - *Treatment plans do not contain required provider and/or member 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 in member record.*

Monitoring Treatment Plans: Member Satisfaction Survey

Another way to monitor treatment planning is through the member satisfaction survey.

- Member satisfaction surveys remain the **most direct measure** of assessing the member's perceptions of quality and outcome of care.
- Gathering member input and feedback allows us to **continuously improve** our processes to become more effective as well as to learn the needs of those we serve in order to improve the member experience of care.
- Magellan sets an internal corporate goal of achieving at least **80% satisfaction** for each element.

Opportunities for Improvement: Member Satisfaction Survey

- **Nine elements** were identified as **opportunities for improvement** that could be **positively impacted** by **comprehensive treatment planning**.
  - *Increasing **member involvement** in the treatment planning can positively impact member satisfaction.*

Question	% Positive
My cultural preferences and race/ethnic background were included in planning services I received.	**74.2**
I, not a staff member, decided what my treatment goals should be.	**75.8**
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)	**72.3**
I deal more effectively with daily problems.	**65.6**
I am better able to deal with crisis.	**56.7**
I am getting along better with family.	**61.3**
I am more comfortable in social situations.	**57.6**
I do better in school and/or work.	**53.7**
My symptoms are not bothering me as much.	**51.2**

Who should be involved 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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Member Involvement in Treatment Planning

- Treatment Plan development for **new clients** takes place in the beginning of treatment, often times before a true therapeutic bond can be formed.
  - ***New clients*** *may be confused, scared, or despondent, depending on where they are in the treatment process.*
  - ***Experienced clients*** *may have been in treatment for years and not see the value of developing a meaningful treatment plan.*
- **Developing rapport** is an essential component of developing a treatment plan. This allows the member to feel more engaged and involved in the process.
  - *When talking with providers, we often hear that the member doesn't understand what he or she needs or the member doesn't have realistic expectations for treatment.*
    - It is **essential** for **successful treatment** that the member, not the provider, identifies the goals for treatment.

Member Involvement in Treatment Planning

Tips on **building rapport** during **treatment plan development**:

- Let the first part of developing the treatment plan **follow the client's succession of thoughts**.
- Provide **guidance and structure** to assist clients who may have trouble organizing their thoughts in order to finish gathering necessary data.
- Ask questions to **invite the clien**t to participate (e.g., open-ended, non-leading questions).
- Use the **client's words**.
- Identify the **client's strengths** as well as potential problem areas.
- Stay away from use technical language.
- Don't ask **"why"** questions.
- Discussion of the client's **cultural preferences** and **racial/ethnic background** should also be addressed.

Reference: Waldinger, R. & Jacobson, A. (2001). The initial psychiatric interview. In J.L. Jacobson & A. M. Jacobson (Eds.). Psychiatric secrets (2nd ed.). Philadelphia: Hanley & Belfus, Inc.

Family Involvement in Treatment Planning

- **Family involvement** in the treatment planning process does not just apply to working with children.
  - *It can reduce stress, enhance communications, reduce family stigmas and help your client's recovery when working with members at any age.*
- Many times clients are not asked whether they want to involve a family member in their treatment.
  - *Simply asking the member during the treatment planning process can be an effective intervention to improve family involvement.*

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Family Involvement in Treatment Planning

Helpful tips to increase family involvement:

- Ask the client to identify family members that they want involved in treatment.
  - *If the members says none, explore if this is an area that should be addressed in the treatment plan (e.g., no support system, family dissonance).*
- Reach out to the family members to set up a meeting to discuss treatment and your program.
- Meet with the identified family members and the client to discuss the treatment goals, how their participation can benefit the client, and determine if they want to participate.
- If the family members agree to participate, this should be documented on the treatment plan.

Ongoing Involvement

Member and family involvement does not stop at treatment plan development.

- Some simple recommendations to increase ongoing member/family involvement in treatment planning:
  - *Review the treatment plan with members on a regular basis* ***(Recommendation: at least once every 90 days).***
  - *During the plan review, ask open-ended questions to determine if they feel like they are making progress towards their goals.*
    - If not, ask what barriers they may be facing in making progress and what can be done to help them make their desired progress.

Ongoing Involvement

Member and family involvement does not stop at treatment plan development.

- Continued recommendations to increase ongoing member/family involvement in treatment planning:
  - *Discuss if any* ***new areas*** *have come up that should be added to the treatment plan.*
  - *Ask client if family members can be involved in the review of the treatment plan.*
    - If the member agrees, ask the family their perception of areas where the client is showing progress and opportunities for improvement.

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Ongoing Member Involvement

Continued recommendations to increase ongoing member involvement:

- Use questions like the following to prompt meaningful discussions regarding progress. If the answer is no, discuss what can be done to improve their outcomes.
  - *Are you better able to deal with crisis?*
  - *Are you getting along better with family?*
  - *Are you more comfortable in social situations?*
  - *Are you doing better in school and/or work?*
  - *Are your symptoms not bothering you as much?*
  - *Do you feel like we are addressing your cultural preferences and racial/ethnic background?*

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Plans of Care

Plan of Care vs. Treatment Plan

Although treatment plans and plans of care are similar, there are distinct differences between the documents:

- **Plan of Care:**
  - *Is a plan that documents what services a member's physical, mental health, substance use, and safety needs (as outlined on the independent assessment).*
  - *Is a broad, overarching plan that informs the treating provider's treatment plan.*
  - *Is required for members in the Coordinated System of Care (children) or adults receiving services through the 1915(i) State Plan Amendment.*
  - *It does not list the specific interventions that the treating provider will implement but rather the type, amount, frequency and duration of services to be provided.*
- **Treatment Plan:**
  - *Is required for all levels of care.*
  - *Is required for all members.*
  - *Outlines the goals and specific interventions that will be addressed and implemented in treatment.*

Who Requires a Plan of Care?

Adults with 1915(i) State Plan Amendment (SPA) eligibility

- 1915(i) SPA allows for expanded access to Home and Community Based Services (HCBS), including: CPST, PSR, ACT, and Crisis Intervention
- Plans of Care are developed and updated by an Independent Assessor/Community Based Care Manager (IA/CBCM)
- Treating providers are required to notify the IA/CBCM if an update is needed.

Who Requires a Plan of Care?

Children in Coordinated System of Care

- Members eligible for CSoC receive expanded services to help them remain in their homes, including: Parent Support & Training, Youth Support & Training, Independent Living/Skills Building, Short Term Respite Care, and Crisis Stabilization

- Plans of Care are developed, maintained and updated by the Wrap Around Agencies (WAA)

- Plans of Care are updated monthly by the WAA in the Child and Family Team (CFT) Meeting
  - *All providers referenced on the Plan of Care should attend the monthly CFT Meeting, including CPST/PSR providers.*

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POCs and Treating Providers

- Providers are required to provide services in the type, frequency, duration, and amount identified on the POC.
- If changes in type, frequency, duration, and amount of services are needed, a POC Update is required.
  - If member is in CSoC, the WAA should be notified in the CFT meeting.
  - If member is 1915(i) eligible, then the IA/CBCM should be contacted.

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Magellan's Role in Monitoring POCs

- There are specific performance measures identified by the Center for Medicaid and Medicare (CMS) related to the Plan of Care
- Magellan is responsible for monitoring records to ensure performance measures related to the POC meet minimum requirements.
- The minimum standard established by CMS for POC performance measures is a **100% compliance rate**.
- If a 100% compliance rate is not attained, then a Corrective Action Plan for achieving compliance must be completed.

Treating Providers' Role in Monitoring POCs

- Providers play an important role in achieving compliance.
- In CSoC, WAAs are responsible for ensuring compliance with **all performance measures** associated with the POC
- In 1915(i) SPA, responsibilities for compliance fall on both the **IA/CBCM and the treating provider.**
- The remainder of the training will review the specific performance measures that involve the treating providers that serve 1915(i) SPA members.

1915(i) SPA Monitoring

Performance Measures that affect treating providers:

- Number and/or percent of participants whose plans of care were updated within 90 days of the last evaluation.
- Number and/or percent of participants whose plans of care were updated when warranted by changes in the participants' needs.
- Number and/or percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care.
- Proportion of new participants who are receiving services according to their POC within 45 days of POC approval.

1915(i) SPA Monitoring

Performance Measure: Proportion of new participants who are receiving services according to their POC within 45 days of POC approval.

- Services identified on the POC (e.g., medication management, ACT, CPST, PSR, etc.) should be fully implemented within 45 days of the POC approval.
- If barriers are identified (e.g., member is not engaged in treatment, member cannot be located, etc.), the treating provider should contact the IA/CBCM to get a plan of care update.
- If a POC update is needed, the IA/CBCM should be notified.
  - *The IA/CBCM is expected to maintain routine appointment access standards (within 14 days) for POC updates.*
  - *If IA/CBCM is not responsive within those time frames, notify Magellan to file a complaint.*
- Documentation should outline efforts made to notify and coordinate with IA/CBCM regarding the POC update.
  - *Treating providers will not be penalized if IA/CBCM is non-responsive.*

1915(i) SPA Monitoring

Performance Measure: Number and/or percent of participants whose plans of care were updated within 90 days of the last evaluation.

- POCs are required to be reviewed within **90 days** of their development.
- What is expected of the treating provider?
  - *Magellan expects the treating provider to meet with the member and discuss with the member if they feel like the current level of services/treatment is meeting their needs.*
    - **If yes,** the treating provider is required to document in the record that the POC was reviewed and no update is needed
    - **If no,** the treating provider should contact the IA/CBCM to conduct a plan of care update.

1915(i) SPA Monitoring

Performance Measure: Number and/or percent of participants whose plans of care were updated within 90 days of the last evaluation.

- Conducting and documenting your member's POC review is simple
- You can either:
  - *Review the POC with the member and complete the 90 Day Review form (located on page 22 of the Initial POC form) OR*
  - *Review the POC with the member and write a progress note of the review*

- Remember: If the member needs more, less, or different services than what is listed on the POC, contact the Independent Assessor/Community Based Care Manager (IA/CBCM) to do a ***Plan of Care Update*** for your member.

1915(i) SPA Monitoring

Performance Measure: Number and/or percent of participants whose plans of care were updated when warranted by changes in the participants' needs.

- Magellan requires at a minimum that a POC update should take place under the following conditions:
  - *2 or more Inpatient Hospitalizations within 90 days;*
  - *3 or more Emergency Room visits within 90 days;*
  - *2 or more unique Crisis Intervention episodes within 90 days;*
  - *2 Residential Substance Use Treatment episodes within 180 days;*
  - *Gross member non-participation in POC; or*
  - *Any significant change in members needs that requires a change in frequency or type of service needed.*
- Providers should track this as part of service delivery.
- If a POC update is needed, the IA/CBCM should be notified as explained in previous slide.

1915(i) SPA Monitoring

Performance Measure: Number and/or percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care.

- Magellan will look for evidence of this performance measure in the record and claims data.
- This applies to both over and under utilization of services.
- If a significant increase or decrease in the intensity of services is needed, a POC update is required.
- It is important to remember that eligibility for the 1915(i) SPA does not mandate the member to participate in behavioral health/substance use treatment; however, it does require the POC to be followed as indicated.
  - *This is why it is important to request a POC update if the POC is unable to be maintained as originally intended.*

1915(i) SPA Monitoring

Performance Measure: Number and/or percent of participants who received services in the type, amount, duration, and frequency specified in the plan of care.

Question: What if the POC identifies a service that is not provided at your agency or provider site (i.e., medication management, residential substance use IOP, PCP monitoring, etc.); is the HCBS treating provider responsible for those services?

Answer: Yes and No.

Magellan does expect HCBS providers to monitor and document the mental health status of its members. This means that HCBS providers should be checking in with the members to ensure all of their physical, safety, and behavioral health needs are being met (i.e., Do you have all are medicines filled? When is your doctor's appointment? Did you attend? Have you been making progress in IOP?) and assisting them to secure services if needed. This monitoring should be documented in the notes.

If the member indicates that another provider is not being responsive, it is not the HCBS provider's responsibility to investigate this. The treating provider should assist the member in filing a grievance with Magellan or a provider complaint can be submitted so Magellan can investigate.

Final Overview

- Treatment Plans are the **required** documents that guide the member treatment.
- It is essential to involve the **member** and **family** in the development of the treatment plan.
- Magellan **monitors** treatment plans and plans of care through the treatment record review process to ensure compliance with standards.
- If the member has a **POC**, then treating providers have **enhanced** requirements.
- If you have questions contact your Network Provider Relations Liaison or Dawn Foster, the Quality Improvement Manager at DMFoster2@Magellanhealth.com.

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