Treatment Planning Microlearning Audio Transcript

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Welcome to our microlearning series, brought to you by the clinical provider training team. This module focuses on treatment planning.

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This series will cover Care Coordination, Treatment Planning, Titration of Services and Discharge Planning. Welcome to our module on Treatment Planning

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By the end of this module, you will be able to

Define treatment planning,

identify key components and considerations,

recognize how to assess progress with a treatment plan and when modification is needed, and identify the process of preparing for discharge planning

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On these slides, we'll introduce the member scenario that will be used throughout this module to help apply concepts to real-world clinical practice. You may wish to review the Member Scenario handout located in the handouts for training section of the Course Outline.

The member is a 34-year-old female with co-occurring substance use, behavioral health, and medical diagnoses, including Alcohol Use Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, and diabetes.

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The member is involved with multiple systems and service providers. There is legal involvement of probation and the child welfare system where there has been the removal of the member's child who is in the care of the members mother.

There are also behavioral health services of targeted case management and individual therapy, a parenting class, psychiatry for medication management, primary care for diabetes management as well as court ordered substance-use treatment.

For the purpose of this training, assume you are one of the providers involved in this member's care. As we move through the module, we will use this scenario to demonstrate how treatment

planning should be individualized, person-centered, and informed by the member's strengths, barriers, preferences, and whole-health needs.

Keep this member in mind as we explore how to develop effective treatment plans, assess progress, modify goals when needed, and prepare for eventual discharge planning.

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There are several important steps in treatment planning. The treatment planning process should be driven by a person-centered approach. This means that the plan is developed collaboratively with the member and or guardian that focuses on their strengths, desires and areas they want to change. The member is involved in creating goals, agrees on the goals, and signs the treatment plan. Motivational interviewing can be a helpful tool to elicit this information. The goals should be written using the SMART format, meaning they are specific, measurable, attainable, relevant and have a time frame. Treatment provided should be based on the member's clinical presentation and needs and include evidence-based treatments. There should be screenings and assessments done to determine a baseline.

All providers should use the treatment plan as a guide at each visit to assess the member's progression, regression or maintenance. For example, if the current goals on a treatment plan are working, then the treatment plan review should reflect the next set of goals. If providers put the same goals on each treatment plan, this will not show progress. If the first set of goals are not working, then new goals should be established. The goals should have a time frame of no more than 90 days. There should be a process in place for regularly scheduled reviews. The goals should be updated after a crisis, hospitalization or diagnosis change. Clinical documentation should reflect what techniques are being used in session, how the member is benefitting from the interventions, and how the member is engaging in session. Discharge planning begins when we first meet with the member and continues throughout the entire treatment process

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Before developing a strong, person-centered treatment plan, it is important to gather comprehensive information. A biopsychosocial assessment is completed to capture the full picture of the member's clinical, social, and medical needs. Next, an in-depth interview is conducted with the member and, when appropriate, with supports, family members, and other treatment providers. This establishes a clear baseline and identifies the member's priorities for treatment. Screening tools are also used to help quantify symptom severity and can include the P H Q 2 or P H Q 9 for depression, the G A D 7 for anxiety, and tools like the cage aid or audit when screening for substance use. Those screening tools are examples, and are not intended to be an exhaustive list. Cultural considerations and social drivers of health are incorporated throughout to ensure the plan is relevant and respectful. Finally, a D S M 5 T R diagnosis is documented that is consistent with the presenting problems, the member's history, the mental status exam, and the assessment findings. Together, these components provide the foundation for effective treatment planning.

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In the previously introduced scenario, the member's individual therapist begins with a comprehensive biopsychosocial assessment. Using an in-depth interview and motivational interviewing, the therapist works with the member to understand their desired goals and outcomes, treatment preferences, cultural considerations, strengths, social supports, and interests. The assessment also includes a review of the member's behavioral and physical health needs, medications, and any other services or providers involved in their care.

With a release of information in place, the therapist gathers collateral input from other involved agencies and the member's mother. This additional perspective helps clarify presenting symptoms, needs, barriers, strengths, and resiliency factors.

Next, the therapist administers appropriate screening tools, such as the P H Q9, P H Q2 and G A D 7. These tools establish a baseline, identify specialized needs, and supports the ongoing measurement of progress throughout treatment.

Based on assessment findings, the therapist renders an appropriate DSM5 T R diagnosis to guide treatment planning.

Finally, the therapist, Targeted Case Manager, and the member collaborate to develop integrated, individualized goals using the SMART format. These goals reflect the member's baseline scores, desired outcomes, preferences, cultural considerations, and strengths.

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After you have completed the initial process and gathered information, you are ready to create a Person-Centered Treatment Plan. You will want to discuss with the member what strengths can be incorporated into their treatment plan, and take into account resiliency factors.

Providers should ask the member if they can identify any barriers to reaching each goal. This should include a discussion of any past successes. The provider and member can discuss past interventions both those that were effective and those that were unsuccessful, and why.

Providers should work collaboratively with the member to build goals that are relevant as to why the member is receiving services and take an integrated approach. This should include all the services that are needed such as physical health, behavioral health and needs related to their specific diagnosis.

It is preferred to use the SMART goals method when developing goals. SMART stands for Specific, Measurable, Attainable, Relevant, and Time-Frame. This method helps goals to be measured and adjusted over time to show incremental progress or regression. SMART goals can be specific to meet the members needs rather than broad. The goals should have a time frame, which should be no more than 90 days. The goals should reflect the person's preferences, desired outcomes and goals.

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Keeping the process from the previous slide in mind, lets apply this to the member scenario. During the intake process, the provider conducted a biopsychosocial assessment and an in-depth interview to gather information on the member's clinical presentation. The provider learned that in terms of

Strengths and Resiliency Factors, the Member has been sober for 90 days, attends AA meetings and has a supportive sponsor for her Alcohol Use. The member's mother currently has custody of her child, and they have a positive relationship with one another, as her mother has been a constant support throughout her life.

In terms of barriers, the provider learned that there is a Lack of transportation due to the DUI with her child in the car, which creates stress around getting to appointments. Though she and her mother have a positive relationship, she is unable to see her child every day, which results in enhanced symptoms of depression such as not wanting to get out of bed, and cravings to drink alcohol as she ruminates about her mistakes that led her here.

Now, with all information gathered, and strengths, resiliency factors, and barriers in mind we can begin to build integrated, relevant goals into a SMART format on the next slide.

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Now, with all information gathered, and strengths, resiliency factors, and barriers in mind we can begin to build integrated, relevant goals in SMART format. Examples of such goals may be:

Within 30 days, member will work with her case manager to apply for at least two transportation assistance resources and develop a weekly transportation schedule to ensure attendance at medical, behavioral health, and DCF-related appointments.

This Transportation and Stability Goal can be written in smart format as

Specific. Reduce transportation barriers to treatment

Measurable. Apply for at least 2 transportation assistance resources, for example, Medicaid transport or community ride programs, and develop a written weekly transportation plan with case manager.

Achievable. Supported through Targeted Case Management at Agency A.

Relevant. Reduce missed appointments and stress that triggers cravings.

Time-Bound. Complete applications and establish a plan within 30 days.

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Recovery is defined by the Substance-abuse And Mental Health Services Administration, as "The process of change through which members improve their health and wellness, live a self-directed life, and strive to reach their full potential." This model considers that recovery includes hope, is person driven, occurs via many pathways, is holistic, includes peer support, is relational, takes culture into account, addresses trauma, involves respect and considers strengths and responsibilities.

Incorporating these principles can help create a person-centered treatment plan that fully addresses the member's needs, at the right time.

To further develop a person-centered treatment plan, let's discuss how to incorporate evidence-based practices.

While it is important to know the member, their personality, and their receptiveness to recommendations, it is also important for providers to be mindful of their personal style. There may be times when you must adjust your approach to provide the best method for the member, and to increase member engagement. Screenings can assist in establishing a baseline, and assessments and screenings can be used to identify any special considerations that should be taken.

Motivational Interviewing can guide that potential, and facilitate the natural change process that is already inherent within the member.

Stages of Change can determine which stage the member is in. You can customize what you will join with them in working toward. This will also help with setting realistic and appropriate goals. These types of goals can lead to a sense of accomplishment for both yourself and the member.

A holistic approach to healthcare results in the best outcomes. This includes a comprehensive treatment plan, and helps to bridge the gap for the member in terms of their recovery. This should be based upon the individual's needs. These can include Behavioral Health, Physical Health, Medication Management and other services.

Integrated Healthcare is when health care professionals consider all health conditions at the same time when creating a treatment plan.

It is important that you understand that the patient's view may be defined by their culture and beliefs. This is not a one-size fits all approach and should take into consideration family involvement and the need to adjust your approach if necessary. Understanding and appreciating a member's cultural background can expand treatment opportunities. Every culture has specific values that can be used in treatment, such as the support of extended families and religious, or spiritual communities. By appreciating a member's culture, providers can tap into the most effective treatment strategies that are based on the personal and social strengths of each member.

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Treatment planning should always be member-centered.

The member is an active partner in developing the treatment plan, and when appropriate,

parents or caregivers should also be involved. Goals should be realistic and attainable, based on the member's age, developmental stage, and baseline level of functioning.

Treatment goals are not static and should be updated as needed. Updates are required when there is a crisis, hospitalization, a change in level of care, diagnosis, or provider, or when the member experiences a significant life change.

progress should be assessed on an ongoing basis using evidence-based screening tools and clearly documented in the clinical record. progress toward discharge should also be considered throughout treatment.

As the member improves, services should be stepped down gradually, based on clinical presentation, progress, and available supports. If symptoms worsen, services may be titrated up when clinically indicated and supported by documentation.

When all of these considerations are in place, the treatment plan stays focused on the member—supporting individualized care that adapts as needs, progress, and circumstances change.

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In applying the treatment planning considerations, we look at the Person-Centered Planning first. "In the case scenario, the member had previously managed anxiety and depression using coping skills and natural supports. However, the temporary loss of custody of her daughter caused symptoms to feel unmanageable. Regaining custody became her top priority. The therapist and Targeted Case Manager actively included the member in treatment planning to ensure goals reflected what mattered most to her. This collaborative approach supports engagement, motivation, and compliance.

Next, we consider goal Review and Updates.

Treatment goals are reviewed regularly and remain flexible as the member's needs change. The therapist and Targeted Case Manager ensure goals continue to align with the member's priorities and clinical presentation as progress is made, and circumstances evolve.

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The next consideration is Monitoring Progress. progress is assessed consistently throughout treatment. At each meeting, the Targeted Case Manager evaluates progress toward goal achievement. During therapy sessions, the therapist reviews treatment goals, follows up on coping skills and tools, and administers evidence-based screenings, such as the P H Q9, every two to four weeks. Providers coordinate care to maintain a shared understanding of progress.

The last consideration is Service Intensity. As the member begins to meet her goals, and symptoms decrease, providers reevaluate the need for ongoing services, and consider reducing

service frequency. Indicators of readiness include sustained sobriety with reduced cravings, significant improvement in mood symptoms, and a reliable transportation plan with reduced anxiety. Services are adjusted to support continued progress, while promoting independence.

This case demonstrates how person-centered planning, guides goal development, progress monitoring, and appropriate service adjustment.

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Now that we have discussed evidence-based practices to incorporate in treatment planning, let's begin a review of what the ongoing treatment process may look like.

Providers will want to document, through their progress notes how their sessions are tied back to the smart goals and interventions.

Providers should document the date goals were initiated, revised and completed.

Providers should conduct ongoing assessment as to whether or not the Treatment Plan Goals and Interventions are working. If the goals are not working, providers should ask themselves "what can we do differently?" Any changes will need to be reflected in an updated treatment plan. There may be instances in which the provider will assess the possibility of titrating services.

It is feasible to consider a reduction in services based on how the member is responding to treatment. It is recommended that the provider has a collaborative conversation with the member about eventual discharge in order to wrap up the treatment plan. If you would like additional information about services titration or discharge planning, we have additional microlearning opportunities. Thank you for attending this microlearning.

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References for this microlearning are shown here. If you would like to review any of these references, please click the pause button and write down the items of interest. To move on from this video, please click the "next" button at the bottom of your screen.