# Treatment Planning at CVH in 2008

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For assorted reasons, it is critical that CVH elevate its quality of treatment planning. This process must begin quickly (to comply with CMS requirements) and continue into the foreseeable future (to make this a better hospital). The purpose of this document is to clarify conceptual issues related to treatment planning. While the new EMR is designed to facilitate this sort of treatment planning, the ideas in this document apply to both written and electronic records. Instruction concerning use of the EMR and more conceptual detail is contained in other documents and will not be repeated here.

Please note that in the Appendix to this document, are examples of "good" and "not-so-good" Goals, Interventions and Objectives. These are taken from early attempts of users to work with the new electronic system. If you find any of your work on the "not-so-good" lists, please do not be discouraged. Your pioneering work using the new system is appreciated, and with a minor tune-up, you will soon be kicking serious treatment planning butt.

## Background

In preparation for drafting this document, I studied the issues raised by CMS concerning our treatment plans and then examined the set of plans that they had reviewed. It became clear to me that we are simultaneously engaged in two distinct, but overlapping processes: complying with CMS (and other guidelines) and enhancing our treatment planning to take full advantage of the possibilities introduced by electronic treatment planning. In the document that follows, I will try to make explicit where we are now (i.e., what's wrong with our current treatment plans), where we want to be, and how we will get there.

## Our Current Treatment Plans

As you may have heard me say before, I find our current plans unpleasant to even pick up in my hands. It is difficult to find a coherent outline of treatment. There is variation among Divisions in exactly how the plan is laid out. The following generalities, however, can be made:

> The logic in our plans is rather basic: we list a bunch of problems and then list a bunch of services. The clarity concerning the associations between the problems and treatments is variable.

There is often a lack of specificity concerning treatments. Sometimes, for example, participation in a group is listed without much information about the group content. There is rarely anything specific to the patient.

Goals often seem to be nothing more than restatements of problems. They are often expressed from the provider's point of view (e.g., "Will stop experiencing auditory hallucinations") or artificially converted to a pseudo-patient viewpoint ("I want to stop seeking attention"). In essence, Goals often contribute nothing to the usefulness of our current plans.

Objectives, also, are often not meaningful in our current plans. They are sometimes nothing more than statements about the process of treatment (e.g., "Will meet with prescriber at least 30 minutes per month"). Often, Objectives are stated vaguely, and are unmeasurable ("Will ask for staff support when needed.")

After looking through a few treatment plans in certain areas, it becomes clear that "cookbook" formulas are being applied.

**Our New Treatment Plans**

In our new process, we interpose a step between the completion of the clinical assessment and the formal treatment planning meeting. The patient, one or a few members of the treatment team, and perhaps a family member or advocate meet to identify the patient's long-term Goals. The product of this effort is the Functional Assessment. Following are the basic steps in creating the rest of the treatment plan:

Barriers to achieving the identified Goals are identified. In the past, this was conceived as "the Problem List."

Once Barriers have been identified, we specify the Interventions to address each one.

Finally, when we have a sense of the patient's ultimate Goals, the Barriers that lie in the way, and what Services are available for treatment, we create some measurable Objectives to track progress.

The hierarchy of the MTP is relatively simple:

Domain
- Goal
  - Barrier
    - Service / Intervention
  - Objective

Things, of course, get a little more complicated, since there can be up to 13 Domains active (though more than 5 is probably unrealistic); for each Domain, there can be any

number of Goals (though more than a couple is probably not necessary); for each Goal, there can be any number of Barriers (but more than 3 seems like overkill); for each Goal, also, there can be any number of Objectives (but 1 or 2 should suffice). For each Barrier, there may be several Services (e.g., a few groups, discharge planning with a social worker, medication from a prescriber, psychotherapy, and interventions by direct care staff).

Unlike most written treatment plans, the electronic plan rigorously captures these relationships among planning elements. Please understand that only by maintaining this logical structure can the treatment plan actively guide everyday treatment. It is essential that we share an understanding of what we mean by each element in treatment planning. Please understand that there are more than one way to define these elements, and more than one way to conceptually connect them. Following is the scheme immortalized in our new EMR:

DOMAIN

Domains are nothing more than aspects of a person's life (Distress from Psychiatric Symptoms, Housing, Substance Abuse, etc.). They are categories within which we organize the description of our clinical work. The 13 Domains in our system provide us with a consistent framework for our treatment plans.

GOAL

These are a patient's long-term aspirations (i.e., what he or she wants out of life). They should generally be grounded in "real life" (e.g., "I want to get out of the hospital and move into my own apartment") and not in our own technical terms ("Will stop experiencing auditory hallucinations"). In some situations (which should be kept to a minimum), clinicians may feel the need to substitute their own concerns for a Goal (e.g., "Prevent self-harm or suicide"). Please see Appendices A and B for laudable and less laudable examples.

OBJECTIVE

An Objective is a step towards the achievement of a Goal that meets the following 3 criteria:

It must be measurable, in the sense that it can be clearly judged to either have been achieved or not at a specified point in time.

It should be achievable in the time frame of the Treatment Plan. (If the next scheduled treatment plan review is to occur in 30 days, for example, the Objective should be designed to be achievable over that period.)

To be effective, an Objective must be compelling to the patient. This is achieved by constructing the Objective in the context of the patient's Goal. It will, then, be grounded more in terms of "real life" than in technical clinical terms. (A person, for example, would probably be more excited about "a visit to the local mental health agency" than about "taking his meds regularly.")

There is a particular source of conceptual confusion that needs to be discussed, involving another (quite praiseworthy) use of the word "objective." This involves the therapeutic (i.e., technical) objectives specified as part of creating a new element of treatment. A clinician establishing a new group, for example, should be clear on the teaching objectives for each session. These objectives are largely the same for all group members. They are sometimes measured with some sort of post-test. This specification and measurement of objectives is good practice. Ideally, it should be documented. We are, in fact, discussing how to do this efficiently in the new EMR. It must be understood, however, that this is not the same idea as the Objectives we are about to add to our Treatment Plan. These, as you will see, are highly individualized. There is some good news here, however. In a Treatment Plan, we will generally need relatively few Objectives, often only one per Goal.

Since the level of ambition appropriate in the creation of an Objective depends on all the other elements in the plan, my suggestion is to establish these as the last step in defining the treatment planning logic. Please see Appendices E and F for magnificent and less magnificent examples.

BARRIER

This corresponds closely to the concept of "problem" in more traditional treatment plans. Use of the word "Barrier" calls attention to an important shift in emphasis. In the old world, problems set the treatment plan into motion. In our new plans, the patient's Goals get the process started, and problems are conceived as obstacles to achieving these Goals.

SERVICE / INTERVENTION

Often, the terms "Interventions" and "Services" are used interchangeably (i.e., to refer to a particular treatment). It is now necessary to refine our use of these terms. A Service should be a very concrete and specific piece of treatment offered to a patient (e.g., attending a certain group for 60 minutes once per week, or doing psychotherapy with a specified therapist 45 minutes twice per week). Interventions describe in more detail the therapeutic efforts that are part of each Service. Two patients in psychotherapy with the same psychologist for 60 minutes weekly, for

example, are receiving the same Service. The Interventions for these two patients, on the other hand, should be distinguished on their treatment plans. Similarly, two patients participating in a particular therapeutic group might be expected to get entirely different benefits from a group. (In a conversation skills group, for example, one person might be taught how to speak up more confidently; another might be taught how to avoid dominating conversations.)

It is not enough to indicate what service (in this case, meetings with an internist) is being applied to a problem. Everyone in CVH has meetings with some sort of general physician. We need to specify what the internist offers this particular patient. For a patient with no known medical problems, for example, the Intervention might be something like: "Monitor routine unit and laboratory medical and dental screening to confirm the continued absence of a need for medical or dental intervention." This would be quite different from someone suffering from obesity, Type 2 Diabetes, hypertension and dyslipidemia. Please see Appendices C and D for fabulous and less fabulous examples of Interventions.

**Our Future**

It is no secret that we do not enjoy the luxury of undertaking our treatment planning challenges in a deliberate and civilized manner. While feeling strongly that the changes described in this document will contribute positively to the lives of our patients, I sincerely regret having to distort our transitional process (including the implementation of the EMR).

We need to immediately make our Interventions more specific and our Objectives more measurable, whether the treatment plans are created in the new EMR or using existing templates. In the Appendices that follow are examples to guide you.

One day, the sun will rise over CVH and we will realize that we are no longer living in fear of visits from agencies with frightening initials. Until that wonderful day, let us slog on fearlessly and, to the extent possible, in good cheer.

## Appendix A: Good Goals

| Goal | Critique |
|---|---|
| I don't want to feel depressed anymore. | This is fine, as long as the patient really identifies depression as an issue. (If we feel that the patient is depressed, but he doesn't see it that way, we should not put words into his mouth.) |
| I want to have more friends. | This is a very positive starting point for a variety of useful interventions having to do with the acquisition of hygiene and social skills. |
| I want to get a job. | This paves the way towards a coherent accounting for services related to symptom reduction, hygiene and social skills acquisition, and vociational issues. |
| I want to get out of the hospital and move into my own apartment. | This is a compelling organizing principle for almost any of the services offeren in CVH. |
| I want to get off my medication. | The fact that stopping medication may not be a good idea should not prevent us from recording this common patient Goal. We can then introduce as Barriers the psychiatric symptoms that, from our point of view, require medication. This becomes a less off-putting way to explain in the treatment plan the need for medication and related psychoeducational programming. |
| I want to get the legal system off of my back. | This captures many patients' perspectives on their legal problems. We then include their legal difficulties in the plan as Barriers to this Goal. |
| I don't want to hurt myself ever again. | This is fine, as long as the patient really sees things this way. If we're concerned about a patient's potential for self-injury, but he or she is not, we need to reframe this as a Clinician Concern. |
| I want to cut down on my drinking. | If this is the patient's way of conceptualizing the Goal this is fine, even if we feel complete abstinence is required. |
| Get a GED. | If a patient really expresses this, write it down. |
| I want to lose 50 pounds | I know the feeling. |
| I want methadone maintenance. | This would be perfectly acceptable Goal, even if we do not feel that methadone maintenance is the appropriate treatment. It opens the door to our working with the patient on the development of a mutually agreeable relationship with the substance treatment system. |
| I want to save $$ for clothing and eating out. | This would be an excellent Goal, even if we might reasonably feel that there are higher priorities than clothes or restaurants for a person. We must leverage the motivation of our patients wherever we find it. |
| I want to meet with brother, A., and other family members. | Let's imagine that this issue relates to a history of the patient having sexually offended against this brother. The acceptance of this as a Goal would depend on whether such a Goal is at all realistic, even over long periods of time. If a patient presents a Goal that is understandable but permanently unrealistic, I would argue for helping the patient identify a related, but achievable, Goal. |

## Appendix B: Not-So-Good Goals

| Goal | Critique | Better Alternative |
|---|---|---|
| J. will independently shower at least three times a week by the end of this assessment period. | This does not seem likely to represent anyones hopes and dreams. It is more of an Objective. | A relevant Goal might be something related to being more socially presentable, such as having more friends. |
| Will be able to initiate conversations with other patients. | This is more of a learning objective for a group than a life Goal for a person. | A relevant Goal might be something related to being more socially presentable, such as having more friends. |
| Will go on a walk twice a week. | This does not seem likely to represent anyones hopes and dreams. It is more of an Objective. | A relevant Goal might involve a desire to lose weight or get into better shape. |
| Patient will lose weight and refrain from eating high fat foods. | If a patient is dangerously obese, losing weight might be substituted for a Goal as a Clinician Concern. The part about diet is better included within Interventions. | If the patient wishes to lose weight, the Goal would be "I want to lose weight." |
| Patient will speak in an adult voice. | It is unlikely that this comes from the patient. | This needs to be related to something the person wants, e.g., "I want people to stop making fun of me." |
| Vocational rehab group 5 per week x 1 week | This is part of a description of Service, not a Goal. | Perhaps: "I want a job." |
| Mr. H will shower at least three times a week. | This could be an Objective. | This should be related to something the patient wants, e.g., having a job or a girlfriend. |
| Referral to be submitted for family tx | This is an Intervention. | The Goal might be something like: "I want to spend more time with my family." |
| Patient spends entire day either injesting heroin or engaging in illegal activities to obtain more money. | This seems like the detail associated with a substance abuse Barrier. | The Goal would depend on the patient's current status; it might involve a desire to remain abstinent or avoid legal trouble. |
| Can identify 3 triggers of my depression that lead to suicidal thoughts. | This is more of an Objective. | The Goal might be something like: "I don't want to make another suicide attempt." |
| H. will brush his teeth 2x daily to promote good dental health. | This might be an Objective. | The Goal (or Clinician Concern) would depend on H's interest in his dental health. |

## Appendix C: Good Interventions

| Intervention | Critique |
|---|---|
| Teach L. the purposes of both psychotropic and general medications, about potential side effects, and about how to avoid medication interactions. | This Intervention could be a part of work with a prescriber or a member of the unit staff. |
| Teach L. how to improve his concentration in the face of auditory hallucinations. | This could be an Intervention associated with membership in a symptom management group or with the work of direct care staff. |
| Facilitate physical conditioning and recreational benefit of team sports. | This could be the Intervention explaining the patient's referral to a leisure group. |
| Help D. deal with losses resulting from his legal difficulties. | This could be part of this patient's referral for individual or group psychotherapy. |
| See physician at least every 6 months to monitor lipid levels and adjust medications as necessary. | This could be part of the explanation in the treatment plan of this patient's work with the unit internist. |
| Ongoing monitoring by Ambulatory Services physician, including nutritional counseling, recommendations concerning exercise, and pharmacotherapy with statins as indicated. | This could be part of the explanation in the treatment plan of this patient's work with the unit internist. |
| Help to understand the role of each psychotropic medication. | This Intervention could be a part of work with a prescriber or a member of the unit staff. It could also be part of the Intervention associated with a psychoeducational group regarding medication. |
| Encourage daily showering. | This could be part an Intervention related to the service type "Direct Care Milieu Management." |
| Provide opportunity to socialize in an informal setting with other patients. | This could be an Intervention associated with suggesting that a patient attend unit dances. Note that this is not generally considered part of active treatment as conceived by CMS. |
| Work with housekeeper for up to 2 hours daily. | This could be part of vocational services. |
| Through use of mood stabilizers and/or antipsychotic agents, reduce symptoms of mania. | This is a clear Intervention, probably associated with prescriber visits. |
| Understand the two-way relationship between depression and alcohol dependence. | This is a clear Intervention that could describe a patient's participation in either a psychotherapy or psychoeducational substance group. |
| Reinforce need to avoid making other people uncomfortable. | This could be part of the Interventions associated with a patient's participation in a social skills training troup. |

## Appendix D: Not-So-Good Interventions

| Intervention | Critique | Better alternative |
|---|---|---|
| Provide opportunity to learn from others and enhance personal development, both as it may bear on substance issues and more generally. | This is too generic to suffice for a particular patient's participation in a psychotherapy group. It might be OK as a generic Intervention for a leisure or milieu support group, however. | For a psychotherapy group, you might want something like: "To deepen understanding of how substances have been used to maintain social distance, and to develop avenues towards more meaningful intimacy. |
| Through education and group support, to reduce or eliminate smoking. | This is too general, even for a generic Intervention for a psychoeducation group. | You need to specify aspects of education (e.g., the physical impact of smoking) and the ways in which group support is invoked. |
| Develop better concentration and organizational skills. | This is too general, even for a generic Intervention for a psychoeducation group. | You need to better specify how these skills are taught. |
| Help improve concentration through topical discussions. | This is a potentially reasonable as an organizing principle in a leisure group description. For this type of group, there does not necessarily need to be a specific Intervention in each member's treatment plan. | If this were a Social Rehab group on social skills developement, the specific Interventions for a given patient might include such elements as "Teach patient to remain on topic" and "Teach patient to listen to others and ask relevent follow-up questions." |
| Improve communication skills. | This is too general, even for a generic Intervention for a psychoeducation group. | You need to better specify how these skills are taught. |
| Help organize thinking through playing games with structured rules. | This clearly relates to a leisure group, which often doesn't require more than attendance. | It is important to recognize that in spite of the undeniable value of groups like this, they do not constitue active treatment as conceived by CMS. |
| Permit spiritual development and involvement with religious community. | It is not clear to what activity on the part of staff this refers. | One needs to specify what staff are doing to facilitate this, e.g., transporting the patient to religious services, or offering inpatient pastoral services. |
| Rehab Counselor will provide strategies for early recovery. | This is the kind of Intervention that would show up in the treatment plans of too many patients, undermining a sense of individualized care. | If this is a Psychoeducation group, some specific teaching methodologies would need to be described. If a Psychosocial Rehab or Psychotherapy group, each patient would need to have unique Interventions in the treatment plan. |
| Social Worker will assist Mr. J. with a referral to the next level of treatment. | This comes across as a standard description of social work services that could be applied to every patient. | This Intervention needs to specify what levels of treatment are relevant, and what activities are required to facilitate it. |

## Appendix E: Good Objectives

| Objective | Critique |
|---|---|
| Client will be able to list 3 strategies, other than meds, for improving mood. | This could be an Objective associated with a controversial Goal like "I want to get off my meds." |
| Will be able to initiate conversations with other patients on the unit. | Some might argue that this has not been quantified enough. (E.g., would one conversation in a 3-month interval suffice?) |
| Will be able to converse in structured situations (e.g., a mock job interview) without interjecting things that will make others uncomfortable. | This would be even better if it were quantified. (E.g.: "More than 50% of the time, will not interject intrusive comments into a mock job interview.") |
| Will be able to describe 3 methods of recognizing when his own thinking is not similar to other people. | This would fit in nicely in a symptom management group. Ideally, the patient would understand the potential advantages of acquiring this skill. |
| H. will utilize a budget as developed by himself and staff to begin saving a designated amount of money each week. | This is clear. Its value as part of the treatment plan would partly depend on how compelling the associated Goal is to H. |
| Mr. G. will have an appointment at Connecticut Counseling to continue methadone maintenance. | Clear, and clearly contributing to something likely to be valued by the patient (i.e., discharge). |
| Satisfy Probation Officer's requirements for adherence to substance treatment. | Very believable as something that is compelling to patients with legal difficulties. |
| Within the next 3 months, Mr. A. will consistently name and give examples of 5 actions that can led to a high level of privileges. | While it is generally better to define positive outcomes in terms related to life outside the hospital, this is not always possible with very long-term patients. |
| Mr. W. will become competent to stand trial. | What could be more measurable than this? |
| Mr. W. will work with the Forensic Liaison from the Southeastern Mental Health Authority and his social worker to develop a plan for living safely in the community if he is released by the court. | This is measurable: either the plan gets developed or not. It seems likely to be achievable in the time frame of the treatment plan. If Mr. W. sees this as worth doing, we're all set. |
| Become involved in at least one new Advocacy Unlimited initiative. | Measurable, achievable and compelling: nice. |
| Identify at least one volunteer work opportunity and submit request for permission from the PSRB for future involvement. | This seems like a meaningful step towards achieving a Goal related to wanting a job. |
| Exercise an average of at least 5 days per week, and participate in a team sport experience an average of at least twice per week. | Frankly, I prefer staying away from these sorts of statistical measures, but it sometimes can't be avoided. |
| Maintain lipids in normal range. | Very clear; one hopes that the patient buys in. |

## Appendix F: Not-So-Good Objectives

| Objective | Critique | Better Alternative |
|---|---|---|
| Will get out of bed and attend morning meetings. | It is not clear how to rate this outcome in the likely event that attendance is not 100%. This, also, is likely to be a bad choice if the patient does not value it. | Will get out of bed and attend morning meetings an average of 5 days per week. |
| Client will verbalize suicidal thoughts as they occur and implement positive coping strategies to help with these feelings. | We are not able to read a patient's mind, and thus will have trouble judging how consistently this is occurring. | Client will be able to verbalize 5 positive coping strategies for suicidal thoughts. |
| Will report any suicidal thoughts to staff. | We cannot always know when this is not happening. | Client will be able to verbalize 5 positive coping strategies for suicidal thoughts. |
| H. will maintain current level of remission of symptoms. | Too vague | Will be able to engage in a 5-minute conversation with a single person. |
| H. will increase ability to utilize coping skills as evidenced by decreasing attention-seeking behavior, excessive worrying, suspiciousness, and impaired reality testing. | It is likely that there will be fluctuations in this array of symptoms over any time period. It will thus be difficult to measure the outcome. | H. will be able to name 3 coping skills to help him deal with excessive worrying. |
| H. will meet with vocational counselor 2x month to discuss opportunties to increase work hours. | This is a common error: describing the process of service delivery as an end in itself. Objectives are outcome measures. | Harun will increase his work hours by at least 3 hours per week. |
| H. will be able to recall 4-6 new facts about the herpes virus. | It is unikely that this would be compelling to H. | This does not seem to have much promise as an Objective. |
| Pt will listen to education on risks and benefits in med ed group 1 x week | Must be more specific about the content of a psychoed. group, though the learning objectives can be the same for all members. | Therapeutic benefits, side effects, and interactions for psych. med classes will be explained. How to start and stop meds is discussed. |
| H. will not have any aggressive episodes. | What might qualify as "an aggressive episode" is not clear. | H. will not hit another person during the next month. |
| J. will participate in Self-Esteem Group 80% of the time. | This would only be acceptable if she resists attending the group. | J. will be able to list 5 factors that interfere with her self-esteem. |
| H. will ask staff for support as needed. | Much too vague. | H. will be able to list 3 negative outcomes of impulsive behavior. |