

The Treatment Planning Module in the Interim Treatment Planning System

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Prologue

Since release of the first section of this document, I have been warned that what was meant to be charming and engaging irreverence could be mistaken for cynicism. My first impulse was to expunge the offending passages.

As I started to sanitize the document, however, I began to feel that important observations were being obscured. So I have decided to release the unexpurgated version, but to precede it with several important disclaimers:

- Please do not misunderstand my concerns about the unwieldy bulk of the complete Master Treatment Plan to suggest that I am not dead serious about the importance of the treatment planning process and its accurate documentation. (Consider the time it took to create even this one manual, not to mention the many incarnations of the system itself.)
- In general, I do not consider surveyors (or internal Quality Improvement wonks) to be sadistic, petty, or unreasonable. Much more often than not, I consider their concerns about our MTP's worthy and fair.
- I do not see our current documentation challenges as primarily matters of compliance. If we focus squarely on the delivery of better care, compliance issues will take care of themselves.

Exactly how we use this document remains to be seen. We will respond to feedback from user with revisions, additional materials, and other training approaches. As we see how the system succeeds – and fails – to meet our needs, we will improve it.

The bad news is that we have a lot of challenging changes to make. The good news is that we are well-positioned to succeed and that our patients will be better off if we do.

The purpose of this document is to explain in detail the use of the Treatment Plan module in ITPS. It is hoped that this can serve as both a self-contained introduction to the system and a User Manual covering all aspects of system use. Conceptual issues underlying the changes in our approach to treatment planning are explained.

Background

The Treatment Plan has long been the most challenging aspect of documentation in the mental health record. Accreditation and funding agencies have delighted in pointing out the inconsistencies among the Treatment Plan and the assessments on which it should be based, and among the Treatment Plan and subsequent progress notes, which should document services consistent in focus and intensity with those prescribed.

Over the last few years, for an assortment of reasons, expectations have risen. In the name of “best practices” and “evidenced-based practice,” the very basic need to get paid has become somewhat more elusive. Simultaneously, the emergence of the Recovery Model has created opportunities for making Treatment Plans more responsive and relevant to the people whose lives they are meant to improve. Often, these influences seem to pull us in opposite and irreconcilable directions.

Conceptual Overview of the Master Treatment Plan

A Master Treatment Plan is a relatively small piece of a complete medical record. This is equally true for a written record and an electronic medical record (or, EMR). It is worth considering, then, why it seems to be the focus of so much attention by surveyors from assorted accrediting agencies. A related and interesting question is why most surveyors will tell you that they virtually never see an institution with truly compliant treatment plans. I will try to answer the second question first.

At the risk of seeming irreverent, I offer the following observation: the Master Treatment Plan (as a document, either written or electronic) is virtually never clinically useful. By this, I mean that a mental health provider attempting to work with patients will generally not find the MTP helpful in any real world situation. Putting compliance issues aside, then, would it be reasonable to abandon the process of creating a Master Treatment Plan?

No. The process of creating the plan is our opportunity to put together a coherent strategy for helping the patient. This, of course, is necessary. The problem is that the product of these efforts is so complex and cumbersome that it is difficult to get at the specific piece of information we need in a particular situation. Example:

During the development of a particular treatment plan, let us imagine that there is a quality discussion among the patient and treatment team members resulting in a referral to a particular group being held off the unit in Page Hall. Let’s assume that this thinking is right on target and, if executed well, will be of enormous benefit to the patient.

One problem is that most treatment plans do not capture well the thinking that leads to particular services. Exactly what this group is supposed to do for this patient is unlikely to be clearly defined; which problems of this patient it is meant to solve may not be clarified; how it brings the patient towards reaching life goals (and shorter-term objectives) is not clear; the integration with other aspects of

treatment is not explicated. The reasons for all this is obvious; knowing that no one is likely to ever look for this stuff in the treatment plan, the treatment team is not inspired to make the somewhat extraordinary effort to document it.

Even were this treatment plan the one among many that approaches the new standards, the group leader in Page Hall is unlikely to be able to travel to all the units of group members and study their treatment plans. (Knowing that the plans will not be helpful ensures that even the most athletic and industrious group leaders will not make this effort.)

Here's where an EMR can make a profound difference. As (I hope) the rest of this document will demonstrate, an electronic approach to treatment planning can facilitate the elements of integration listed above. More to the point, however, an EMR can extract from the treatment plan the information needed in a particular situation. As the group leader in Page is adding our patient to the group, the system can automatically analyze the MTP and insert the Interventions and Objectives into the group setup. When the group leader is writing progress notes, these elements of the treatment plan can be automatically inserted to assist the integration of this aspect of treatment with the treatment plan. At any time, the group leader can print out a summary of the group, summarizing the relevant aspects of each member's treatment plan. (This would be especially useful to a substitute leader.)

Note that the full MTP itself (whether viewed on the screen or printed) tends not to be clinically useful. The advantage of the EMR is the ability to extract information and present it in ways customized to particular clinical situations. (Understand, by the way, that this is only possible if the information in the MTP is highly structured; this accounts for the somewhat complex relationships among Goals, Barriers, Services and Objectives.) For this reason, I ask you to suspend your opinion of whether the EMR is a good thing until we have both the MTP and other elements (such as progress notes) in the system.

The Master Treatment Plan (as a large and unwieldy document) is therefore best viewed as an artifact of the treatment planning process that is of primary interest mainly to auditors and surveyors. Clinicians will rarely turn to it; instead, their work will be guided by extracts suited to specific situations. (Another example of an extract would be the Nursing Plan of Care, which helps direct care providers on the unit understand their roles in the treatment of a given patient.)

The Relationship between Assessment and Treatment Planning

When a new patient enters the system, the first step is to conduct a thorough assessment. Whether called an "Intake" or a "Comprehensive Assessment," this includes elements conducted by assorted disciplines. In total, these often result in a somewhat overwhelming inventory of potential problems.

Traditionally, this was understood to result in a “Problem List,” which then became the basis for the Treatment Plan. All you then needed to do was to list the treatments to solve all these problems, and you were off to the races.

Not so fast. There are at least three major problems with this model:

The patient’s input is missing from the equation. In this model, the patient is the passive object of assessment. The selection of treatments is a technical matter driven by the Problem List; there is really no role for the patient here. Experience has shown that treatment plans that are not understandable and compelling to patients lead to suboptimal participation on their parts.

The bewildering array of Problems identified during the assessment phase must somehow be prioritized, since it is impossible to really address all the deficits uncovered in the assessment of a person with severe psychiatric illness. This process is generally not explicated in the plan (leading surveyors to bemoan the absence of some sort of “formulation”).

A distinction must be made between “clinical” problems (sometimes referred to as “symptoms”) and “functional” problems. It is now known, for example, that many people who experience auditory hallucinations find them neither unpleasant nor problematic for the conduct of their lives. Somehow, then, the functional perspective needs to be reconciled with the more traditional clinical assessments.

In the new treatment planning system, the Functional Assessment serves the purpose of addressing these issues. Interposed between the clinical assessment and formal treatment planning phases, it serves the following purposes:

Patient input regarding priorities and life goals is assured.

The extent to which clinical deficits impact on functioning is assessed from both the patient’s and the providers’ points of views. (Note that these elements of the system will be enhanced in the near future, in collaboration with Dr. Bob Liberman, through the integration of his CASIG tools.)

Based on the patient’s priorities and the provider’s sense of the most coherent approach to treatment over time, the areas of focus for the impending treatment planning process are determined. Apparent discrepancies between deficits and treatment are explained. Examples:

Clinical assessment identifies one or multiple “symptoms,” but the patient does not see it this way. (Many “paranoid” people, for example, consider their “delusions” real.) Here, one might address these “paranoid delusions” as Barriers to other patient Goals (e.g., being discharged to an apartment or getting a job). We will examine this in depth later.

The patient may have obvious deficits in handling money, but realistic approaches to this issue must await addressing underlying cognitive issues first.

The need for substance abuse treatment seems clear to the provider, but the patient refuses for now.

The patient wants a job, but the appropriate services are not available on the unit, and the client is judged not able to safely leave the unit at this time.

As part of the Functional Assessment, then, these issues are explained. This paves the way for a treatment plan that is focused squarely on issues that are to be addressed during the interval defined in the current plan. Let's take a moment to consider the treatment planning cycle itself.

The Treatment Planning Cycle

Perhaps the most damning criticism a surveyor can make of a treatment plan is that it does not accurately describe the treatment that a particular patient is receiving. Here are a few obvious examples:

A patient who has been actively engaged in treatment suffers an exacerbation of symptoms, and is unable to participate in the extensive spectrum of services described in his plan.

For an assortment of reasons, a patient does not get to the many groups listed in the treatment plan.

New services are added (probably for good reasons), but the treatment plan is not updated.

These inevitable issues call attention to the dual nature of a treatment plan. On one hand, it is an effort towards strategically planning treatment over a pre-defined time frame. This ranges from a few days (e.g., on a detoxification unit) to 3 months (on a long-term unit, for a patient who has resided there for some period of time). One aspect of this pre-defined treatment planning interval is that Objectives are created to be meaningful measures of progress specifically over this interval.

While the treatment plan is expected to operate over an arbitrary interval, it is also expected to reflect the reality of current circumstances. In the world of written treatment plans, this dilemma is addressed by the construct of the (loathsome) Brief Treatment Plan Review. The idea seems to go like this:

At some long interval (often a year), Master Treatment Plans are created.

At some shorter interval (e.g., 3 months), Treatment Plan Reviews are conducted.

When necessary, Brief Treatment Plan Reviews are created, to explain temporary deviations from the plan.

In theory, then, to get a picture of treatment, a person would have to go back to the last Master Treatment Plan, superimpose in his mind subsequent Treatment Plan Reviews, and then further superimpose any Brief Treatment Plan Reviews that have occurred since the last Treatment Plan Review.

Give me a break. (And people wonder why there is less than optimal enthusiasm for creating these documents.) In the new world, there will be only one construct: the Treatment Plan. Here's the idea:

The treatment planning cycle will vary in length, depending on clinical need. (At risk of getting people upset, I will mention that 3 month cycles are probably not going to be acceptable to accrediting agencies. Please suspend your concern and rage until you read further, however.)

At the end of the pre-defined treatment planning cycle, a new Treatment Plan will be constructed. This will facilitate the review of all Objectives from the previous plan over the intended time frame.

When necessary, a revised Treatment Plan will be created, reflecting appropriate additions, deletions or revisions of elements.

The creation of a revised Treatment Plan based on any previous Treatment Plan must be so ridiculously fast and simple (i.e., by importing the elements of the previous plan) that it can be accomplished in minutes. This process will replace the BTPR. A scheduled treatment plan review would allow similar efficiencies, though it is essential that legitimate time and attention be given to elements that should not remain unchanged. (Objectives, for example, should rarely be carried forward, since they are designed to be meaningful over a confined interval.)

The result of this new process is that there is always a single document that reflects the current pattern of treatment.

Having extolled the glories of our new system, it would be unfair and unhealthy to deprive you any longer of experiencing it directly. In order to avoid our discussion becoming overly abstract, it seems best to develop a fictitious, somewhat oversimplified case history to use as our example for treatment planning. Here it is:

Clinical Summary

Sam is a 46 year old man who was first diagnosed with Schizophrenia, Paranoid Type at age 19, when he was first hospitalized with paranoid delusions. Sam's

psychotic symptoms remitted with Haldol 15mg per day, and he was discharged after 2 weeks. Sam returned home and enrolled in a local community college, but left school after one unsuccessful semester. This was probably related to his having stopped taking his medications.

Sam has subsequently been hospitalized 17 times, most of them relatively brief. He recompensates quickly when antipsychotic medication is resumed, and is willing to take medication in the hospital. He clearly states, however, that he does not believe that he needs to take medication, and stops taking it within a few weeks after discharge. With some financial support from his family, he has intermittently maintained his own apartment; at other times, he has lived with his family, and has occasionally spent time in shelters.

Sam has maintained a marginal relationship with a local private-non-profit mental health agency. In light of Sam's marginal existence, and their conviction that Sam is capable of maintaining an apartment and working in a competitive environment, they requested a case conference with Ken Marcus. It was decided that his next hospitalization should result in admission to a state bed, with a plan to treat his chronic illness more definitively. This resulted in his admission to CVH yesterday evening, on a PEC written after he was walking down the middle of a busy Hartford street, apparently inspired by the belief that God wanted him to demonstrate his immortality to his fellow men.

Highlights from the Intake

Let's assume that our comprehensive assessment yields the following:

The diagnosis of Paranoid Schizophrenia, characterized by paranoid and grandiose delusions, seems accurate.

During recent admissions to the hospital, Sam has responded quickly to Risperdal 4mg hs. He has had moderate elevations in his prolactin levels, but has denied any sexual or other side effects.

Sam has had many discussions with mental health providers about the risks and benefits of antipsychotic medications in the treatment of psychosis associated with Schizophrenia. While he states that he believes that he "has Schizophrenia," he does not believe that meds have been helpful.

An OT assessment suggests that Sam lacks some necessary skills (e.g., cooking and cleaning) for maintaining an apartment. There are safety issues involving the safe use of a gas stove. The impression was that he is capable of learning these skills, and could potentially succeed in his own apartment, with some level of case management support. Vocationally, Sam is felt to be able to maintain competitive employment, preferably in a

low-stimulus setting without extensive interpersonal requirements. He is not interested in further education.

Sam has clear limitations in his interpersonal social skills. Without improvement, he will have difficulty finding and maintaining employment, even in carefully selected jobs. He is generally pleasant, but does not seem to understand social conventions about what sorts of subject matter will seem odd or intrusive to other people. This limitation persists, even when he is not psychotic.

Sam's ADL skills are adequate, except when he is experiencing psychotic symptoms. At these times, he begins to look disheveled and his personal hygiene deteriorates.

Sam has not felt to be a danger to others. He has never attempted suicide, but has put himself at risk when psychotic (e.g., walking in the middle of a busy street). When decompensated, he has been felt to be "gravely disabled" to an extent requiring psychiatric commitment.

Sam was found to be medically healthy, and has never required medication or other treatment for any general medical conditions.

Let's now work through the entire process of treatment planning. The best plan is probably to create this demo treatment plan under the name of a patient with whom you are associated who is unlikely to be chosen by many other users. You will be able to mark this record as a training sample to distinguish it from legitimate patient information.

If this is your first exposure to the electronic system, and especially if you are not fully conversant with our new approach to treatment planning, the completion of this training program will take several hours. You will find, however, that you can suspend work at any time, save what you've done, and continue at your convenience.

Reach deep within your soul for a sense of serenity, and let's begin.

Getting Started

Log on to ITPS and ensure that you are using Version 3.7 or later. Click on the “I Live to Document” button. You should now find yourself on the Main Menu:

The screenshot shows a window titled "Main Menu" with a blue header bar. Inside the window, there is a large blue button labeled "Main Menu" at the top center. To the right of this button, the date "Sunday, November 25, 2007" is displayed. On the left side, there is a vertical stack of three buttons: "Write Group Notes", "Administration", and "Reports". In the center, there are two input fields: "Client:" followed by a drop-down menu, and "or MPI:" followed by a text box. To the right of these fields are three buttons: "Treatment Plans", "Risk Assessments", and "Group Contacts". At the bottom center, there is a button labeled "Sign Docs". On the bottom right, there is a vertical stack of two buttons: "Return" and "Exit Program".

Select the client, either by last name or MPI.

NOTE: The most reliable method for using the sort of drop-down list for selecting a client is to first single-click on the down arrow at the right side of the Client box. Then, start typing the last name of the client. When you have typed enough characters, you will either see the name you want or the name itself might be highlighted. Click on the name you want.

Click on Treatment Plans, and you should see something like the following:

Treatment Plan List

Samuel CVHperson

	Date	Type	Staff LN	Staff FN	Draft?
▶	12/2/2007	Functional Assessment	Forman	Stuart	<input checked="" type="checkbox"/>
	12/2/2007	Functional Assessment	Forman	Stuart	<input checked="" type="checkbox"/>
	12/2/2007	Master Tx Plan	Forman	Stuart	<input type="checkbox"/>
	11/29/2007	Master Tx Plan	Forman	Stuart	<input checked="" type="checkbox"/>
	11/13/2007	Functional Assessment	Faraclas	Sam	<input checked="" type="checkbox"/>
	11/6/2007	Master Tx Plan	Forman	Stuart	<input checked="" type="checkbox"/>
	11/5/2007	Master Tx Plan	Faraclas	Sam	<input checked="" type="checkbox"/>
	11/5/2007	Master Tx Plan	Faraclas	Sam	<input checked="" type="checkbox"/>
	10/19/2007	Master Tx Plan	Forman	Stuart	<input checked="" type="checkbox"/>
	10/19/2007	Master Tx Plan	McKinlay	Thomas	<input checked="" type="checkbox"/>
	10/18/2007	Functional Assessment	Jaskulski	Alexande	<input checked="" type="checkbox"/>
	10/17/2007	Functional Assessment	McKinlay	Thomas	<input type="checkbox"/>

View

Edit

CREATE NEW

Functional Assessment

Master Tx Plan

Return

This is a list of Functional Assessments and Treatment Plans for the current client in reverse chronological order. (It may well be empty.) It is from this list that you can select a document to view or edit.

NOTE: The right-most column in the list of Functional Assessments and Treatment Plans is labeled “Draft?.” If this is checked, it indicates that the document is still in Draft mode, and can therefore be edited. A document without a check has been finalized, and can therefore be viewed, but not edited.

To view or edit a document, highlight it and then click on the View or Edit button.

NOTE: To highlight an item on this sort of list, click on the small grey square just to the left of the document.

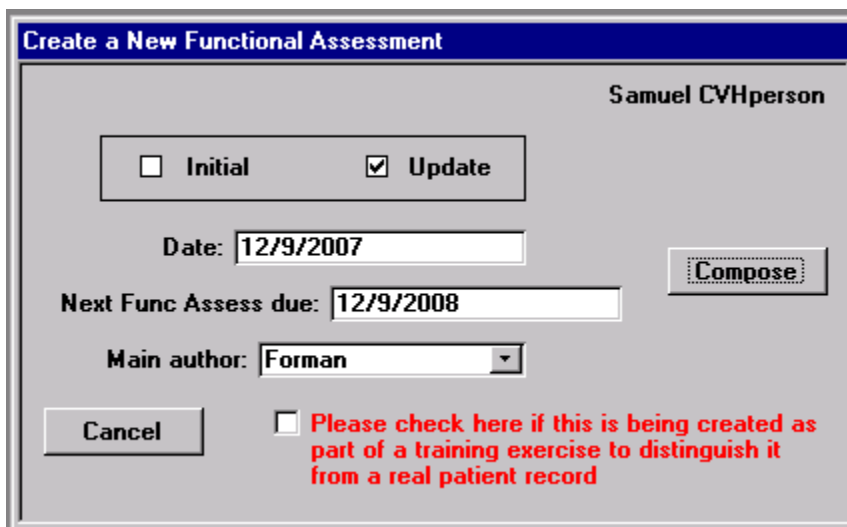
You can also start a new Functional Assessment or Treatment Plan using the buttons towards the bottom of the screen. To start a new Functional Assessment or Treatment Plan, click on the appropriate button in the Create New box towards the bottom of the screen.

Creating a New Functional Assessment

In the Create New box, click on Functional Assessment. Depending on the presence of other Functional Assessments for your patient, you may see a message regarding the presence of an existing Functional Assessment or draft. Indicate in your answer to these warnings that you wish to create a new Functional Assessment (not, for example, work on an existing draft).

Note: If you suspend work while creating a Functional Assessment, you can resume your work by highlighting your Functional Assessment and then clicking on the Edit button. (Do not use the View button, since this will not allow you to make changes to the Functional Assessment.)

You should see a screen looking like this:



The screenshot shows a dialog box titled "Create a New Functional Assessment". In the top right corner, the name "Samuel CVHperson" is displayed. Below the title bar, there are two radio buttons: "Initial" (unchecked) and "Update" (checked). Below these is a "Date:" label followed by a text box containing "12/9/2007". To the right of the date box is a "Compose" button. Below the date box is a label "Next Func Assess due:" followed by a text box containing "12/9/2008". Below that is a label "Main author:" followed by a dropdown menu showing "Forman". At the bottom left is a "Cancel" button. At the bottom right is a checkbox that is unchecked, followed by red text that reads: "Please check here if this is being created as part of a training exercise to distinguish it from a real patient record".

I suggest clicking the "Initial" box (if it is not already checked) to indicate that this is the first Functional Assessment being created for this patient (even if it isn't). Change the "Date" if you wish. Don't worry about the date in the "Next Func Assess due" box at this time. Change the author if necessary. **IMPORTANT:** Since this is a training exercise, please click in the box towards the bottom of the screen to mark this record as other than real patient information. Finally, click on the Compose button.

You should now see the following screen:

This is where the Functional Assessment is viewed, edited or created. The content is spread over 13 Domains, each on a separate tab. To move among the tabs, click on the Roman numeral for the tab. As you will see, Domains are nothing more than aspects of a person's life. Each Domain consists of 1 to 3 subsections.

NOTE: For now, I suggest paying little attention to the rating scales on each tab, since this rating system will be replaced by the CASIG tool developed by Bob Liberman. (The CASIG tool contains functional ratings from the perspectives of both the patient and provider.) You can feel free to leave the rating section of each tab blank.

In each of the 13 Domains, the user is asked to perform three tasks:

Determine if the Domain will be addressed in the current treatment plan. Only if the Domain is set to Active status will it be available to be worked on when the treatment plan is created. The "Status" drop-down list is towards the lower left corner of the screen.

For each Domain that will be addressed in the Treatment Plan, at least one Goal must be specified. (We will discuss below the possible substitution of a Clinician Concern for a Goal when necessary.)

When there is a significant discrepancy between the clinical assessment and the work to be done in a Domain, that should be explained in the “Narrative” text box. (This will be demonstrated below.)

In upcoming months, Dr. Liberman will return to CVH to discuss the methodology described in his CASIG tool for helping patients develop their treatment goals. For now, let’s imagine that a small group of people meets with our fictional patient, Sam, to get an understanding of what he wants out of treatment. (In addition to Sam, this group might include a couple of unit staff members with whom he has good rapport, an advocate, and a friend or family member.) Assume that the end result of this meeting is that Sam’s wishes can be distilled into the following:

“I want to get out the hospital and move into my own apartment.”

“I want to get a job.”

“I want to get off my medication.”

If we compare these statements with the outcomes of the clinical assessment summarized on Pages 6 through 8, we recognize the familiar situation of a patient who sees his situation quite differently from the treatment team. In a traditional treatment plan, in fact, one would guess that the starting point would be a Problem List looking something like this:

- Paranoid delusions
- Medication non-compliance
- Poor household skills
- Poor interpersonal skills
- Risky behavior when psychotic

The almost complete mismatch between Sam’s perception of his situation and the conceptual basis for his treatment plan augers poorly for its success over time. His history of non-adherence to treatment, followed by decompensation and hospitalization, testifies to this. Let’s see whether our new treatment planning strategy offers anything new and promising.

Let’s look at each of the 13 Domains, and decide where to focus our attention and how to capture Sam’s goals. We’re currently looking at Domain I (Distress from Psychiatric Symptoms). Note that this Domain is not called simply “Psychiatric Symptoms.” Ideally, it should be activated only if the patient identifies symptoms as a source of dysfunction or subjective distress.

NOTE: It needs to be recognized that there are times when a treatment team cannot ignore issues, even if the patient disagrees. A patient who wishes to commit suicide, for example, must be kept safe; it would be silly to distort the treatment plan by somehow not listing this problem directly. In this case, the need to prevent suicidal behavior would be listed as a Clinician Concern (as discussed below).

Although one might be tempted to list paranoid delusions as a Clinician Concern in Domain I, we shall take another approach (see below). Since, as discussed above, there is a clear discrepancy between the presence of paranoid delusions and our decision not to work in this Domain, one should explain the situation in the “Narrative” text box. Something like the following would suffice:

Although clinical examination reveals the presence of paranoid and grandiose delusions, Sam does not see his thinking as distorted and has resisted treatment, resulting in a long series of hospitalizations. These issues, then, will be conceptualized as obstacles to his achievement of personal goals, as described elsewhere in this treatment plan.

For now, then, leave Domain I “Inactive” and move on to Domain II (Work / School) by clicking on the Roman numeral II on the second tab.

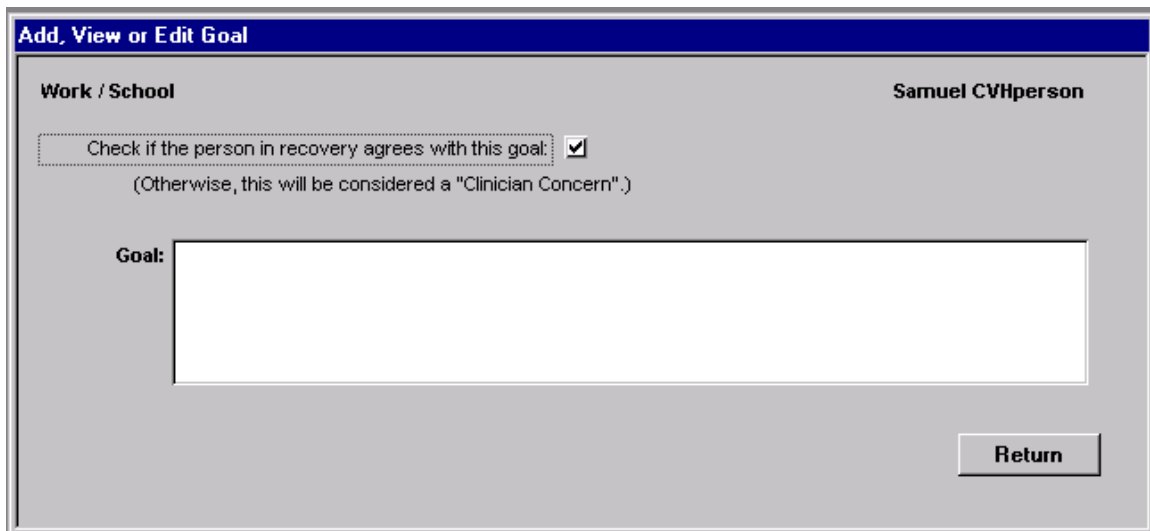
NOTE: For now, we will make use of only two statuses for Domains: Active and Inactive. In the future, we may decide to use others.

Sam has clearly indicated his interest in working. It therefore makes sense to enter this goal in this section. Click on the Goals button. The system will indicate that it is changing the status of Domain II to “Active” (if you haven’t already done so). You will now see this screen:

The screenshot shows a software window titled "Long Term Goals". Inside, there's a tab labeled "Work / School" and a user name "Samuel CVHperson". Below the tab is a table with one header row labeled "Goal" and a large empty area for text entry. To the right of the table are four buttons: "Add", "View", "Edit", and "Delete". At the bottom right is a "Return" button.

Goal

This is a list of the Goals associated with the current Domain. The list is empty at the moment. To add the Goal, click on the Add button. You will now see the following screen:



First, note that you have the opportunity to uncheck the box indicating that Sam agrees with this Goal. (This would identify this item as a Clinician Concern instead of a Goal.) Since this is Sam's own Goal, leave the box checked. In the "Goal" text box, type Sam's Goal: "I want to get a job." Click on Return. This brings you back to the previous screen, but with the new Goal added to the list.

By highlighting an item (Goal) on this list, and clicking on the View, Edit or Delete buttons, you can manage this list. You will find that this list configuration will be repeated throughout the program.

Since this is the only Goal we wish to add to Domain II, click on Return. Then, click on the Domain III tab (Medical / Health Needs). Although our fictional patient is not known to have any general medical issues, we have an obligation to tend to his medical and dental needs while he is our patient. My recommendation, then, is that for all patients, we add the following Goal (or, Clinician Concern, if the patient disagrees): "Maintain optimal medical and dental health." Please add this using the same steps as for Domain II. (Assume that Sam buys into this idea; make it a "Goal," then, rather than a "Clinician Concern.")

Domains IV (Food and Diet), V (Issues with Daily Living) and VI (Finances / Budgeting) can be left inactive. Domain VII (Interpersonal / Social Skills) was clearly identified as an area of concern in the clinical assessment. One is certainly tempted, therefore, to make this Domain Active. This would certainly not be wrong, but I will suggest an alternative that is likely to be more appealing to Sam and that will keep the treatment plan simpler. As you will see below, we will not make this Domain active; instead, we will deal with these issues in overcoming obstacles to Sam's own Goals. For similar reasons, let's keep Domains VIII (Leisure Skills / User of Community Resources) and IX

(Communication Skills) inactive; we will deal with them in other contexts. Domain X (Legal) should remain inactive.

Domain XI (Housing) is an area of clear focus for Sam. Using the same methodology outlined above, add his Goal: “I want to get out the hospital and move into my own apartment.”

NOTE: It is sometimes the case that a patient articulates a Goal that the treatment team is convinced is permanently unreachable. (Let us assume that this is not the case here.) I do not recommend putting into a treatment plan a clearly unrealistic Goal. Instead, I suggest that an alternative, somewhat less ambitious, Goal be suggested, ideally capturing the essence of what the patient seems to be seeking.

Domain XII (Substance Abuse) will be left inactive, since this is not part of Sam’s clinical picture.

NOTE: Substance Abuse is a frequent point of contention between patients and their treatment teams. If there is to be treatment focused on this issue, Domain XII needs to be active and either a Goal or Clinician Concern needs to be added. If, in spite of the presence of abuse or dependence, treatment is not contemplated, I suggest leaving it inactive and explaining this discrepancy in the Narrative.

Domain XIII (Other) obviously opens the door to a variety of approaches to treatment. Let’s try something that may seem a trifle offbeat, and add Sam’s third Goal here: “I want to get off my medication.” Here’s my thinking:

For 27 years, Sam has been fighting with providers who probably constructed treatment plans based on “Paranoid delusions” and “Medication non-compliance.” While we may consider it a manifestation of Sam’s illness that he refuses to respond to an obvious pattern of failure in his approach, are we not equally suspect in continuing the approach to treatment that has failed so many times? So, humor me, and let’s try it my way.

We are not going to deal with the “Sign” tab, since CVH has not yet implemented electronic signatures. This may happen soon, and when it does, use of this feature will be explained.

Having now completed the Functional Assessment, we are ready to change it from “Draft” mode to “Real” mode.

Note the word “Draft” in red letters at the top of the screen. This indicates that this Functional Assessment is not yet complete. In essence, it is not considered part of the patient’s medical record. This allows you to work on it over a series of sessions; similarly, it can be a collaborative effort among several people (though it is important that more than one person not attempt to work on a particular Functional Assessment or Treatment Plan at the same time). If you print the

Functional Assessment (using the Print button), the word “Draft” will appear on each page.

To make the Functional Assessment permanent, click on the Make Real button. The word “Draft” will disappear at the top of the screen, and the button you just clicked is now labeled “Make Draft.” If you now print the Functional Assessment, you will no longer be able to edit it. (This is to avoid having conflicting printed versions of a record.) Similarly, if you click on the Return button with the Functional Assessment in “Real” mode, the record will be filed and will thereafter be uneditable.

There are two buttons on the screen that we have not yet mentioned. The idea of the Import button is that you can base a Functional Assessment on a previous Functional Assessment for this patient that may be similar to the one you need to create. To start with a previous Assessment, select it from the drop-down list and then click on Import. Note that this will overwrite work that you have done; it is therefore best done when you first start a Functional Assessment. (Obviously, if this is your first Functional Assessment for this patient, there is nothing to import.)

The Error button essentially deletes the current Functional Assessment. This should only be used if you have screwed things up so badly that you really wish to start over again.

NOTE: I hesitate to mention this, since I do not wish to encourage sloppy system use. It is generally true, however, that in the event of having deleted something important, the document can be rescued. You will need to contact me for this, however, and suffer through a brutal and degrading tirade. (Not really.)

When you print a document, it is printed to a window on the screen, rather than sent directly to the printer. When the window appears, you can toggle back and forth between 2 zoom settings by clicking in the window. To print the report, click on the printer icon on the Access tool bar. To make the report window disappear, click on the “X” in the upper right hand corner of the report. (Be careful not to click on the “X” in the upper right corner of the Access window; this would close ITPS entirely.)

Only after being made “Real” can a Functional Assessment be used as the foundation for a new Treatment Plan. Now that you have successfully created a Functional Assessment, we are ready to wade into the treacherous waters of creating a new Treatment Plan. (I can feel your excitement.)

Creating a New Treatment Plan

Let's take stock for a moment of where we are in the treatment planning process. The patient, one or a few members of the treatment team, and perhaps a family member or advocate have met to identify the patient's long-term goals. The product of this effort is the Functional Assessment. As previously noted, this is a transitional document, conceptually located between the clinical assessment and the Master Treatment Plan. We are now ready to discuss the creation of the notoriously elusive MTP.

There is no single mechanism for accomplishing this task, but it seems to involve the following major steps:

By virtue of completing the Functional Assessment, Goals have already been identified (and have been categorized as falling within specific Domains).

Barriers to achieving these Goals need to be identified. In the past, this was conceived as "the Problem List." Although Barriers and Problems are somewhat similar concepts, our treatment of them here differs from traditional approaches in two major respects:

Rather than creating a complete list of all identified Problems, we will now present a much shorter list of Barriers; we will only include the Barriers on which we will actively work in the process of treatment. In the Functional Assessment, we will have commented on the reasons for not presently addressing other problems.

In the past, the Problem List was the organizing principle for the Treatment Plan. The new Treatment Plan, instead, is structured more in keeping with patient Goals. Our sample case illustrates this. In the past, the Treatment Plan would have been mainly organized under the Problems of Paranoid Delusions and Medication Non-Compliance. Instead, we will now find the plan driven by the Goals "I want a job," "I want to get out of the hospital and move into my own apartment," and "I want to get off my medication."

Once Barriers have been identified, we will 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 will create some measurable Objectives to track progress.

Let's take a moment to think about the role of the patient in all this.

During the creation of the Functional Assessment, the patient's Goals drive the entire process. In some cases, it is necessary for staff to include issues (Clinician

Concerns), even though the patient disagrees. This should be done openly (e.g., by saying something like “As staff, we have no choice but to try and stop you from harming yourself”).

The specification of Barriers is a clinical process. Our sample patient, Sam, for example, does not believe that he is delusional. To create a meaningful Treatment Plan, however, we need to indicate that we believe that paranoid delusions are interfering with him achieving his Goals (i.e., working, getting discharged, and getting off his meds). This should be acknowledged to Sam directly (e.g., “While we understand that you do not see it this way, we feel that you are suffering from a psychotic illness that is interfering with your life. It is our professional responsibility to report our findings to you.”)

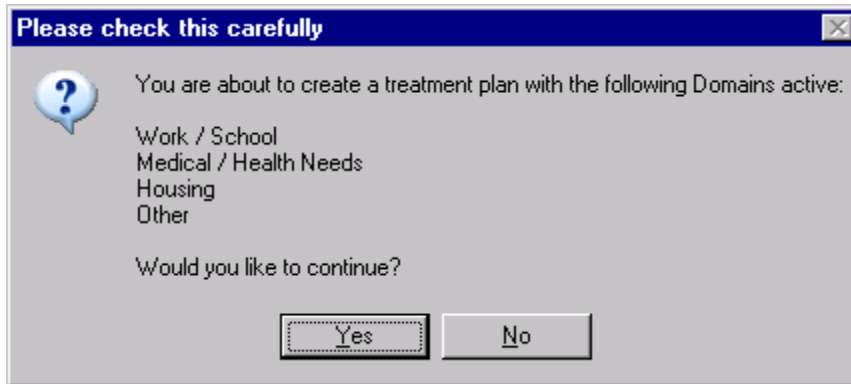
The application of Interventions to Barriers is primarily a clinical process. Here, however, patients can almost always choose which treatments they will accept. With rare exceptions, it is useless to create a Treatment Plan with which a patient is not inclined to cooperate.

The creation of Objectives to track progress should be a collaborative effort. Staff should exercise clinical judgment in defining realistically achievable outcomes for the treatment planning period. They need to assure that Objectives are measurable. It is important, also, to create Objectives that seem like clear steps towards achieving the patient’s Goals; they need to be compelling to the Patient. Example:

Bill hates taking medication; he considers it poisonous (and is convinced that his delusional concerns are real). He is therefore unlikely to warm up to an Objective like “Bill will take his medication on a regular basis.” He might, however, be able to acknowledge the value of meeting an Objective like this: “Bill will learn to anticipate which of his thoughts are likely to be considered psychotic by others.”

To streamline the process of holding the treatment planning meeting, I would suggest using the treatment planning apparatus to create a preliminary treatment planning outline. Prior to convening the team, a clinician (or two) can start the electronic plan by applying Barriers to patient Goals. This incomplete draft can then be printed and used at the treatment planning meeting as an outline to organize discussion. You might want to also jot down on the draft some preliminary ideas about Services and Objectives, but must remain open to input from the patient and others during the meeting. So, let’s imagine that you want to take my advice and start the electronic Treatment Plan prior to convening the treatment planning meeting.

Repeat the steps on Page 9 to get to the list of existing Functional Assessments and Treatment Plans. In the Create New box, click on the Master Tx Plan button. You will see a message box something like this:



If all has gone well, this should confirm your choices of which Domains to make “Active.” With this reassurance, click on Yes.

Depending on the possible presence of other Treatment Plans, you may see warning messages confirming that you really want to create a new plan at this time. Answer the questions so as to indicate that you wish to create a new Master Treatment Plan. You should see something like this:

I suggest clicking the “Initial” box (if it is not already checked) to indicate that this is the first MTP being created for this patient (even if it isn’t). Change the “Date” if you wish. Don’t worry about the date in the “Next MTP due” box at this time. Change the author if necessary. **IMPORTANT:** Since this is a training exercise, please click in the box towards the bottom of the screen to mark this record as other than real patient information. Finally, click on the Compose button.

You will probably be offered the option of trying to import information from a previous MTP. This option, in the long run, will prove very powerful. For now, however, since there is no previous information to import, please click on No. You should now see the following screen:

Initial Master Treatment Plan

Samuel CVHperson **DRAFT** Staff: Stuart Forman 12/15/2007

Recovery | Narrative | Treatment | Client | Progress | Dx | Supports | DC Plan | Sign

Domain	Status
Work / School	Active
Medical / Health Needs	Active
Housing	Active
▶ Other	Active

Goals

Error Make Real Print Guides Return

You are looking at the first of nine tabs (labeled “Recovery”). Happily, in this document, it will be necessary to pay attention to only two of these nine tabs (Recovery and Treatment). It is here that the logic of the treatment plan is established. Let me very briefly summarize the other tabs. You might want to click on each and have a look.

Narrative

This is a narrative version of the logic that has been created using the Recovery and Treatment tabs. It approximates the format that will appear in the Recovery Plan and Treatment Plan sections of the printed Master Treatment Plan. If you have added to the structure of either the Recovery or Treatment tabs, you should click on the Repeat Import button to import the new information. (This happens automatically when the plan is saved.)

Client

This requests input of information about the patient, e.g. level of participation and Strengths. It may be the case, by the way, that we collectively decide to eliminate some of the text boxes on these tabs to avoid possible duplication.

Progress

If you chose to make this an Initial MTP, the progress box will be disabled. The Staff Formulation is meant to be a brief, high-level formulation of the plan. (Exactly how we use this, however, remains to be determined.)

Dx

Axes 1 through 5 should be entered here. In the future, when diagnoses are contained within the system, this information will be automatically imported.

Supports

This is where you summarize the involvement of outside agencies and other collaborators.

DC Plan

Planning for discharge should begin at the time of admission, and this is where that wisdom is collected.

Sign

We are not yet using electronic signatures, so you can ignore this tab for now.

Let's return to the first (Recovery) tab and take stock of our situation. We are looking at a list of the four Domains we made active during the process of the Functional Assessment. If you highlight the first Domain (Work / School) by clicking in the small gray square to its left, and then clicking on the Goals button, you should see the following:

The screenshot shows a software window titled "Goals List". The window has a header bar with "Work / School" on the left and "Samuel CVHperson" on the right. Below the header is a table with one row containing the goal "I want to get a job." To the right of the table are four buttons: "Add", "View", "Edit", and "Delete". At the bottom of the window are three buttons: "Objectives", "Barriers", and "Return".

This should remind you of a similar screen you encountered when you were constructing the Functional Assessment. If you have been living cleanly, you will see the Goal you entered for this Domain (“I want to get a job.”) You have the option here of adding, editing or deleting Goals, using the buttons to the right of the list.

The Barriers and Objectives buttons allow you to “drill down” deeper into the logic of the Treatment Plan (just as you “drilled down” from the Domain level to the Goals level). Let’s take a few moments to consider the overall hierarchy of the Treatment Plan. There is good news and bad news here. The good news is that if you get your mind around the overall logic, everything that follows will fall nicely into place. The bad news is that you’re likely to lose patience along the way and think ungenerous thoughts about everyone associated with the electronic record.

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).

Just to get all the dirt out on the table: there are two other reasons that explain why the logic of the MTP is tough to pin down. One Barrier can be an obstacle for multiple Goals. Sam’s paranoid delusions, for example, are likely to interfere with 3 of his Goals (getting a job, getting discharged to his own apartment, and getting off his meds). Similarly, one Service may be applied to more than one Barrier. (Direct care staff, for example, are part of the treatment of virtually every Barrier.)

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.

Back to the real world... Recall that we are seeking to prepare a worksheet to be used in the treatment planning meeting. We want to add the Barriers into the system, and then print out a draft that will include Domains, Goals and Barriers.

Adding Barriers

Let's keep life simple, and imagine that we are happy with the Goals we created in the Functional Assessment. We are looking at the "I want to get a job" Goal in the Work / School Domain. Take a deep breath, and click on the Barriers button. Here's what you'll see:

The screenshot shows a window titled "Barriers for this Goal". Inside the window, the top left corner displays "Work / School" and the top right corner displays "Samuel CVHperson". Below this, the "Goal: I want to get a job." is listed. A table with two columns, "Category" and "Barrier", is shown, but it is empty. To the right of the table are four buttons: "Add", "View", "Edit", and "Delete". At the bottom of the window, there are two buttons: "Unduplicated Barriers List" and "Return".

Note that in the upper left hand corner of the screen, you are reminded of the hierarchy: you are working in the Work / School Domain, and are looking at the Barriers for the Goal "I want a job." Since we haven't added any Barriers for this Goal, the list is empty. And just when you might be thinking that this isn't too bad, things get a little complicated.

As noted above, one Barrier may be associated with multiple Goals. Were we to list a Barrier multiple times (and repetitively list the treatments for it) on the plan, there would be a great deal of confusing duplication. To avoid this, we add the step of creating an "Unduplicated Barriers List." Each Barrier appears once on this list; any Barrier, however, may be associated with as many Goals as is appropriate. To descend into the hellish world of Unduplicated Barriers, please click on the button of the same name.

It should look like this:

Category	Barrier
----------	---------

Samuel CVHperson

Add
View
Edit
Delete

Return

This list, and the buttons to the right of it, work very much like other lists in the system. You can add Barriers to the list, and then view, edit or delete them after highlighting them. The list is now empty, since we have not yet added any Barriers.

Please be clear about what we're doing on this screen. We are creating a list of Unduplicated Barriers. Once we have completed this list, we will associate each Barrier with the Goals for which it seems to be an obstacle. If you glance at the Clinical Summary and Intake (Pages 6 through 8), I think that you would agree that the following is a reasonable list of Barriers:

- Paranoid delusions
- Something about not working collaboratively with providers (e.g., refusing meds)
- Poor interpersonal skills
- High-risk behaviors when psychotic (e.g., walking down the middle of busy streets)

Let's add these to the list. Click on the Add button. Here's what you'll see:

My advice is to immediately click on the Print Barrier List. A six-page document will appear in a window on the screen. Click on the print icon to print it, and then close the window (by clicking on the “X” in the upper right-hand corner of the window). It is much easier to get a sense of how Barriers are organized into categories if you use the printed list as a reference. Some people might find it useful to scan this list as a way of selecting Barriers in the first place.

Our task now is to find items that best match the Barriers noted above. In many cases, there is more than one choice; let your sense of clinical aesthetics be your guide. A reasonable set of choices might be as follows:

- Paranoia: Item #184 (Delusions)
- Poor treatment collaboration: Item #51 (Does not take meds...)
- Poor interpersonal skills: Item #83 (Impaired social functioning)
- High risk behaviors: Item #92 (Excessive high-risk activities)

For technical reasons, I suggest adding one more Barrier. Even though Sam is not known to have any medical problems, an inpatient facility is obligated to offer him basic medical and (if a long-term admission) dental care. To structure these elements in the treatment plan, and in the absence of specific medical conditions, I would suggest adding: Item #40 (Medical: Other).

As already noted, this is not the only set of selections that capture the relevant Barriers. Frankly, it does not seem to matter much exactly which items you select. I would avoid, however, allowing this list to become overly lengthy. (Example: having identified Delusions, you probably do not need to list other psychotic symptoms as separate Barriers, since the treatments for psychotic symptoms would tend to be the same.)

Let's now add our selections to the Unduplicated Barriers List. The easiest way to find them is to limit the search to a single category. Click in the "One Category" circle; a drop-down "Category" box will appear. Select "Symptoms-Psychosis." In the "Barrier" drop-down list, you should be able to find "Delusions." Select it.

We have not yet fully decided how to use the "Barrier detail" and "As evidenced by" boxes. One approach for the "Delusions" Barrier might be as follows:

Barrier detail: Delusions tend to be paranoid and grandiose.

As evidenced by: Bill calls the local police frequently to report situations that he considers suspicious. He has barricaded himself in his apartment, and has thrown away many of his possessions, believing that they are infested with "bugs."

Click on the Save and Add Another Barrier button. You will remain on the same screen, but your previous entries will disappear, to allow you to add another Barrier. Repeat the above process, and use your imagination in filling in the "Barrier detail" and "As evidenced by" boxes. After adding the fifth Barrier, click on Return. The five Barriers should now appear on the Unduplicated Barriers List. Click on the Return button, and you should now be back at the screen listing Barriers for the "I want to get a job" Goal (as shown on Page 24).

Now that we have a list of 5 Unduplicated Barriers, let's associate them with the Goals for which they are obstacles.

To reorient yourself, I would suggest clicking on Return buttons twice, which should return you to the Recovery tab of the main treatment planning screen (as celebrated on Page 21).

Highlighting the first Domain (Work / School) and clicking on the Goals button will bring you back to the screen shown on Page 22. Highlighting the one Goal and clicking on Barriers should produce the screen shown on Page 24. Now we're ready to associate one or more Barriers with this Goal. Click on Add, and you should see the following screen:

If you click on the down arrow at the right end of the “Barrier” drop-down list, you should see a list of your 5 Unduplicated Barriers. You should now select the first item that seems to be an obstacle for the current Goal (getting a job). I would argue for including the “Does not take meds...” item. Select this, and then click on Return. You should see the new item. I would suggest repeating the above process to add the “Impaired social functioning” and “Delusions” Barriers. (The idea is that all 3 of these Barriers impede Sam’s ability to get a job.)

When you have all 3 Barriers associated with the first Goal, click on Return buttons twice, and select the second Domain (“Medical / Health Needs”). Click on the Goals button. Highlight the only Goal (“Maintain optimal medical and dental health”). Click on Barriers, and then add the one relevant item from the Unduplicated Barriers List (“Medical: Other”).

Repeat the above process to associate Barriers with Goals in the other Domains. In some cases, it is arguable as to whether to associate a Barrier with a particular Goal. (Would you, for example, see medication non-adherence as an obstacle to getting off one’s meds? I think that this could be argued either way.) For reasons that will only become clear when the entire treatment plan has been completed, I would suggest not overdoing the connections between Goals and Barriers; make the association only if the relationship is clear and strong.

You have now created enough of the treatment plan to print out a draft to use as a guide during the treatment planning meeting. Return to the main Master Treatment Plan screen (Page 21), and click on the Print button. You will be warned that the word “Draft” will be printed on each page, but go for it and click Yes. Send this to the printer. In preparation for the treatment planning meeting, you might wish to hand-write some notes

concerning possible Services and Objectives. You will have a much better idea of what this entails once you have worked through the rest of this document.

Specifying Treatment

Teams will probably differ as to whether to actually enter information electronically during the treatment planning meeting. If so, I would strongly suggest having someone not actively involved in the discussion doing this. Maintaining a sense of two-way communication is essential, and a computer interposed in the process can interfere with this rapport.

At the treatment planning meeting, the Goals and Barriers should be reviewed. Copies of the printed draft might be distributed as an outline. The elements still needing to be constructed are the Interventions and the Objectives.

As noted above, it is often the case that a given Service (e.g., psychotherapy or a particular group) can be helpful in overcoming more than one Barrier. As with Barriers, there are advantages to avoiding the duplication that would result from listing details of Services under multiple Barriers. Instead, we will first create an Unduplicated Services list, and associate Services with Barriers.

To this point, I have used the terms “Interventions” and “Services” as if they both mean the same thing (i.e., some kind of 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.)

In the remainder of this document, details concerning data entry will be provided. As noted, however, it is up to the treatment team whether to take notes and enter the electronic data later, or to assign a technical wonk to creating the electronic plan during the meeting itself.

So let's put on our hip boots, wade out into the waste, and finish this sucker.

If you return to the main Treatment Plan screen and click on the Treatment tab, you should see something like this:

Initial Master Treatment Plan

Samuel CVHperson **DRAFT** Staff: Stuart Forman 12/15/2007

Recovery Narrative Treatment Client Progress Dx Supports DC Plan Sign

This is an unduplicated list of barriers for which Interventions should be specified:

Category	Barrier
▶ Disease Management-Medical	Medical: Other
Disease Management-Rehabilitation	Does not take, or consistently take psychiatric medication as prescribed
Rehabilitation-Social	Impaired social functioning
Risk Management	Excessive high-risk activities
Symptoms-Psychosis	Delusions

Interventions for Selected Barrier

Unduplicated Services List

Error Make Real Print Guides Return

You're looking at the Unduplicated Barriers list. Before assigning Services / Interventions to each Barrier, you need to create an Unduplicated Services list. Click on the button with that name. I deeply hope that you see something like this:

Unduplicated Services List

Samuel CVHperson

Service Type	Group	Staff

Add View Edit Delete Return

The list is empty, since we haven't added any Unduplicated Services yet. Click on the Add button, and you'll see this:

Add, View Or Edit a Service

Samuel CVHperson

NOTE: The list of Service Types has been radically shortened as of 10-10-07. There is now a single listing ("Group") for all services delivered in a group format.

Service type:

Group:

Frequency: Duration (days):

Minutes per unit of service: Credentials:

Responsible staff:

☒ Internal ☐ External

Internal Program:

I suggest immediately using the Print Service Type List button to print yourself a copy. You will find that this is nothing more than a list of 20 very general types of services offered at CVH. It is hoped that you can find a type that allows you to reasonably describe each of your patients' services; if not, we will need to expand the list. I should call attention to two particular items on the list:

Item #6 is called Direct Care Milieu Management. It includes the Interventions by which direct care staff on the unit support treatment (e.g., reinforce other Interventions). It seems likely that this type of service will be applied to almost every Barrier on the plan.

Item #11 is used for any group intervention. As you will see, this is designed to interface closely with the group notes module described in a separate manual.

The idea of the above screen is to define each service completely and specifically enough to meet both clinical and compliance needs. For the purposes this exercise, we will not attempt to create a rich enough assortment of treatment to be considered adequate for a hospital level of care. To permit us to share a frame of reference, I have created 4 fictitious groups for the Battell 3 South unit (which is not currently in use). As you will see, these are all relevant for our current patient. Let's add them to the Unduplicated Services List.

On the above screen, first choose “Group” on the “Service type” list. You now need to specify the group. You have two choices here: either sort through a list of all CVH groups (over 1300), or first narrow the search to a particular unit. I generally recommend the latter approach. Select “One unit” and then specify Battell 3 South. Select the first group on the list (Conversation Skills). Note that after you select it, the group setup information is inserted automatically into the appropriate text boxes. (It’s a wonderful world.) The one field that needs to be specified is “Duration.” This refers to the period over which the service will be in force. This is to allow for time-limited services (e.g., groups that only last 2 weeks). If a service is expected to persist throughout the period of the treatment plan, enter the number of days in the treatment planning cycle. (Let’s assume here that the treatment plan is going to be reviewed in 30 days; enter “30” into this box.)

Click on the Save and Add Another Service button. Add the other 3 groups to the Unduplicated Services list. (Let’s assume that all have a 30-day duration.) Let’s now continue by adding some other kinds of Services, perhaps the following:

- Direct Care Milieu Management
- Discharge Planning
- General Medical Services
- Individual Psychotherapy
- Medication Management
- Peer Support Services
- Vocational Services (Individual)

It should be acknowledged that for some of these service types, some of the specifiers are hard to pin down. Direct Care Milieu Management, for example, includes input from both nursing and non-nursing unit staff and is difficult to quantify. We will be discussing how to handle these matters consistently; for now, let’s not worry about these details.

After repeatedly using the Save and Add Another Service button, and then entering the specific information for each Service (using your whimsy and imagination to choose the details), you can eventually return to the Unduplicated Services list (by clicking on the Return button). You should now find a list of 11 Unduplicated Services. Click on the Return button, and we shall now start applying the Unduplicated Services to the Barriers they are intended to help. (You should be looking at the Treatment tab on the main Treatment Plan screen, as gloriously displayed on Page 30).

Highlight the first Barrier (Medical: Other). This indicates to the system that you wish to start linking Unduplicated Services with this Barrier. Then, click on the Interventions for Selected Barrier button. Unless you (or I) have been deemed by the Powers That Be to be deserving of some sort of existential punishment, you will see the following:

Interventions for this Barrier				
Medical: Other		Samuel CVHperson		
	Intervention	Service	Group	Staff
				<input type="button" value="Add"/> <input type="button" value="View"/> <input type="button" value="Edit"/> <input type="button" value="Delete"/>
				<input type="button" value="Return"/>

This is a list of the Unduplicated Services that have been linked to the specified Barrier (in this case, “Medical: Other,” as indicated in the upper left corner of the window). The list, of course, is empty at this point; that is about to change.

Click on the Add button, and enjoy seeing the following:

Add, View or Edit an Intervention	
Medical: Other	Samuel CVHperson
Related Goals: GOAL: Maintain optimal medical and dental health	
Service	<input type="text"/>
Intervention:	<input type="text"/>
<input type="button" value="Return"/>	

Let's take a moment to get our bearings. In the upper left corner of the window, we are reminded that the Barrier for which we are about to specify an Unduplicated Service is "Medical: Other." We are further reminded that the Goal (or Goals) for which this Barrier is felt to be an obstacle is: "Maintain optimal medical and dental health."

From the "Service" drop-down list, choose an Unduplicated Service that seems relevant. ("General Medical Services," for example, might fit the bill.) Now we come to a discussion that warrants your full attention. If necessary, get yourself a cup of coffee.

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. Bill, for example, has no known medical problems. In his case, then, 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, for example. When you click on Return, you will see that this Service (with its specific Intervention component) has been added to the list of Interventions for this Barrier.

For this Unduplicated Barrier, there are probably no other Unduplicated Services that need to be applied. You can, therefore, click on Return and select the second Unduplicated Barrier. Your task is to now apply relevant Services (along with specific Interventions) to each of the other 4 Unduplicated Barriers.

In order to help you conceptualize this somewhat complex process, and to reduce the drudgery of this exercise, I am going to propose the sets of Services (and Interventions) for each of the remaining Barriers. (If you wish, you can "cut and paste" the text for the Interventions in this document into the "Intervention" box for each associated Service.) First, however, get a feeling for how some of the Unduplicated Services are applied to more than one Barrier. Note, however, how the Interventions are different, depending on the Barrier to which they are being applied.

Following, then, are my suggested linkages of Unduplicated Services to the remaining Barriers:

Barrier: Does not take, or consistently take psychiatric medication as prescribed

Service: Medication Management

Intervention: Discuss with Sam his fears about taking medication. Explain the risks and benefits, and try to establish connections between symptom reduction and success in real life situations (e.g., work). Prescribe antipsychotic medication to reduce delusional thinking; consider the possibility of involuntary medication administration as appropriate.

Service: Individual Psychotherapy

Intervention: Examine potential sources of his aversion to taking medication (e.g., stigma). Help Sam identify potential successes that are likely to contribute positively to his sense of self-esteem.

Service: Peer Support Services

Intervention: Provide Sam an opportunity to discuss with people who have had direct experiences with taking psychotropic medication their approaches to dealing with this issue.

Service: Medication Psychoeducation Group

Intervention: Provide Bill with factual information in a neutral setting (i.e., where he is not the sole focus of attention).

Service: Symptom Management Group

Intervention: Provide Sam with an opportunity to attempt to adequately control his symptoms with methods other than pharmacology.

Service: Direct Care Milieu Management

Intervention: Answer questions about medications. Provide positive reinforcement when Sam seems to be successfully managing his symptoms.

Barrier: Impaired social functioning

Service: Conversation Skills Group

Intervention: Teach Sam how to anticipate what topics or interpersonal approaches other people will find intrusive or strange. Help him avoid staring at other people. Teach him how to "read" responses in other people.

Service: Individual Psychotherapy

Intervention: Help Sam better understand how he feels about his social limitations and how these feelings impede his efforts to engage more successfully.

Service: Peer Support Services

Intervention: Provide Sam with multiple opportunities to interact with others in a variety of settings.

Service: Direct Care Milieu Management

Intervention: Provide positive feedback when Sam seems to be successfully using his understandings of effective interpersonal relations. Point out to him continuing instances of intrusiveness or off-putting conversation.

Service: Vocational Services (Individual)

Intervention: Teach Sam the fundamentals of how to conduct himself during a job interview, and the general expectations of conduct in the work setting.

Barrier: Excessive high-risk activities

Service: Symptoms Management Group

Intervention: Teach Sam to apply a series of safety considerations in advance of doing anything unusual. Help him understand the dangers of overvaluing thoughts (e.g., that he is immortal).

Service: Medication Management

Intervention: Point out to Sam the relationship of dangerous behavior to increased psychosis. Point out patterns between these behaviors and the presence or absence of medication.

Barrier: Delusions

Service: Discharge Planning

Interventions: Work with Sam to understand what he needs to accomplish (e.g., regarding symptom reduction) to have a reasonable chance of success in the community. As appropriate, work with him on engaging with the local mental health agency. Maintain entitlements, and when ready, identify and arrange for appropriate housing in collaboration with the LMHA.

Service: Medication Psychoeducation Group

Intervention: Teach Sam the risks and benefits of psychotropic medication.

Service: Symptom Management Group

Intervention: Teach Sam techniques for recognizing and managing symptoms such as paranoid delusions.

Service: Medication Management

Intervention: Manage the prescription and monitoring of antipsychotic medication.

Service: Direct Care Milieu Management

Intervention: Help reinforce for Sam the relationship between his efforts in his assorted services with his ultimate goals of getting out of the hospital, having his own apartment, getting a job, and, perhaps, ultimately reducing his need for medication.

It seems important to acknowledge that this is not the only way to link Services and Barriers. One could, for example, be more inclusive. (Might psychotherapy, for example, potentially be related to virtually any Barrier?) My recommendation is that one not be overly inclusive; that will only serve to obscure more salient relationships. As long as the connections you create are coherent and reasonable, and as long as each Barrier has at least one Intervention, and as long as each Service is linked to at least one Barrier, you should be all right. (A Barrier without an Intervention is essentially an untreated problem; a Service not linked to a Barrier has not been justified as necessary.)

Defining Objectives

We are now only one (daunting) step away from completing the logical backbone of this Treatment Plan. All we lack are Objectives, to measure the progress of treatment. First, we need to be completely clear about what we mean by this concept.

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. (Sam, for example, would probably be more excited about "a visit to the local LMHA" than about "taking his meds regularly.")

There is a particular source of conceptual confusion that needs to be discussed, involving another (quite laudable) 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.

Hang in there. The end is in sight...

Now that we understand the patient's Goals, have identified remediable Barriers that lie in the way, and have agreed with the patient about what Services are to be applied, it seems reasonable to make some educated guesses about where we hope to be in about 30 days. Return to the main Treatment Plan screen, and click on the Recovery tab. We are now going to sequentially select each Domain, and for each Goal therein, define one or more Objectives. My suggestion is to try to define one good Objective per Goal, though the system will let you define as many as you would like.

Select the “Work / School” Domain and click on Goals. Select the Goal (“I want to get a job”). Click on the Objectives button. You are now looking at this:

Objectives for this Goal

Work / School Samuel CVHperson

Goal: I want to get a job.

Objective	Target Date
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Add View Edit Delete

[Review Barriers and Services for this Goal](#) Return

You are looking at (an empty) list of Objectives for the selected Goal. You might find yourself attracted to a tastefully colored button towards the lower left corner of the window. It seems to be tempting you to review the Barriers and Services associated with the current Goal. You want to click on this button, but your wish to get this exercise out of your life drives you to resist. Please: give in, and click on it.

If you do, you will see a rather intimidating summary of the clinical logic underlying our approach to helping Sam reach his Goal. Try to overcome your disgust and read through the information. All you need to do is get a sense of what might be an exciting step (to Sam) towards getting a job that is likely to be accomplished during the time frame of the current treatment plan (assumed to be 30 days). Let us imagine that we consider it reasonable to expect Sam to create a resume, and to be able to answer questions about it that might be expected from a prospective employer.

Click on the Add button, and you will see the following screen:

Add, View Or Edit Objectives

Work / School **Samuel CVHperson**

Goal: I want to get a job.

Objective:

Target Date: 3/15/2008

Return

Please type something like my suggestion above (or anything that you prefer) into the “Objective” text box. Although it doesn’t matter for this demo, you should adjust the “Target Date” to match the time frame until the next Treatment Plan review. We have been speaking in terms of 30 days, though the system currently defaults to 90 days.

If you click on Return buttons twice, you will be in position to add the Objectives for the remaining 3 Goals. Please permit me to suggest sample Objectives for each of the remaining Goals:

Domain: Medical / Health Needs

Goal: Maintain optimal medical and dental health

Objective: Sam will be able to list at least 3 common medical conditions for people his age for which he needs to be screened, both in the hospital and after discharge.

Domain: Housing

Goal: I want to get out the hospital and move into my own apartment.

Objective: Sam will meet with representatives from the LMHA to which he will be discharged, and by virtue of these discussions, will be able to describe what criteria he needs to meet in order to be discharged.

Domain: Other

Goal: I want to get off my medication.

Objective: Sam will be able to describe at least 3 behaviors that he understands will cause mental health providers to believe that he requires antipsychotic medications.

Completing and Printing the Master Treatment Plan

We have now completed the logic of Sam's Treatment Plan. You would now be expected to work through the remaining tabs (discussed above) to fill in some ancillary information about Sam and his treatment. Since our use of some of these fields is likely to change, and since there is little new about it, we do not need to concern ourselves with it at this time. The system will not require you to attend to the information requested on these tabs to complete the demo. (When creating an actual treatment plan, you would be required to enter data into some of these fields.)

Having now completed the Treatment Plan, we are ready to change it from "Draft" mode to "Real" mode. (This is virtually identical to the process described for the Functional Assessment.)

Note the word "Draft" in red letters at the top of the screen. This indicates that this MTP is not yet filed into the medical record. This allows you to work on it over a series of sessions; similarly, it can be a collaborative effort among several people (though it is important that more than one person not attempt to work on a particular Treatment Plan at the same time). If you print the MTP (using the Print button), the word "Draft" will appear on each page.

To make the Treatment Plan permanent, click on the Make Real button. The word "Draft" will disappear at the top of the screen, and the button you just clicked is now labeled "Make Draft." If you now print the MTP, you will no longer be able to edit it. (This is to avoid having conflicting printed versions of a record.) Similarly, if you click on the Return button with the MTP in "Real" mode, the record will be filed and will thereafter be uneditable.

The Error button essentially deletes the current MTP. This should only be used if you have screwed things up so badly that you really wish to start over again.

When you print a document, it is printed to a window on the screen, rather than sent directly to the printer. When the window appears, you can toggle back and forth between 2 zoom settings by clicking in the window. To print the report, click on the printer icon on the Access tool bar. To make the report window disappear, click on the "X" in the upper right hand corner of the report. (Be careful not to click on the "X" in the upper right corner of the Access window; this would close ITPS entirely.)

Looking to the Future

Now, as we come to the completion of his hellish exercise, I invite you to experience a moment of ecstasy, which, I hope, will be the beginning of your life-long love affair with electronic treatment planning. On the main Treatment Plan screen, click on the Guides button. You should see this:

The image shows a software window titled "Treatment Guide Reports". Inside the window, there is a "Service:" label followed by a dropdown menu. Below this is a "Service details:" label followed by a large text input area. Underneath that is a "Service focus:" label followed by another large text input area. At the bottom left of the window is a "Print" button, and at the bottom right is a "Return" button.

Reach deeply into your soul, and try to make available whatever remains of your passion for delivering wonderful clinical care. Imagine that you are any of the deliverers of service mentioned in this treatment plan. (Let's say, for example, that you are a direct care staff member.)

Use the "Service" drop-down list to pick the type of service that you deliver. (In our example of being a direct care provider on the unit, you would pick "Direct Care Milieu Management.") In essence, you are given an extract of the treatment plan that would guide you in doing your part in caring for this patient. (If you choose "Direct Care Milieu Management," you get something very close to the Nursing Plan of Care; if you choose one of the groups, you would get a nice summary for the group leader of what you need to know about why Sam is in your group and what to track to ensure that he's making progress.)

Suffice it to say that these examples of extracts are only the beginning. By constructing an internally consistent description of treatment, we are in a position to deliver and demonstrate a quality of care that is hard to imagine without the information management support of an electronic database.

That day will come. Until other elements of the EMR are available within the system, however, you will need to keep the faith. The alternatives – trust me – are not pretty.

Peace.