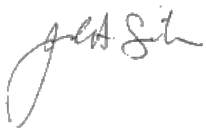
Section: **Substance Abuse Treatment & Prevention**	Policy Name: **Treatment Planning SUD**	Policy Number: **11.01**
Owner: **Substance Use, Prevention & Treatment Director**	Reviewed By: **Joel A. Smith**	Total Pages: **6**
Required By: ☐ **BBA** ☐ **MDHHS** ☐ **NCQA** ☒ **Other (please specify):** **PA 368 of 1978; SUD Administrative Rules**	Final Approval By: 	Date Approved: Jul 14, 2022
Application: ☒ **SWMBH Staff/Ops** ☒ **Participant CMHSPs** ☒ **SUD Providers** ☐ **MH/IDD Providers** ☐ **Other (please specify):** _____	Line of Business: ☐ **Medicaid** ☒ **Healthy Michigan** ☒ **SUD Block Grant** ☒ **SUD Medicaid** ☐ **MI Health Link** ☐ **Other (please specify):**	Effective Date: **1/1/2014**

Policy: It is the policy of SWMBH that treatment planning must be a product of the active involvement and informed agreement of the customer. The direct involvement of the customer in establishing the goals and expectations for treatment is expected to ensure appropriate level of care determination, identifying true and realistic needs, and increasing the motivation to participate in treatment. Treatment planning requires an understanding that each individual is unique and each treatment plan must be developed based on the individual needs, goals, desires and strengths of each customer.

Purpose: To establish the standards that define, guide and detail how Southwest Michigan Behavioral Health (SWMBH) and its provider network system comply with the federal laws and Michigan Department of Health and Human Services (MDHHS) Contract requirements pertaining to the practice of individualized treatment planning for persons with a Substance Use Disorder (SUD).

Scope: This policy applies to all SWMBH contracted SUD treatment providers.

Responsibilities: SWMBH contracted SUD treatment providers are responsible for treatment planning creation and implementation. SWMBH is responsible for monitoring treatment plans and associated documentation.

Definitions: None

Standards and Guidelines:

A. Requirements:

1. The Administrative Rules for Substance Abuse Programs in Michigan, promulgated under PA 368 of 1978, as amended, state "a recipient shall be allowed to participate in the development of his or her treatment plan" [Recipient Rights Rules, Section 325.1393(1)].

2. All SUD providers of SWMBH must also be accredited by one of six approved national accreditation bodies. Accreditation standards also require evidence of customer participation in the treatment planning process.

3. Based upon the assessments made of a customer's needs, a written treatment plan shall be developed and recorded in the customer's record. A treatment plan shall be developed as promptly after the recipient's admission as feasible, but before the recipient is engaged in therapeutic activities.

B. All SUD Providers shall comply with the following procedures:

1. Treatment planning begins at the time the customer enters treatment, either directly or based on a referral from an access system and ends when the customer is discharged. Treatment planning is a dynamic process that evolves beyond the first or second session when required documentation has been completed. Throughout the treatment process, as the needs of the customer change, the treatment plan must be revised to meet these new needs.

2. The treatment plan is not limited to just the customer and the clinician(s) providing services/treatment. The customer can request any family member, friend or significant other, be involved in the treatment process. Once the treatment plan is completed, the customer, clinician(s) and other involved individuals must sign the form indicating understanding of the plan and the expectations.

3. <u>Establishing Goals and Objectives:</u>

   i. The initial step in developing an individualized treatment plan involves the completion of a Biopsychosocial Assessment. This is a comprehensive assessment that includes current and historical information about the customer. From this assessment the needs and strengths of the customer are identified, and it is this information that assists the clinician and customer in establishing the goals and objectives that will be focused on in treatment. The identified strengths (i.e., healthy support network, stable employment, stable housing, willingness to participate in counseling, etc.) can be used to help meet treatment goals and objectives of treatment. After strengths are identified, the clinician assists the customer in using these strengths to accomplish the identified goals and objectives. Identifying strengths of the customer can provide motivation to participate in treatment and may take the focus off possible negative situations that surround the customer

getting involved in treatment (i.e., legal problems, work problems, relationship problems, etc.).

4. Writing the Plan:

    i. Once the goals and objectives are jointly decided on, they are recorded in the treatment plan document utilized by the provider. Goals must be stated in the words of the customer or based on the customer's reported concerns. Each goal that is written down should be directly tied to a need that was identified in the assessment. Once a goal has been identified, the objectives (i.e., the steps that need to be taken to achieve the goal) are recorded. The objectives must be developed with the customer, but do not have to be recorded in the exact words of the customer. The objectives need to be written in a manner in which they can be measured for progress toward completion along with a targeted completion date. The completion dates must be realistic to the customer or the chances of compliance with treatment are greatly reduced.

5. Establishing Treatment Interventions:

    i. The next component of the plan is to determine the intervention(s) that will be used to assist the customer in being able to accomplish the objectives (i.e., what action will the customer take to achieve it and what action will the clinician take to assist the customer in achieving the goal). Again, these actions must be mutually agreed upon to provide the best chance of success for the customer.

6. Framework for Treatment:

    i. The individualized treatment plan provides the framework by which the treatment should be conducted. Any individual or group sessions that the customer participates in must address or be related to the goals and objectives in the treatment plan. When progress notes are written, the note should reflect what goal(s)/objective(s) were addressed during a treatment episode. The progress notes are also where to document any adjustments/changes to the treatment plan. Once a change is decided on, it should then be added to the treatment plan in the format described above.

7. Treatment Plan Progress Reviews:

    i. Per the administrative rules, treatment plans must be reviewed by a program supervisor or his/her designee at least every 120 days. The reviews must include input from all clinicians/treatment providers involved in the care of the person being served as well as any other individuals the person being served has involved in their treatment plan. This review should reflect on the progress the customer has made toward achieving each goal and/or objective, the need to keep specific goals/objectives or discontinue them and the need to add any additional goals/objectives due to new needs of the customer. As with the treatment plan, the customer, clinician and other relevant individuals should sign this review.

1. The treatment plan and the treatment plan reviews not only serve as tools to provide treatment, they help in the administrative function of service authorization for the customer. All decisions concerning, but not limited to, authorizations, length of stay, transfer, discharge, continuing care and authorizations by SWMBH or delegated access management and utilization management providers must be based on individualized determinations of need and on progress toward treatment goals and objectives. Such decisions must not be based on arbitrary criteria such as pre-determined time or payment limits.

8. Policy Monitoring and Review

   i. As the PIHP, SWMBH will monitor compliance with individualized treatment planning and these reviews will be made available to the Michigan Department of Health and Human Services (MDHHS) during site visits. Reviews of treatment plans will include:

      1. A review of the Biopsychosocial Assessment to determine where and how the needs were identified.

      2. A review of the Treatment Plan to check for:

         a. Matching goals to needs (needs from assessment to goals on the treatment plan).

         b. Goals are in the words of and are unique to the customer (no standard or routine goals that are used by all persons being served) or based on the customer's reported concerns.

         c. Measurable objectives (the ability to determine if and when an objective will be completed).

         d. Target dates for completion (the dates identified for completion of the goals and objectives are unique to the customer and not just routine dates put in for completion of the plan).

         e. Intervention strategies (the specific types of strategies that will be used in treatment [i.e., group therapy, individual therapy, cognitive behavioral therapy, didactic groups, etc.]) or more specific strategies as known.

         f. Signatures (customer, clinician and involved individuals).

      3. A review of progress notes to ensure documentation relates to goals and objectives, including client progress or lack of progress, changes, etc.

      4. An audit of the treatment and recovery plan progress review to check for:

         a. Progress note information matching what is in review.

b. Rationale for continuation/discontinuation of goals/objectives.

c. New goals and objectives developed with input from the customer.

d. Participation/feedback from the customer is present in the review.

e. Signatures.

References:

A. MDHHS/OROSC Policies and Technical Advisories #P-T-06

B. Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems, Substance Use Disorders Service Program

Attachments: None

Revision History

Revision #	Revision Date	Revision Location	Revision Summary	Revisor
1	6/20/22	Multiple locations	Merged to new policy template; Aligned policy to updated SUD admin rules	J. Smith

11.01 Treatment Planning SUD

Final Audit Report 2022-07-14

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