Subject: Treatment Planning SUD	**Accountability:** SAPT Director	**Effective Date:** 1/1/2014	Pages: 4
REQUIRED BY: **BBA Section** _____ **PIHP Contract Section** _____ **NCQA/URAC Standard** _____ **SA SARF** PA 368 of 1978 **Other BSAS Technical Advisory #6**		Last Reviewed Date: 11/3/16	Past Reviewed Dates: 12/23/14 5/15/15
LINE OF BUSINESS: ☐ Specialty Waiver(B/C) ☐ I Waiver ☒ Healthy Michigan ☒ SUD Medicaid ☒ SUD Community Grant ☐ MI Health Link ☐ OTHER: _____	**APPLICATION:** ☒ SWMBH Staff and Operations ☒ Participant CMHSPs ☒ SUD Providers ☐ MH / DD providers ☐ DD providers ☐ Other:_____	Last Revised Date: 11/3/16	Past Revised Dates: 5/15/15
Approved By: Thunder Smith Date: 11/11/16		Required Reviewer: SAPT Director	

I. 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).

II. 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.

III. Standards and Guidelines

A. Assessment and forms should be reviewed on at least an annual basis to ensure that the information that is being gathered or the manner in which it is recorded continues to support the individualized treatment planning process.

B. Requirements:

1. The Administrative Rules for Substance Abuse Programs in Michigan, promulgated under PA 368 of 1978, as amended, state "a recipient shall participate in the development of his or her treatment plan" [Recipient Rights Rules, Section 305(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.

C. 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 and 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. Establishing Goals and Objectives:
   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 counselor 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. After strengths are identified, the counselor 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:
   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. 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 objective 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:
   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 objective (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:
   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:
   a. Treatment plans must be reviewed and this review must be documented in the record of the customer. The frequency of the reviews can be based on the time frame in treatment (i.e., 60, 90, 120 days) or on the number of treatment episodes that have taken place since admission or since the last review (i.e., 8, 10, 12 episodes). Per the administrative rules, treatment plans must be reviewed by a program supervisor or his/her designee every 90 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.
   b. 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 RCA's 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

   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:
   a. A review of the Biopsychosocial Assessment to determine where and how the needs were identified.
   b. A review of the Treatment Plan to check for:
      1. Matching goals to needs (needs from assessment to goals on the treatment plan).
      2. 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).
      3. Measurable objectives (the ability to determine if and when an objective will be completed).
      4. 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).
      5. 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.
      6. Signatures (customer, clinician and involved individuals).
   c. A review of progress notes to ensure documentation relates to goals and objectives. Items to check for:
      1. Progress note information matching what is in review.
      2. Rationale for continuation/discontinuation of goals/objectives.
      3. New goals and objectives developed with input from the customer.

4. Participation/feedback from the customer is present in the review.
5. Signatures

IV. Definitions

None

V. References

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

VI. Attachments

None