Chapter 4
Treatment Plans

Deborah W. Frazer

Introduction

Treatment plans are the central tool for accountability in the psychotherapy process: accountability to the patients, to the insurance companies, to the referring physicians, to the nursing home or assisted-living facilities, and to us, the therapists. Through this tool, we briefly state in writing why we are using psychotherapy, what we hope to accomplish, how we hope to accomplish it, and when we hope to accomplish it.

Background Material

Qualities of Treatment Plans. Constructing a treatment plan is a therapeutic intervention in itself. As a patient and therapist work toward a plan together, they engage in a forthright discussion of the problem(s), what steps will be required to address the issues of concern, and how will they recognize when the treatment has been successful. The therapist must listen to the older adult's unique expressions of distress: his or her "voice" may be influenced by age cohort, educational level, geographic and language origins, race and ethnicity, sexual orientation, religion, and comfort level talking about "personal" issues or with someone of a different background.

Optimally, the therapist must be able to focus the treatment planning discussion on the dominant issues and to explain the appropriate therapeutic strategies, reflecting and incorporating the person's own verbal style. Both patient and therapist then agree on a clear and objective therapy outcome, and identify how they will recognize when it has been achieved. The statement, clarification, and negotiation of these goals are the beginning of psychotherapy.

Codevelopment of a treatment plan engages the older adult, right from the start, as an equal and responsible partner in the therapeutic process. Some older people, who have not previously been included as full partners in their own health care, or who have experienced prior discrimination in health care, might be surprised, confused or skeptical about such a partnership approach. However, sustained therapeutic

E. Rosowsky et al. (eds.), *Geropsychology and Long Term Care*,
DOI: 10.1007/978-0-387-72648-9_4, © Springer Science+Business Media, LLC 2009

partnership and respect will establish the mutual responsibility that will fuel progress on the treatment plan.

Medicare and other mental health insurance payers (including individual managed care plans) require documentation that the treatment plan has been discussed with, and agreed to by the patient or patient representative (e.g., power of attorney, public guardian). Overall, the construction of, and guidance by, a treatment plan is the essential distinction between psychotherapy and "friendly visiting."

- A treatment plan is dynamic. It should be updated whenever there is a major change of the patient's status, goals, objectives, or the therapist's interventions.
- A treatment plan is integrated with the care plans of other providers. In a psychiatric facility, this is accomplished through interdisciplinary care conferences and a single integrated treatment plan. In nursing homes, therapists face a more difficult challenge to align, coordinate, and integrate the psychotherapy plan with the nursing home's assessment (minimum data set – MDS) and care plan. In assisted-living facilities, documentation requirements vary from state to state and among residential providers; therapists must seek information from the facility about how to best integrate treatment plans into the overall "service plan." Psychotherapists working under Medicare are required to consult with the patient's attending or primary care physician. For outpatients or in-home patients, sending the treatment plan to the attending/primary (with the patient's consent) is an efficient way to maintain this communication.
- A treatment plan has specific, individualized, objective, and measurable patient-centered long- and short-term goals. The plan tells what the patient (not the therapist) will accomplish.

Psychologists who have worked in psychiatric hospitals or mental health clinics are familiar with treatment planning, especially if the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) approves the site. JCAHO insists on a formal treatment planning process, stressing the need for detailed plans with quantifiable objectives. Many managed care companies and other insurance carriers have followed JCAHO's lead and have adopted its high standard for treatment planning.

Although Medicare does not specify what must be included in a treatment plan, therapists are well advised to develop plans compatible with the JCAHO and managed care standards. This ensures the greatest probability of acceptance of the plan by any insurance carrier.

In their local determinations of coverage (LCDs), Medicare carriers often outline elements they expect to see in the beneficiaries' records. For example, if it is the plan to treat a person with dementia, most carriers' LCD requires there be a "reasonable expectation" of improvement or maintenance of functioning that would otherwise decline absent services; that the beneficiary has the capacity to "actively participate" and is cognitively intact enough to have "meaningful" verbal interaction and develop a therapeutic relationship allowing for effective insight-oriented, behavior modifying or supportive therapy. The frequency of services should be both consistent with practice standards and medically necessary for the beneficiary's

given condition. Documentation in the treatment plan should provide evidence that the beneficiary is able to meaningfully participate in treatment.

How to Construct a Treatment Plan

Treatment planning is a logical, step-by-step process that follows naturally from the referral and assessment process. To demonstrate the logical progression, include the referral question (the justification for assessment or treatment) and the diagnosis (the conclusion of the assessment process that should guide the treatment process) at the top of the treatment plan. Then proceed to construct the plan itself.

First, choose the most significant and feasible problems to work on. Many problems are raised during the assessment process – some by the patient, others by family members, paid caregivers, or other treating professionals. The initial treatment plan should narrow the focus of treatment to one or, at most, a few problems that are in need of the therapists' attention. Whatever the reason for the referral it is important to address high-risk problems such as suicidal ideation or planning, including documentation of physician notification.

Second, define each problem in behavioral, i.e., observable terms, including statements made by the older adult. For example, instead of stating, "depression," use "depression as evidenced by tearfulness and complaints of sadness." This behavioral definition can seem tedious to therapists who use diagnosis as shorthand for symptom clusters. However, it can be extremely helpful in clarifying communication with the patient, family, physician, the nursing home or assisted-living facility, and insurance payers.

Third, set long-range goals. These are generally framed as positive statements of what the therapist and patient will be striving toward together. Rather than simply "reducing signs of depression," the goal might be to "increase interest in life and feelings of pleasure." The process of specifying these long-range goals gives the therapist and patient time to develop a joint vision of the positive possibilities in the patient's life. Long-range goals are the framework of hope.

Fourth, set specific, measurable objectives for each goal (these are sometimes considered "short-term goals"). These are the small steps that the patient must accomplish to move toward the long-range goal. These are always written as patient objectives or goals, not therapist objectives. To ensure the proper format, start with the stem, "The patient will…." Many therapists find this and the next step the most onerous, as they reduce the artful, almost mystical, process of psychotherapy to very concrete statements of observable behavior. While seeking and experiencing profound moments with the patient, the therapist may be required to write something rather flat, for example: "patient will verbalize conflicts with and ambivalence toward the deceased loved one."

However concrete these behavioral objectives sound, they do help the therapist to focus the treatment. Target dates for the completion of objectives should be included and new objectives added as previous objectives are met. If an objective

is not met after the expected time interval, it should serve as a discussion point between the therapist and patient. Perhaps the objectives should be changed, or the therapist's intervention should be modified.

Fifth, and finally, specify the therapist's interventions and the frequency of therapy. This states what the therapist will do, and how often, that are intended to result in the patient's accomplishing particular objectives. Try the stem, "the therapist will…." to ensure proper format. These interventions can be written from any theoretical orientation. It may require several therapist interventions for the patient to accomplish an objective. If one intervention is not working, substitute another. Be as specific and as jargon-free as possible, so that reviewers can understand the therapeutic interventions.

If the intervention significantly deviates from standard practice – either in type or frequency of intervention – justify the change in approach on the treatment plan. For example, the therapist and care team may decide that short daily sessions are needed for a 2-week period to prevent hospitalization of a patient. Specify clearly on the plan that daily sessions are a short-term therapeutic strategy with a specific goal. It should be added that third-party payers may also look closely at the interventions portion of the treatment plan. When the psychologist's interventions are explicitly stated in the plan and in the ongoing progress notes, there is greater likelihood of coverage for the service by the payer, if the documentation is reviewed or audited. Conversely, when the interventions are vague or does not differentiate between what a licensed mental health practitioner provides and what any other staff person may provide, there is increased risk of denial of the claims. This is an important consideration in the development of comprehensive treatment plans for the older adult residing in a long-term care setting.

Summary

The completed treatment plan, then, consists of six elements specified in writing: diagnosis, identified problem(s), behavioral definitions of problems(s), patient long-range goals, patient objectives or short-term goals, and therapist interventions. Such a plan, developed together with the resident, should serve both the older adult and the therapist well.

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