Nevada Medicaid
Outpatient Mental Health Treatment Plan
Components & Documentation
FACT SHEET

Elements of the Treatment Plan:

- ☑ Treatment planning is based upon the individual recipient's psychological assessment, diagnosis, reason for referral and Level of Intensity (LOI).
- ☑ Recipient and/or legal guardians are directly involved in the development of the treatment plan (identifying goals, service providers, etc.) and are required to sign.
- ☑ When family or others participate in services, the focus remains on supporting recipient progress and positive outcomes (e.g., parent training to manage recipient's behaviors).
- ☑ Services identified in the Treatment Plan are focused exclusively on the benefit of the recipient and aligned with the Intensity of Need Assessment tool.
- ☑ A Treatment Plan is a fluid document and needs to be reviewed/updated at regular intervals and revised based upon the recipient's progress and/or clinically indicated needs based upon Intensity of Needs Assessment tool.

Required Components of the Treatment Plan:

- ☑ Strengths of the recipients (and their families in the case of legal minors and when appropriate for an adult).
- ☑ Intensity of Needs Determination.
- ☑ Needs of the recipient based upon the Intensity of Needs Assessment tool.
- ☑ Goals:
  - Goals are the larger, broader outcomes that the provider and client are working toward.
  - Goals must be specific, measurable (action oriented), achievable, realistic and time limited.
  - Examples of goals:

✗ Jill will be less depressed.

✓ Symptoms of depression will be significantly reduced and will no longer interfere with Jill's functioning. This will be measured by a score of 60 or below on the YSR Withdrawn/Depressed scale at the time of discharge. Anticipated completion date is 6 months.

✗ Eric will be nicer to his family.

✓ Reduce family conflict and increase positive family interactions. This will be measured by reducing evasive/withdrawn interactions with his father to 1 time a week for 3 consecutive weeks; reducing arguing/rudeness towards his step-mother to 7 times a week for 3 consecutive weeks; and family will report at least one positive interaction/family activity per day for 3 consecutive weeks. Anticipated completion date is 6 months.

☑ Objectives

- Objectives are short-term steps that the client will take that are necessary to meet the overarching treatment goals.
- Objectives must be specific, measurable (action oriented), achievable, realistic and time limited.
- Objectives are what the recipient is going to **do** to accomplish their goals.
- Examples of objectives and format:

Objective	Date established	Projected completion date	Date achieved
Jill and her father will develop a safety plan/no self-harm contract.	4/1/18	4/1/18	4/1/18
Jill will learn coping skills, including problem solving and emotional regulation. This will be measured by her demonstrating these skills during therapy sessions and bringing in homework assignments for two consecutive weeks that show she practiced them between sessions.	4/1/18	5/1/18	
Jill will report no suicidal ideation for 3 consecutive weeks.	4/1/18	6/1/18	

☑ Evidence-based treatment strategies or interventions that will be used:

- Identified treatment strategies/interventions must specify **amount, scope, duration** and **anticipated provider(s)** of the services.
- Examples - Strategies / Interventions:
  - Staff will assist client in scheduling an intake with the Domestic Abuse Women's Network (DAWN) by specified date.
  - Staff will allow client to call her primary care provider in session.
  - Staff will teach clients skills to cope with cravings for alcohol.
  - Staff will assist client in finding a sober support group for women.

☑ Discharge plan, which includes:

- Expected timeframe and criteria for discharge based upon treatment goals and level of care determined by the Intensity of Needs tool
- Identified aftercare service/providers
- Current treatment provider's plan to assist recipient in accessing necessary aftercare services/providers upon discharge

☑ Evidence of care coordination by those involved with the recipient's care (for high-risk recipients accessing services from multiple government-affiliated and/or private agencies)

☑ Legible date and signatures of clinician, recipient (or guardian), other treatment team members. To include a statement that recipient participated and agreed with treatment plan; evidenced by recipient signature.

Progress Notes *– Reflect the recipient's specific progress/regress toward meeting the goals and objectives within the Treatment Plan and/or identify any emerging needs that may require revisions to the Treatment Plan. The Progress Notes must be current and up-to-date with the information reflecting the justification or medical necessity of services.*