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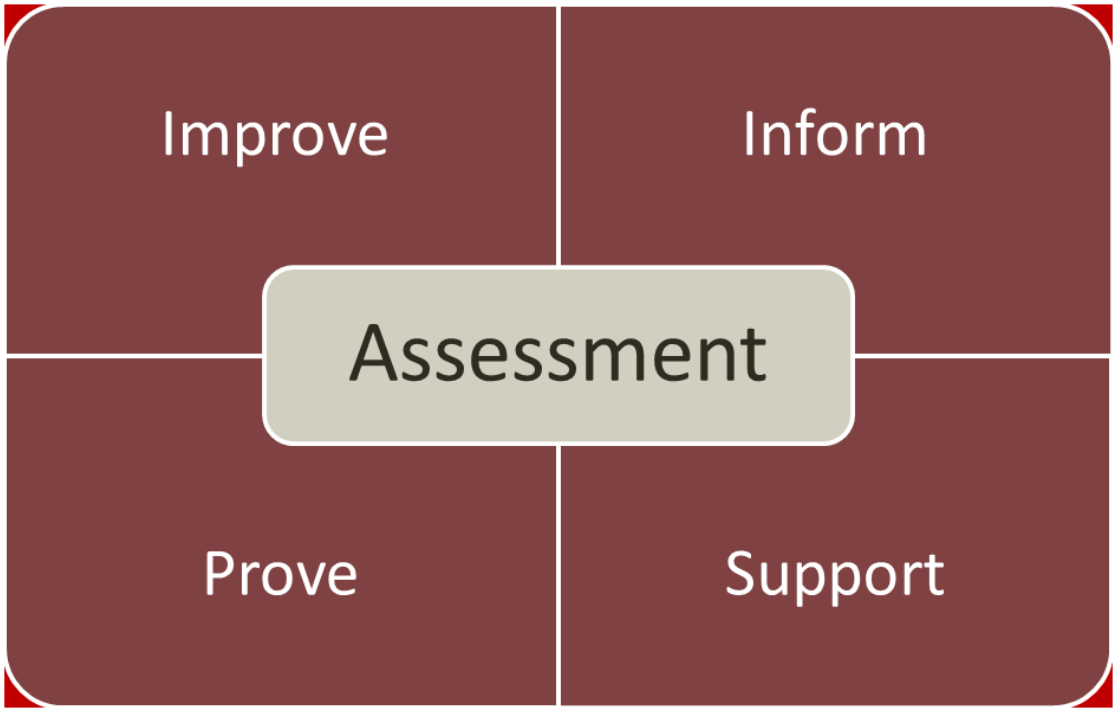

Goals and Measureable Objectives

Handout Manual
For Newly Hired Behavioral Health Therapist

Updated 03/12/2023

By Executive Director

▸ MENTAL HEALTH EVALUATION AND DIAGNOSIS

The Mental Health Evaluation/Diagnosis determines eligibility for Clients services and establishes the basis for treatment.
Usually the first activity that occurs between a direct service provider and beneficiary.
▸Occurs before treatment services/activities have been established or delivered (Exception: Crisis Intervention)
▸May reoccur over time as medically necessary (up to 16 units per year without extension of benefits)
Through the Mental Health Evaluation/Diagnosis the mental health professional must establish a baseline measurement of the beneficiary's:

▸Symptoms
▸Behaviors
▸Strengths
▸Skills/abilities
▸Limitations
Is the individual capable of responding to and benefiting from the treatment prescribed?
▸Does the primary diagnosis and focus of treatment meet Client requirements?
▸Are the services to be provided medically necessary

▸ MEDICAL NECESSITY REQUIRES

▸A mental health diagnosis
▸Either causes marked functional impairment or interferes with functioning,
▸Those functional issues interfere with the beneficiary's achievement of his/her own personal recovery goals.

FUNCTIONAL IMPAIRMENT

Using information from the Mental Health Evaluation/Diagnosis the mental health professional should determine and document how these symptoms impacts the beneficiary's ability to function in the community/family (Functional Impairments).

- Activities of daily living
- Social functioning
- Concentration, persistence, or pace
- Episodes of decompensating

A marked limitation may arise:

- when several activities or functions are impaired, or
- when only one is impaired,

As long as:

- the degree of limitation is such as to interfere seriously with the ability to:
- function independently,
- appropriately,
- effectively,
- and on a sustained basis
- Taking public transportation
- Using the post office
- Using telephones and directories
- Scheduling and keeping appointments
- Caring appropriately for grooming and hygiene

- Eating
- Bathing
- Dressing
- Brushing teeth
- Understanding and taking prescribed medications

Functional Impairment: Social Functioning

Ability to get along with others such as	Initiate social contacts
Family members	Communicate clearly
Friends	Interact and actively participate in group activities
Neighbors	Display cooperative behaviors
Grocery clerks	Social maturity
Landlords	Awareness of other's feelings
Bus drivers	Consideration of others
Teachers	

Social Functioning in Work Setting:

- Interaction with the public
- Responding appropriately to persons in authority (supervisors, police, teachers, school administrators)
- Cooperative behaviors involving coworkers, classmates, peers)

Examples of impaired social functioning:

- Evictions
- Firings
- Fear of stranger's
- Avoidance of interpersonal relationships

- Social isolation
- School avoidance
- Altercations/fights

Functional Impairment: Concentration, Persistence, and Pace

- The ability of the beneficiary to sustain focused attention and concentration sufficiently long to permit the timely and appropriate completion of tasks commonly found in work settings.

- Ability to work at a consistent pace for acceptable periods of time until a task is completed
- Ability to repeat sequences of actions to achieve a goal or objective. (Adults only)

Functional Impairment: Episodes of Decompensating

- May be demonstrated by an exacerbation in symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or combination of the two)
- May be inferred from:
- Documentation of significant change in dose or change of medication

- Documentation of the need for more structured psychological support system (e.g. hospitalizations, placement in halfway house, or a highly structured living situation, increased supervision)

- Other relevant information in the record about the existence, severity and duration of the episode.

- Exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace.

Functional Impairment: Activities of Daily Living

- Maintaining a household
- Managing money

PSYCHOSOCIAL HISTORY AND ASSESSMENT

A psychosocial history and assessment should:

- Communicate pertinent information about a beneficiary to colleagues for treatment planning and referral purposes.

- Establish in writing "where the beneficiary is functioning" at a particular moment in time; the psychosocial assessment offers baseline information about the beneficiary.

Identifying information

- Beneficiary name
- Gender
- Date of birth and age
- Marital status
- Race, ethnicity, and nationality
- Language spoken
- Socioeconomic status (income)
- Living arrangements

Referral rational

- Source (Who referred the beneficiary to the agency?)
- Nature of request (What type of assistance is being sought?)
- Presenting problem(s), history of presenting problem(s), including duration, intensity, and response(s) to prior treatment
- Describe the problem/s for which the beneficiary requested (or was referred) for help
- Include beneficiary's definition of problem/need and expectations of service.

- Include a brief history of the presenting problem:
- Length of duration of the problem
- Prior attempts to resolve the problem and results
- Previous involvement with other agencies for assistance with the problem
- If the beneficiary is in crisis or considered “high risk” describe and complete brief assessment of the risk

General Description of the Beneficiary

- Beneficiary’s appearance, attitude, affect and interpersonal style during the interview/s
- Mention any apparent problems with memory, thinking speech, or beneficiary’s sense of reality

- Note any signs or mention of anxiety, depression or other mood states if they are present

- Indicate how beneficiary related to you during the interview/s

Family Composition and Background

- Nuclear family members and significant relationships; list members, ages, marriages, deaths, divorces.
Include dates.
- Describe relationships –focus on marital and parental strengths and difficulties, if relevant.
- Family of origin (family with whom one grew up); list members, ages, where they live, deaths, divorces. Include dates.
- Describe all these relationships.
- History of relevant substance abuse, legal problems, and/or psychiatric problems among family members. Include dates.

Educational background

- School history and current status.
- Highest level of education
- Degree/s earned
- Special School/ educations talents, challenges, goals.
- Disciplinary actions, alternative school, suspensions

Employment

- Occupation, work history, and current status
- (employed, unemployed, full-time, part-time, disabled, etc.) Include dates, reason for multiple employments, quit, terminated,
- Special training or skills

Religious and spiritual involvement

- Level of involvement with and support from religious community and/or spiritual practices and beliefs.
- Physical functioning, health conditions and medical background
- Physical development, general health, disabilities, and current functioning
- History of disease, accidents, genetic predispositions, and prescription medication/s (get list of medications, current and past)
- Effectiveness of medications, side effects, compliance
- Psychological and Psychiatric Functioning and Background
- History of mental health/psychiatric problems, prescription medication, addictions (e.g. alcohol, and other substance use including prescription medications, gambling, etc.)
- History of physical, mental, and/or sexual abuse or neglect

Social, Community and Recreational Activities

- Social functioning, (are there any significant friendships, interpersonal relationships, support network?)
- Use of community organizations or resources (e.g., as a Client, member, volunteer)
- Hobbies, or leisure activities

Basic Life Necessities

- How is the beneficiary functioning with respect to basic life necessities –food, housing, employment

- What assistance does the beneficiary receive?
- What assistance does the beneficiary require?
- Legal concerns
- Housing
- Marital issues
- Domestic violence
- Parole/probation
- FINS petition
- DWI's

- Current charges
- DCFS involvement

Other environmental and psychosocial factors

- Military service,
- Sexuality issues,
- Etc.

Client strengths, capabilities, and resources

- What are his/her strengths and problems solving capacities?
- What are his/her limitations to deal with the current problem/s?
- What natural supports are available?
- Family
- Friends
- Community supports
- Etc.

Clinical summary, impressions, and assessment

- Give a brief, 3-5 sentence summary of what you have already written:
- Identify the primary problem, need, or concern the beneficiary is dealing with and the contributing factors.
- Describe the sense of urgency the beneficiary has with the problem/s.
- Identify secondary problems, needs, or concerns if these are raised.
- Summarize how the beneficiary appeared during the interview/s.
- Give and overview of beneficiary's mood, signs of anxiety or depression, problems with memory, speech sense of reality, judgment, attitude toward their situation/difficulty.
- Indicate how the beneficiary related to you. Your impressions give clues to where the beneficiary is right now and how the beneficiary is handing the problem emotionally and cognitively.

Clinical summary, impressions, and assessment

- Note the beneficiary's expectations of service
- Note your assessment of the beneficiary's motivation for change and likely use of service/s.

Admission/Referral

- Does the beneficiary meet the criteria for admission?
- If beneficiary does not meet the criteria for admission, was referral made to appropriate program or service?

Treatment Recommendations

- Goals and Recommendations
- Identify goals for treatment with the beneficiary
- Identify recommendations for services and resources
- What are the next steps
- Psychological Testing
- Educational Testing
- Medical, hearing, vision screening
- Substance abuse evaluation/treatment

MEASURABLE GOALS AND OBJECTIVES

Scope

A range of mental health rehabilitative or palliative services is provided by a duly certified **NLYFCS** provider to Medicaid-eligible beneficiaries suffering from mental illness, as described in the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV and subsequent revisions).
Rehabilitative Services for persons with mental illness may be covered only when:

A.Provided by qualified providers,
B.Approved by a physician within 14 calendar days of entering care,
C.Provided according to a written treatment plan/plan of care, and
D.Provided to outpatients only except as described
E.In order to be valid, the treatment plan/plan of care must:
1. Be prepared according to guidelines developed and stipulated by the organization's accrediting body and
2. Be signed and dated by the physician who certifies medical necessity.
If the beneficiary receives care under the treatment plan, the initial treatment plan/plan of care must be approved by the physician within 14 calendar days of the initial receipt of care.
The physician's signature is not valid without the date signed.

Master Treatment Plan

For each beneficiary entering the **NLYFCS** Program, the treatment team must develop an individualized master treatment plan. This consists of a written, individualized plan to treat, ameliorate, diminish or stabilize or maintain remission of symptoms of mental illness that threaten life, or cause pain or suffering, resulting in diminished or impaired functional capacity. The master treatment plan goals and objectives must be based on problems identified in the intake assessment or in subsequent assessments during the treatment process.

Service Definition

SERVICE: Master Treatment Plan
DEFINITION: A developed plan in cooperation with the beneficiary (parent or guardian if the beneficiary is under 18), to deliver specific mental health services to the beneficiary to restore, improve or stabilize the beneficiary's mental health condition. The plan must be based on individualized service needs identified in the completed Mental Health Diagnostic Evaluation. The plan must include goals for the medically necessary treatment of identified problems, symptoms and mental health conditions. The plan must identify individuals or treatment teams responsible for treatment, specific treatment modalities prescribed for the beneficiary, time limitations for services and documentation of medical necessity by the supervising physician.

DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 4
YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension: 839

Service Definition

DOCUMENTATION REQUIREMENTS (additional requirements):

•Date of service (date plan is developed)
•Start and stop times for development of plan
•Place of service
•Diagnosis
•Beneficiary's strengths and needs
•Treatment goal(s) developed in cooperation with and as stated by beneficiary that are related specifically to the beneficiary's strengths and needs
•Measurable objectives 40

Service Definition

(Documentation Requirements continued)
•Treatment modalities —the specific services that will be used to meet the measurable objectives
•Projected schedule for service delivery, including amount, scope and duration
•Credentials of staff who will be providing the services
•Discharge criteria
•Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/ date of signature(s)
•Beneficiary's signature (or signature of parent, guardian, or custodian of beneficiaries under the age of 18)/date of signature
•Physician's signature indicating medical necessity/date of signature

NOTES and COMMENTS: The service formerly coded as T1023 and titled "Assessment and Treatment Plan/Plan of Care" is now incorporated into this service. This service may be billed one (1) time upon entering care and once yearly thereafter. The master treatment plan must be reviewed every ninety (90) calendar days or more frequently if there is documentation of significant acuity changes in clinical status requiring an update/change in the beneficiary's master treatment plan. It is the responsibility of the primary mental health professional to ensure that all paraprofessionals working with the Client have a clear understanding and work toward the goals and objectives stated on the treatment plan.

SERVICE: Periodic Review of Master Treatment Plan
DEFINITION: The periodic review and revision of the master treatment plan, in cooperation with the beneficiary, to determine the beneficiary's progress or lack of progress toward the master treatment plan goals and objectives; the efficacy of the services provided and continued medical necessity of services. This includes a review and revision of the measurable goals and measurable objectives directed at the medically necessary treatment of identified symptoms/mental health condition, individuals or treatment teams responsible for treatment, specific treatment modalities and necessary accommodations that will be provided to the beneficiary, time limitations

for services and the medical necessity of continued services. Services are to be congruent with the age, strengths, necessary accommodations for any disability and cultural framework of the beneficiary and his/her family.

DAILY MAXIMUM OF UNITS THAT MAY BE BILLED: 2

YEARLY MAXIMUM OF UNITS THAT MAY BE BILLED without extension:

DOCUMENTATION REQUIREMENTS (for additional requirements):

Completed by the primary MHP (If not, then must have a rationale for another MHP completing the documentation and only with input from the primary MHP.)

•Date of service
•Start and stop times for review and revision of plan
•Place of service
•Diagnosis and pertinent interval history
•Beneficiary's updated strengths and needs
•Progress/regression with regard to treatment goal(s) as documented in the master treatment plan
•Progress/regression of the measurable objectives as documented in the master treatment plan
•Individualized rationale to support the medical necessity of continued services
•Updated schedule for service delivery, including amount, scope and duration
•Credentials of staff who will be providing the services

•Modifications to discharge criteria

•Signature/credentials of staff drafting the document and primary staff who will be delivering or supervising the delivery of the specific services/date of signature(s)

•Beneficiary's signature (or signature of parent, guardian or custodian of beneficiaries under the age of 18)/date of signature(s)

•Physician's signature indicating continued medical necessity/date of signature

NOTES and COMMENTS: This service must be provided every ninety (90) days or more frequently if there is documentation of significant change in acuity or change in clinical status requiring an update/change in the beneficiary's master treatment plan. If progress is not documented, then modifications should be made in the master treatment plan or rationale why continuing to provide the same type and amount of services is expected to achieve progress/outcome. It is the responsibility of the primary mental health professional to ensure that all paraprofessionals working with the Client have a clear understanding and work toward the goals and objectives stated on the treatment plan.

Importance of Treatment Planning

- Treatment plans are essential (and required) tools that provide a map to assist beneficiaries.
- The treatment plan addresses problems identified in the beneficiary's Mental Health Evaluation/Diagnosis, defines and measures interventions and provides a measure for the beneficiary's progress in treatment.
- The treatment planning process is key in demonstrating the effectiveness of treatment interventions for beneficiaries.
- Good progress notes begin with effective treatment planning.
- Comprehensive treatment planning leads to easy documentation in progress notes; poorly developed treatment planning leads to incomplete or unclear documentation of services.

DEVELOPING TREATMENT GOALS AND OBJECTIVES

Treatment Goals are:

•An observable and defined result having one or more objectives to be achieved within a fixed timeframe.
•A behavioral outcome statement.

Developing Treatment Goals:

•Review the beneficiary's Mental Health Evaluation/Diagnosis and other assessments.

•Develop long term goal/s and begin to formulate, with the beneficiary and/or guardian, what objectives need to be met in order to achieve the goal/s.

Helpful questions to ask the beneficiary:

•What do you want to accomplish?
•What do you want to do differently?
•How do you think treatment can improve your life?
•What new skills do you want to learn to improve your quality of life?

Treatment Objectives are:

- The roadmap on the path toward achievement of the goals.
- A statement in specific and measurable terms that describes what the beneficiary will accomplish as a result of treatment and interventions.

Why are Treatment Objectives Important?

Achieving a goal is easier with a plan….

Objectives:

- Set treatment priorities
- Monitor progress toward goal/s
- Set targets for accountability
- Provide framework for treatment and outcomes

Treatment Objectives should be individualized:

- Symptom severity and chronicity vary by beneficiary with the same diagnosis.
- Developmental and intellectual factors result in symptoms being expressed differently by beneficiaries with the same diagnosis.
- Expression of symptoms varies between genders.
- Cultural issues which impact treatment must be considered.
- Community, support systems, and environmental factors must be considered in the formulation of objectives (i.e. toxic environments, transportation, family support, access to basic necessities, etc.).

Treatment Objectives are individualized:

- What will the beneficiary do that indicates that a goal is attained?
- The objective must be measurable and specific.

- Objectives should be written from the perspective, “The beneficiary will….”
- The objective should be realistic, something the beneficiary can achieve or accomplish.

Should be: SMART

- **Specific:** concrete, detailed, and well defined.
- **Measurable:** numeric or descriptive, quantity, quality or comparative
- **Achievable:** feasible, attainable, actionable
- **Realistic:** considers resources, barriers, strengths, can be achieved
- **Time Specific:** identifies target dates, includes interim steps to monitor progress and defines a time line in which objectives are to be achieved

Specific:

- State specifically what the beneficiary wants/needs to achieve.
- Describe the action, symptom, or behaviors to be addressed
- Include both the current “level” (frequency, intensity, etc.) and the “level” of behavioral change desired.
- State the specific target behavior
- Should be brief, to the point and understandable by the beneficiary and/or guardian.

Measurable:

- Be able to determine the extent to which the action, behavior or objective has changed from the baseline to desired outcome.
- Identify a device, system, person, or method to track and record the target action, symptoms or behaviors.
- The type of measurement or measuring tool must be specified.
- Whatever the means of measurement, it should be valid and reliable.
- If the objective is measurable, the measurement source/s is identified and the beneficiary and/or guardian and treatment team are able to track progress toward the objective.
- It is important to have measures that will encourage and motivate beneficiaries on their way as they see change. This may require interim measures or short target date intervals.
- Measurements go a long way to help all members of the treatment team as well as the beneficiary and/or guardian to know when the objective/s has been achieved.

Achievable:

Can it be accomplished?

▸There should be a reasonable belief in the beneficiary's ability to accomplish the objective.
▸Consider beneficiary's symptoms, behaviors, skills, strengths, abilities, limitations, as well as any potential barriers to achieving the objective.
▸Objectives should be achievable within the identified target date and should keep the beneficiary motivated.

Realistic:

Realistic means that the beneficiary has the ability to accomplish the objective within the identified target date.
▸Achievement of the objective/s should be meaningful to the beneficiary and/or guardian.
▸Are the resources available or can they be developed to achieve this objective?
▸Are family/significant others supportive and involved in attaining the agreed upon objective?

Time Specific:

When should the objective be accomplished?
▸Time specific means setting a deadline for the achievement of the objective.
▸Target dates need to be achievable and realistic.
▸Target dates create the necessary urgency and prompts for action.
▸Clearly state the target date for each specific objective.
▸Consider any real or perceived obstacles,(what are they and can they be overcome), to accomplishing the objective on or before the target date.

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