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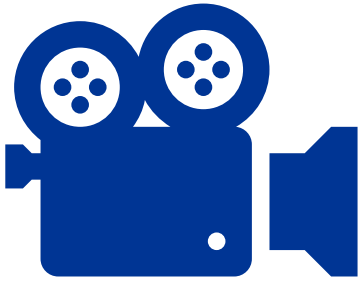

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- Everyone on every Program Evaluation and Research Unit (PERU) webinar is **valued**. Everyone has an expectation of **mutual, positive regard** for everyone else that respects the **diversity** of everyone on the webinar.
- We operate from a **strength-based, empathetic, and supportive** framework – with the people we serve, and with each other on PERU webinars.
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- We strive to **listen** to each person, avoid interrupting others, and seek to **understand** each other through the Learning Network as we work toward the highest quality services for Centers of Excellence (COE) clients.
- Information presented in Learning Network sessions has been vetted. We recognize that people have different opinions, and those **diverse perspectives** are welcomed and valued. Questions and comments should be framed as **constructive feedback**.
- The Learning Network format is **not conducive to debate**. If something happens that concerns you, **please send a chat during the session** to the panelists and we will attempt to make room to address it either during the session or by scheduling time outside of the session to process and understand it. **Alternatively, you can reach out offline to your PERU point of contact.**

Acknowledgements

- The COE project is a partnership of the University of Pittsburgh's Program Evaluation and Research Unit and the Pennsylvania Department of Human Services; and is funded by the Pennsylvania Department of Human Services, grant number 601747.

- COE Vision: The Centers of Excellence will ensure care coordination, increase access to medication-assisted treatment and integrate physical and behavioral health for individuals with opioid use disorder.

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Program Evaluation and Research Unit

Care Planning

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Learning Objectives

By the end of this module, trainees should be able to do the following:

- Define care planning and **distinguish** between that and a care plan.
- Discuss how to **develop** a COE care plan with the client and the team.
- Outline the required and recommended **components** of a COE care plan.
- Describe how to use a care plan **throughout** the clients' COE program participation.

Why Care Planning?

Key Aspect of Care Management

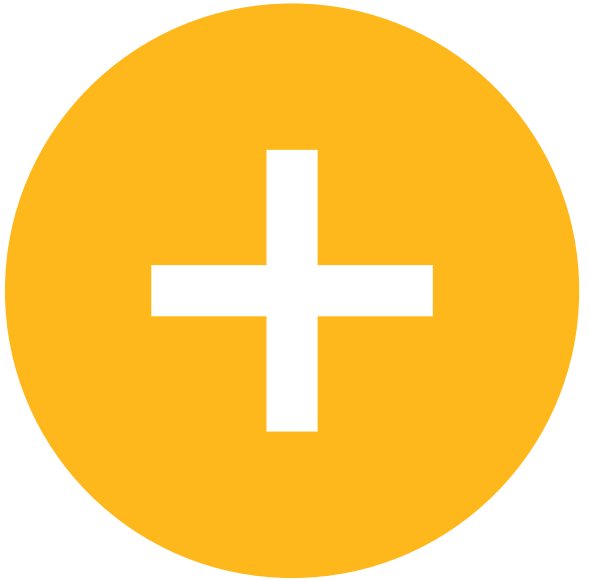
Care Plan Advantages/Outcomes

- Help improve performance in the areas of client and family teaching, coordination of services, collaboration and communication, and discharge planning
- Cost effectiveness and reduction in lengths of stay
- Improved quality of care and client satisfaction
- Better allocation of resources and coordination of services
- Improved communication systems among various disciplines

(Tahan, 2002)

Benefits for Clients

- Learning a process for systematically setting goals
- Understanding how to achieve desired goals through the accomplishment of smaller objectives
- Gaining mastery of themselves and their environment through brainstorming ways around possible barriers to a particular goal or objective
- Experiencing the process of accessing and accepting assistance from others in goal setting and goal attainment



Care Planning and Care Plans

Distinction Between:

Care Planning

Care Plan

Defining Care Planning

Key Elements

- Anticipatory
- Defines Key Roles and Tasks
- Negotiating Agreements
- Supporting Clients
- Promote Care

(Burt et al.,2014)

Care Planning Includes:

- Identification and Discussion[1]
- Decision making[2]
- Location of services[1]
- Who will monitor progress[1]
- Coordination of services[1]

([1]CSAT, 2006; [2]Coulter et al., 2015)

Care Planning Considers the Following for Each Individual:

Needs

- Health, personal, social[1]
- Economic, educational, mental health[1]

Circumstance

- Ethnic and cultural background[1]
- Housing situation[2]
- Welfare benefits[1]
- Access to care[3]
- Stage of change[2]

([1]Ross et al.,2011;[2]Mancini, 2012;[3]CMSA, 2016)

Defining Shared Decision-Making

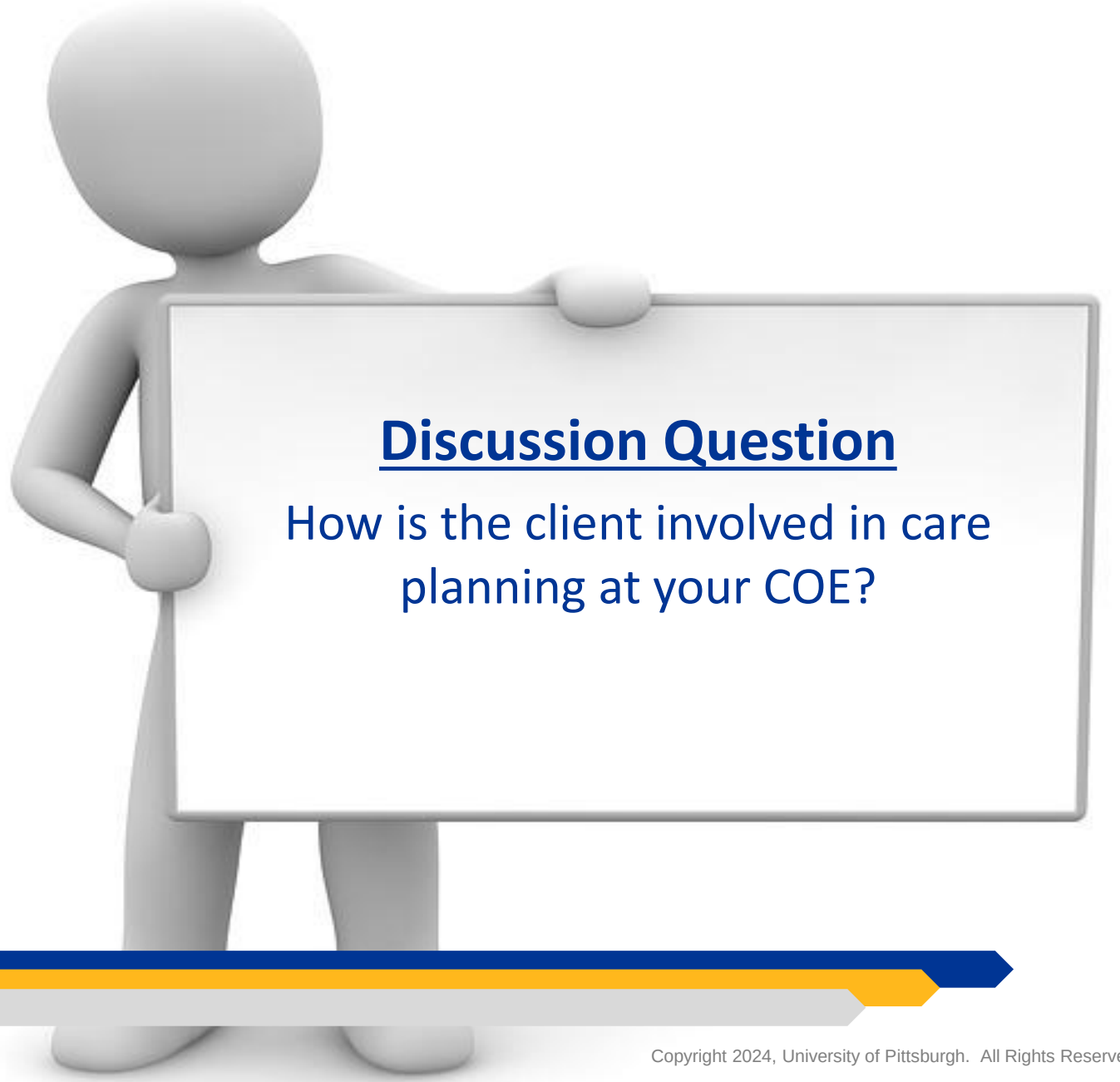
- Considers expertise of client and professional
- Increases motivation
- Shared understanding
- Preferred goals/outcomes
- Shared decisions/mutual agreement
- Shared responsibility

(Coulter et al., 2015)

Shared Decision-Making Techniques

- Motivational Interviewing[1]
- Encourage clients to share[1]
- Open-ended questions[2]
- Elicit client's goals[2]
- Clarify client's understanding[1]

([1]Coulter et al., 2015; [2]Theodorou et al., 2020)



Discussion Question

How is the client involved in care planning at your COE?

Positive Impact of Client Involvement in Care Planning

- Engaged client is more likely to manage their condition effectively[1]
- Strengthens relationship between clients and providers[2]
- Increased use of behavioral treatment, routine medical care, HIV tests, suicide prevention counseling[3]
- Improvements in self-confidence[4]
- Improving client engagement in effective substance use treatment services[3]
- Improvements in certain indicators of physical and psychological health status[4]
- Improved health and better quality of life[4]

([1]Rossr et al., 2011; [2]AHRQ, nd; [3]Park et al.,2020;[4]Coulter et al., 2015)

Review and Inclusion of Formal Assessments

- Social Determinants of Health
- ASAM
- Suicide screening
- BARC-10

Care Plans

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Defining Care Plans

- Plan of care is a structured, dynamic tool used to document the opportunities, interventions, and expected goals[1]
- A care plan is a patient-centered health document designed to facilitate communication among members of the care team and with the client[2]

([1]CMSA, 2016; [2]AHRQ, nd)

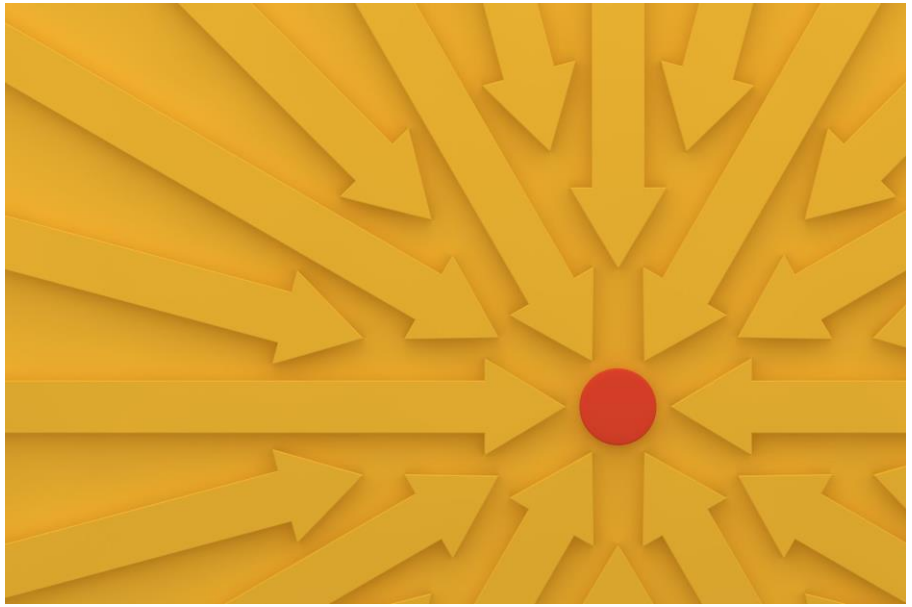
Care Plan Purposes

- Identifies goals in all relevant life domains, using the strengths, needs, and wants articulated in the assessment process[1]
- Identify jointly agreed upon goals and actions for managing the client's health problems[2]
- Identify care needs, barriers and opportunities for collaboration with client, family, and members of care team[3]
- Outline prioritized goals and outcomes to be achieved and interventions needed to reach the goals[3]

[1]SAMHSA, 2015; [2]Coulter et al.,2015' [3]CMSA,2015)

Care Plan Purposes continued

- Aims to provide support from health professionals[1]
- Enables the care manager to make referrals, coordinate the services, ensure that referrals have been acted on, monitor the individual's progress[2]
- Highlight the modifiable aspects of a client's unique psychosocial context, providing a road map to better health[3]



[1]Coulter et al., 2015; [2]Ross et al.,2011' [3]Theodorou et al., 2020)

Care Plan Guidance from DHS

- A client's treatment and non-treatment needs
- A client's phase of recovery
- Recovery specific needs and goals
- A client's strengths
- Documentation that the client agrees with the goals and participated in the development of the plan
- Signatures from the community-based care management team

Care Plan Key Elements

Individualized

Client Involvement

Strength-Based

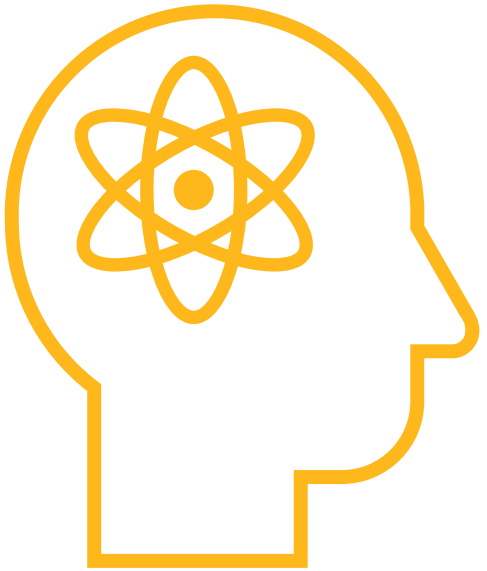
Care Plan Considerations

- Examination of community resources to determine what forms of assistance are available and how case management efforts can help clients attain necessary assistance[1]
- Plans are most useful when they are structured around the aspirations and long-term goals of clients and also meet their immediate needs[2]
- Represent a timeline of client care activities based on the services provided including well-defined milestones[3]

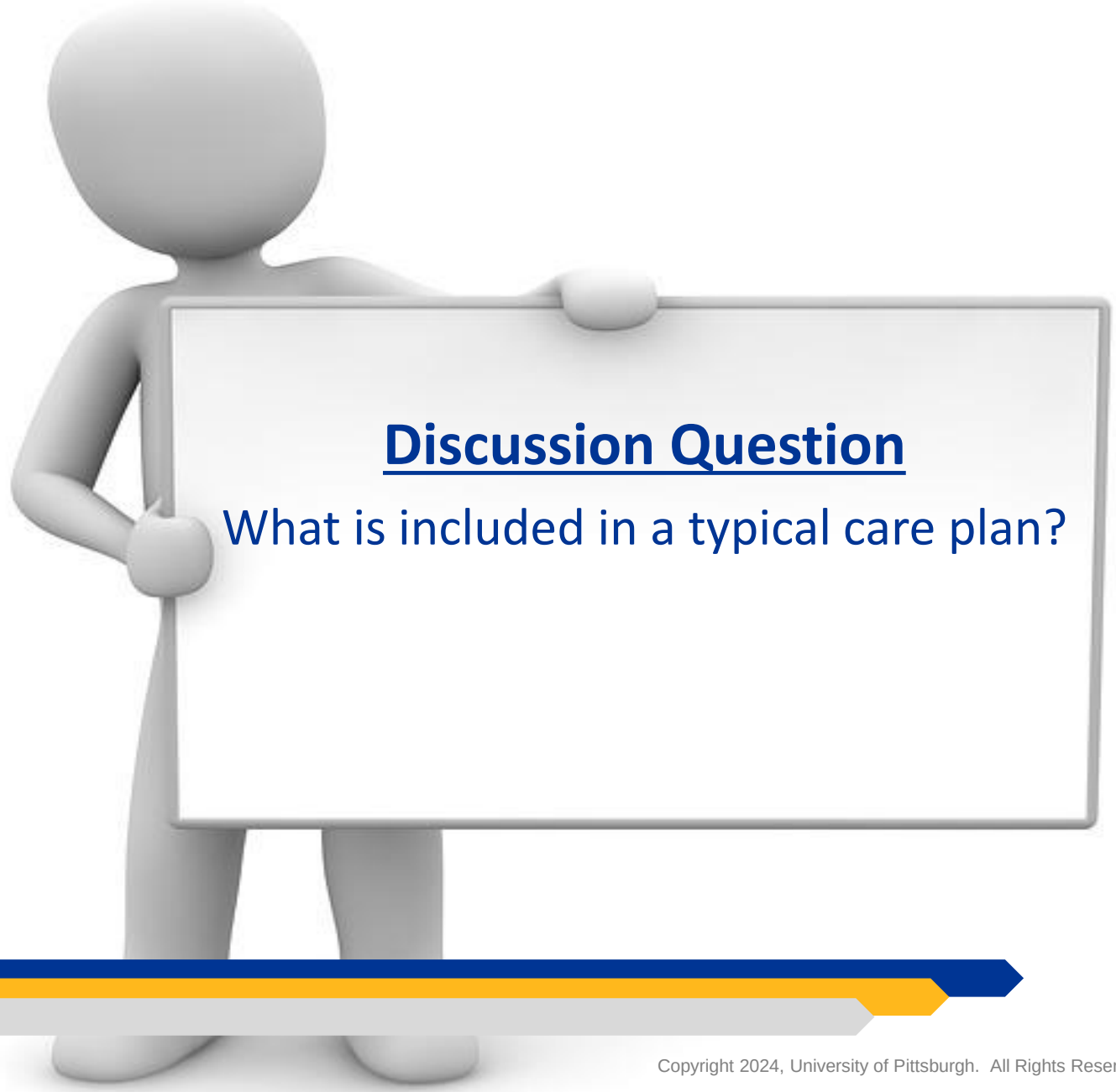
[1]SAMHSA, 2015; [2]Mancini,2012' [3]Tahan, 2002)

Care Plan Considerations continued

- Importance of providing client's a sense of control or empowerment that provides them the confidence and motivation to take on and persist with new and difficult tasks
- Focus on confidence building and equipping individuals with the knowledge and skills to set personal goals and develop effective problem-solving



(Coulter et al., 2015)



Discussion Question

What is included in a typical care plan?

Care Plan Inclusions

A range of care management and support needs:

- Clinical tests and treatments
- Self-management information
- Education or support
- Strategies for modifying behaviors, stress, or solving practical problems
- Referring to external sources of support

(Coulter et al., 2015)

Care Plan Components

- Goals
- Objectives
- Interventions

Goals

	Attribute	Content
S	Specific	What exactly is to be accomplished?
M	Measurable	How can the extent to which the goal has been met be known? How will it be demonstrated and clear to anyone who review the goal of how it would be determined if the goal were met?
A	Attainable	It's realistic for the client to achieve the goal. Its reasonable to expect them to achieve the goal in the amount of time determined.
R	Relevant	Related to the purpose of services and the client's needs/interests.
T	Timely	Identify the timeline for the goal to be accomplished. A specific date should be used, not vague references to time, such as "soon" or "in the future".

(SAMHSA, nd)

Examples of Goals

1. Within the next 3 months, improve my ability to manage cravings and reduce opioid use through personalized coping strategies as evidenced by daily self-report.
2. Within the next 3 months, build my support system and decrease isolation by connecting with family, friends, community resources and support groups tailored to recovery needs.

Objectives

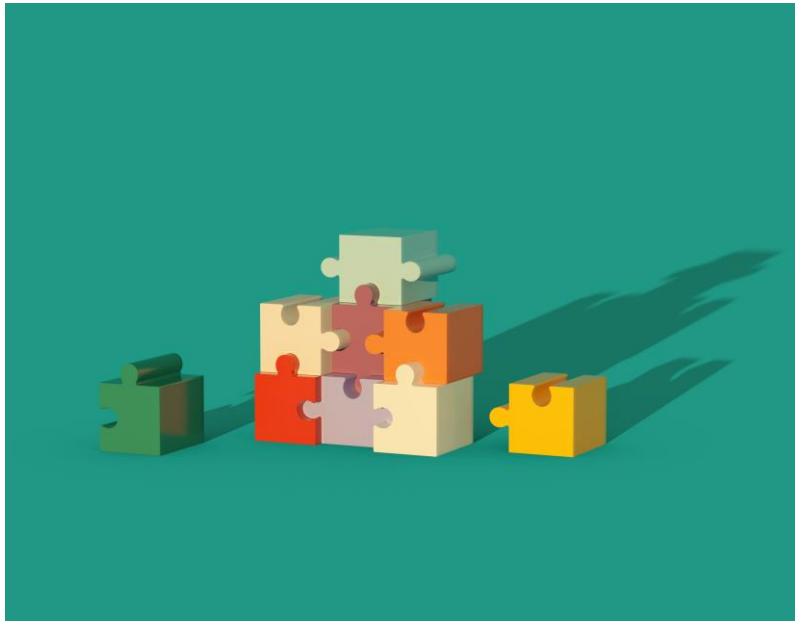
- Identify the outcome indicators[1]
- Are distinct and manageable to help keep clients from feeling overwhelmed and provide a benchmark against which to measure progress[2]
- Are framed in a positive context[2]
- Include time frames[2]

[1]Tahan, 2002; [2]SAMHSA,2015)

Outlining Objectives

Treatments and Supports:

- MOUD
- Counseling for substance use disorder
- CRS support
- Community-based recovery
- Other medical care
- Skill development



Examples of Objectives

Goal 1: Within the next 3 months, improve my ability to manage cravings and reduce opioid use through personalized coping strategies as evidenced by daily self-report.		
Objective 1: Develop a relapse prevention plan with clear strategies and steps to take when facing high-risk situations or triggers (within 1 month)	Objective 2: Find a method that works for me to track cravings and coping strategies (within 2 weeks)	Objective 3: Track cravings and coping strategies 5 out of 7 days per week for the next 2 months

Examples of Objectives

Goal 2: Within the next 3 months, build my support system and decrease isolation by connecting with family, friends, community resources and support groups tailored to recovery needs.	
Objective 1: Within the next month, identify and reach out to 2 family members or friends	Objective 2: Within the next month, identify and attend 3 mutual aid support groups per week

Interventions

- The strategy/action items that will be taken by staff to assist the client in achieving objectives toward overall goal completion[1]
- Clearly delineate the responsibilities of various team members[2]

[1]DHS, 2021; [2]Tahan, 2002)

Sample Interventions for Goal 1

Objective 1: Develop a relapse prevention plan with clear strategies and steps to take when facing high-risk situations or triggers (within 1 month)	• CRS will provide a relapse prevention plan template and coach client on completing it
Objective 2: Find a method that works for me to track cravings and coping strategies (within 2 weeks)	• Care manager will provide and review options of tracking cravings and coping strategies • CRS will review pros and cons of methods
Objective 3: Track cravings and coping strategies 5 out of 7 days per week for the next 2 months	• Care manager and/or CRS will check-in with the client weekly to remind them to track • CRS will discuss coping strategies with client and identify which are most effective

Care Plan Best Practices

- Identify and incorporate client strengths[1]
- Focus on achievable goals[2]
- Considering stage of change[1]
- Include client's family[3]

[1]CSAT, 2006; [2]DHS,2021' [3]CMSA, 2016)

Care Plan Logistics

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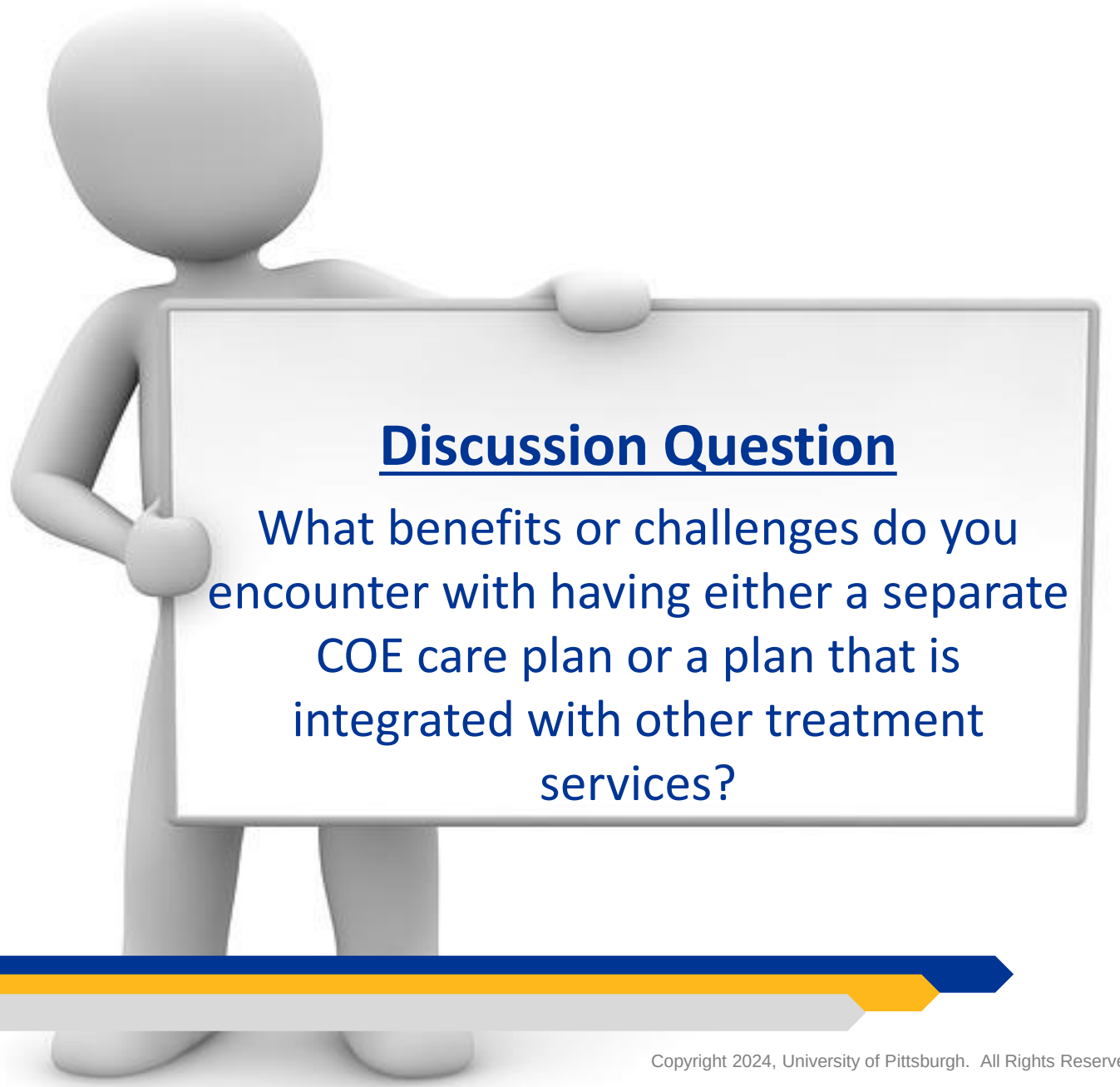
Zoom Poll

Is your care plan part of a larger organization plan? (yes, no)



Discussion Question

What benefits or challenges do you encounter with having either a separate COE care plan or a plan that is integrated with other treatment services?

Zoom Poll

Who completes the COE care plan? (select each person)

COE Team Roll Discussion

- How do you determine who completes the plan?
- Are all team members involved in care plan development?
- Who signs the care plan?

Team Involvement in Care Plan

- Consider clients' unique needs and situation when identifying a care team
- When taking a team-based approach to care, COEs need to be thoughtful and explicit in developing care teams and assigning roles
- One or more members of the team should become skilled at introducing the process of developing goals and creating the plan

(AHRQ, nd)

Types of COE Care Plans

Rapid

- Client engagement
- Highest indicated needs

Extended

- Treatment and non-treatment needs
- Client strengths
- Recovery specific needs and goals

Timing of Care Plans

Rapid Care Plan-develop within 24 hours

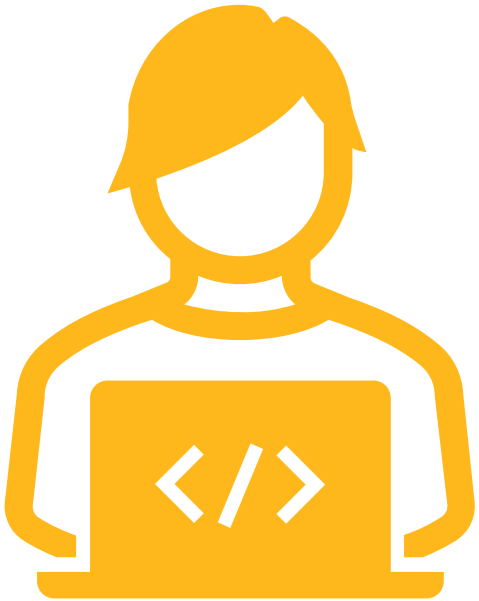
Extended Care Plan-develop by the end of the second month

Care Plan Access Considerations

Where is the care plan stored?

Who needs access?

- Internal (care manager, CRS, nurse, MOUD prescriber, therapist)
- External (family, therapist or CRS from another organization)



Access and Sharing of the Care Plan

- Rather than relying on separate medical and behavioral health care treatment plans, a shared plan of care will help encourage a team-based approach[1]
- It is important that plans are documented via a standardized record and shared with physicians[2]
- Every professional who is part of the client's care should be familiar with the client's care plan[1]
- All care team members should refer to the care plan when managing and treating clients and record any changes in treatment or client's status[1]

([1]AHRQ, nd; [2]Theodorou, 2020)

Ongoing Use and Updating of the Care Plan

Implementation of the Care Plan

Plan of care is put into action by facilitating:

- Coordination of care
- Providing interventions and/or services
- Sharing resources and making referrals
- Offering support
- Providing health education

(CMSA, 2016)

Care Plans and Encounter/Progress Notes

- Each COE community-based care management team member's notes should tie to the care plan
- Identify for each appointment:
  - Goal and/or objective being worked on
  - Interventions provided
  - Client's progress on the goal and/or objective
  - Plan for the next session

Discussion Questions

- How frequently do you make care plan updates?
- Is it based on a specific time frame or individualized based on client need?

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Care Plan as a Live Document

- Continually review client's health and non-health needs[1]
- Updated at any time[2]
- Care planning is ongoing[1]

([1]Ross et al., 2011; [2]Theodorou, 2020)

Effective Monitoring Activities

- Awareness of changes in the client's condition
- Assessing client's progress
- Evaluating if goals/objectives/interventions remain appropriate, relevant, and realistic
- Awareness of changes in client's preferences
- Knowledge of transitions across settings and/or providers
- Identify barriers to care and services
- Determine if revisions or modifications are needed

([1]CMSAl., 2016)

Role of Team, Client, Family in Ongoing Monitoring

- Ongoing participation of multiple members of the care team is needed [1]
- Ongoing follow-up with the client and family[2]

([1]AHRQ., nd; [2]CMSA, 2016)

Key Takeaways

Care Planning Key Takeaways

- It is an essential piece of care management
- Shared decision-making is critical
- Appropriate team members should be included

Care Plan Key Takeaways

- Care plans are individualized, and strength based
- Care plans need goals, objectives and interventions
- Care plans are living documents and need monitored and altered

Questions

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