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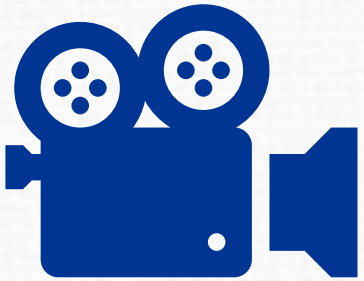

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Acknowledgements

- The COE project is a partnership of the University of Pittsburgh's Implementation and Research Center for Healthy Communities 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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Care Planning II

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Learning Objectives

By the end of this training, you will be able to do the following:

- Apply shared decision-making techniques to prioritize client needs and translate them into actionable care plan components.
- Develop client-centered care plans that clearly link goals, objectives, and interventions to identified needs and recovery priorities.
- Integrate care plan activities into ongoing documentation and team-based care coordination to support engagement and retention.

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Care Plan Background

Defining Care Plans

A care plan 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 Guidance in the State Plan

Individualized care plan that includes at a minimum:

- A client's treatment and non-treatment needs
- Client's preferred method of care management
- Identifies the client's community-based care management team members and support system

COE Fidelity Guidelines

- Were **released** by the Department of Human Services (DHS) on August 1, 2025

- Your COE will **communicate** with you about the details of these guidelines

Care Plan Guidance in the Fidelity Guidelines

- A client's **phase of recovery**
- **Recovery-specific** needs and goals
- Incorporate 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

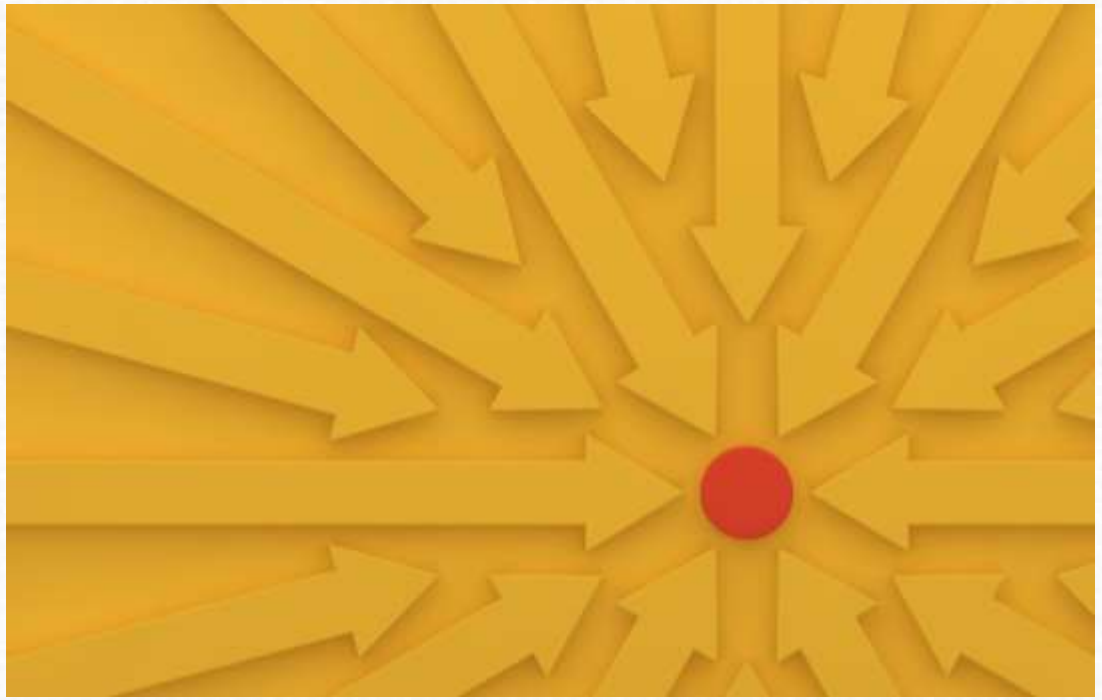
Care Plan Purposes

- Identify **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 them.[3]

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

Care Plan Purposes (cont.)

- **Aim** to document the support provided from health professionals.[1]
- **Enable** the care manager to make **referrals**, coordinate the services, ensure that referrals have been acted on, and 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 Key Elements

- Individualized
- Client Involvement
- Strength-Based

Care Plan Considerations

Examine community resources to determine **what forms of assistance are available** and how case management efforts can help clients attain necessary assistance.[1]

Structure plans around the **aspirations** and **long-term goals** of clients and meet their immediate needs.[2]

Include 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)

Additional Care Plan Considerations

- Provide and support a client's a sense of control 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)

Jordan

Jordan is a 29-year-old client newly enrolled in the COE after a recent **non-fatal overdose**. They are not currently on MOUD and say they're 'open to hearing about it but not sure yet.' Jordan has been staying with different friends for the past month and has **no stable place to live**. They also report **daily anxiety** and **trouble sleeping**, especially when thinking about returning to work. Jordan's biggest long-term goal is to '**get my life steady so I can be there for my 6-year-old again**' and to restart regular visits with their child, who currently lives with a relative. Jordan wants help, but says they feel overwhelmed and embarrassed asking for too much at once.

Shared Decision Making

- Clients and providers collaborate on decisions.
- Priorities reflect what feels pressing to the client right now.
- Goals focus on achievable next steps.
- Client autonomy is emphasized.

(Coulter et al., 2015)

Translation to Care Plan

- Goal
- Needs Identified
- Objectives
- COE Care Manager/CRS Interventions

Translation to Care Plan

Goal

- "Stay off opioids and keep my job."

Needs Identified

- Medication for OUD
- Support with depression
- Harm reduction education
- Employment stability

Objectives

- Decide on and initiate MAT within 14 days.
- Engage with behavioral health provider for mood management.
- Develop relapse prevention plan.
- Obtain naloxone and overdose education.

COE Care Manager Interventions

Provide education on treatment options (Buprenorphine vs. Methadone).

- Coordinate intake with chosen MAT provider.
- Facilitate warm handoff to behavioral health.
- Provide naloxone and overdose prevention education.
- Conduct weekly follow-up for 30 days to support engagement.

Ranking Poll

Rank the following from most to least urgent:

A. Housing
B. MOUD
C. Visitation with child
D. Anxiety/mental health

From Conversation to Care Plan

- Care planning is guided by priorities identified by the client.
- The care plan reflects a shared decision-making process between the client and care team.
- Immediate, achievable steps support progress toward long-term recovery goals.

Deciding on Care Plan Goals, Objectives, Interventions

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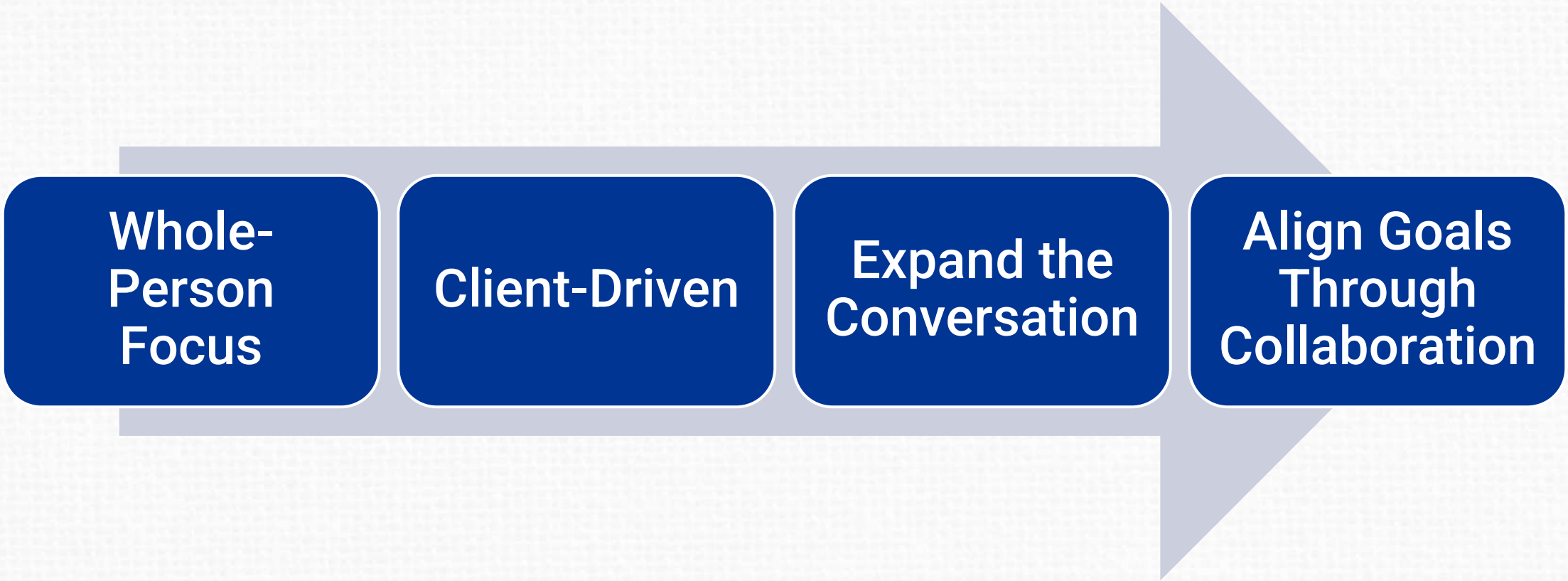
Begin Broadly



Translate Barriers into Goals

- Identify barriers that may be getting in the way of the client's goals
- Recognize how barriers impact motivation, energy, and follow-through
- Explore triggers, patterns, and past situations that led to setbacks
- Keep the focus on progress and possibility rather than problems

(Stanhope et al., 2021)

Look Beyond Clinical Needs

- Consider supports like relationships, community connection, and natural supports
- Identify factors that promote stability and a sense of connection
- Include life skills that support independence and daily functioning
- Be aware of needs that may not be immediately identified

(Stanhope et al., 2021

Focus on Long Term Engagement

- Identify motivation, past success, and what feels manageable
- Anticipate and plan for barriers to engagement
- Align the plan with the client's chosen recovery pathway
- Ensure goals reflect what the client values

(Stanhope et al., 2021

Making the Care Plan Actionable

- Break life goals into realistic, measurable objectives
- Define clear, actionable steps
- Identify care team interventions to support progress
- Clarify roles for both client and team
- Turn the plan into something concrete and trackable

(Stanhope et al., 2021

Ongoing Care Planning

- Early plans reflect only part of the story
- Needs and goals evolve as trust builds
- Update plans based on changes in client situation or progress
- Treat the care plan as a living, evolving document

(Stanhope et al., 2021

Discussion Question

Are there client goals that are difficult to translate to a care plan?

Care Plan Document

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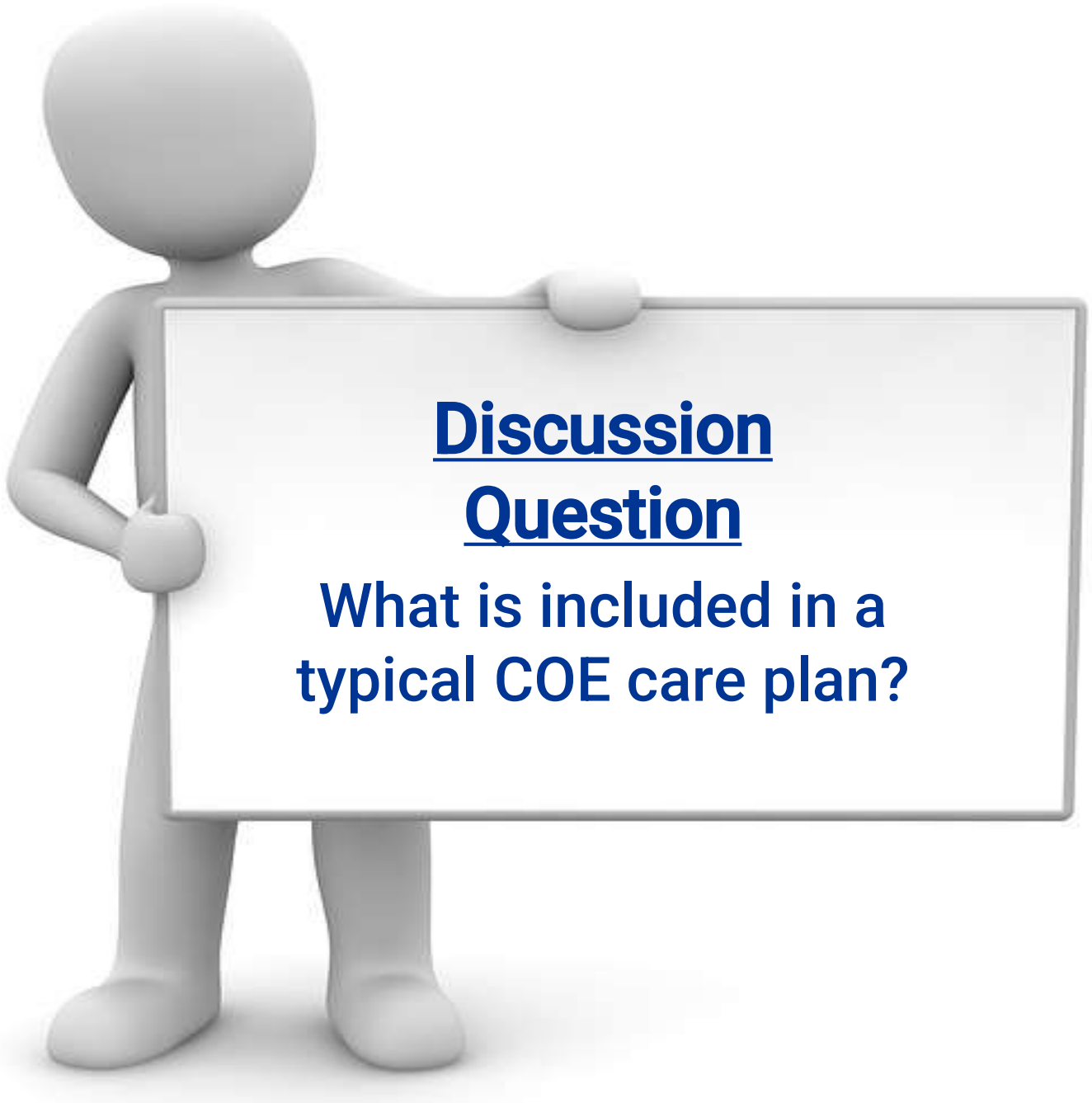
Discussion
Question
What is included in a
typical COE care plan?

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

(CMSA, 2016)

SMART 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, 2015)

Examples of SMART Goals

1. Within the next 3 months, develop and implement 3 personalized coping strategies to manage cravings and reduce opioid use. Track daily progress through self-reports to assess effectiveness.

2. Within the next 3 months, connect weekly with 2 family members or friends and attend 1 support group to build my support system and decrease isolation.

(SAMHSA, 2015)

Objectives

Identify the outcome **indicators**[1]

Distinct and manageable to help keep clients from feeling overwhelmed and provide a **benchmark** against which to measure progress[2]

Framed in a positive context[2]

Include **time frames**[2]

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

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Outlining Objectives

MOUD	Attend appointment every other week for 3 months	
Counseling	Group counseling 2x per month for next three months	
CRS	Meet with CRS 2x per month as scheduled	Reach out to CRS when feeling triggered to use substances
Community Based Recovery	Attend NA 3x per week for 3 months	Talk to 1 new potential sponsor per week until they find one
Medical	Test blood sugar 3 times a day for 3 months	
Skill Development	Work with X to develop a budget by next month	

Examples of Objectives

Goal 1: Within the next 3 months, develop and implement 3 personalized coping strategies to manage cravings and reduce opioid use. Track daily progress through self-reports to assess effectiveness.		
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

Goal 2: Within the next 3 months, connect weekly with 2 family members or friends and attend 1 support group to build my support system and decrease isolation.

Objective 1: Within the next month, identify and reach out to 2 family members or friends each week	**Objective 2**: Within the next month, identify and attend 1 mutual aid support group per week

Interventions

- **Strategy or 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)

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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 completion.
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

Zoom Poll

Is your COE care plan a part of a larger agency care 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 Role Discussion

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

Client Permission for Sharing of the Care Plan

- **Standard** practice
- Education related to **what and how** information will be shared:
  - Internally
  - Externally
- **Written** agreement

Types of COE Care Plans

Rapid

- Client **engagement**
- **Highest** indicated needs
- Develop within **24 hours**

Extended

- Treatment and non-treatment **needs**
- Client **strengths**
- **Recovery specific** needs and goals
- 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 are **familiar** with the client's care plan[1]
- All care team members 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)

Care Plans and Progress Notes

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Care Plans and Encounter/Progress Notes

- Each COE community-based care management team member's **notes 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
  - Address acute stressors promptly

Good/Bad Notes Exercise

- Update “In progress”

Ongoing Use and Updating of the Care Plan

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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)

Discussion Questions

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

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)

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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

(CMSA, 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]

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

Care Plan Key Takeaways (cont.)

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

Wrap up and Next Session

- Please complete the **session evaluation**
- Slides and recording available on Tomorrow's Healthcare

- **Next Session:**

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