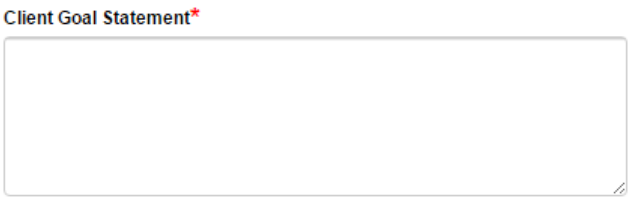
Plan of Care Tips and Tricks

Writing a Goal Statement:

Goal Statement should be broad, person-centered, future focused, written in positive terms and articulate an overall issue/achievement or outcome the child/family wishes to achieve as a result of being in the program. Goals are a desired result, behavior or condition which shows progress, and should be understandable and inspirational to the child/youth/family. In Netsmart, the child/family will develop a ***single, overarching goal*.**

Questions to ask the youth/family:

- What is most important to you?
- What do you want to change?
- What do you want to gain from this program?
- If things in the future are much better for you, what would be different?



Examples of Goal Statements:

- "Robert wants to feel better"
- "Sally wants to get her life back on track"
- "I just want everyone to get along"
- "We would like to be a happy family"

Strengths and Preferences:

Strengths should be listed as identified in the CANS-NY related to services and treatment, well-being and recovery. Strengths should identify the internal and external resources and attributes the youth **and caregiver** brings to the table. A good strengths & preferences inventory is personal to the youth/family and includes such things as skills, opportunities, motivations, abilities, values, motivational factors, resources, relationships and preferences to be mindful of. In addition to the CANS-NY, review the summary pages on the comprehensive assessment where strengths related to achieving desired outcomes for their physical, behavioral and social health needs have been identified!

Questions to ask the youth/family:

- What are you good at? What are some of your accomplishments?

Source:
Adams, N., & Grieder, D. (2005). Treatment Planning for Person-centered Care: The Road to Mental Health and Addiction Recovery: Mapping the Journey for Individuals, Families and Providers. Academic Press.

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- What has worked for you in the past?
- Who supports you?
- What do you enjoy doing?
- How would your best friend describe you?

Example of some Client Strengths and Preferences:

- Committed and concerned family – she has a good relationship with mother and grandmother and feels comfortable and happy spending time with them
- She is involved in faith community – she has sung in the choir before and has a good relationship with Pastor Johnny
- He is currently attending school every day and says he does enjoy school
- She has a good relationship with her guidance counselor
- She likes her mental health therapist, Dr. Bird, and her pediatrician Dr. Jones
- Michelle, Brian's mom, has reliable transportation and has a good network of neighbors who are willing to assist with babysitting and transportation if needed
- Mary prefers that the Care Manager text her to set up meetings
- Bill prefers going to male doctors

Barriers:

Barriers should identify what stands between the individual/family and their goals for the future. Barriers may lead to risks if they aren't addressed. They should include such things as personal needs, environmental factors, family issues and resource needs.

Barriers should be listed as identified in the CANS-NY related to services and treatment, well-being and recovery as agreed upon by the child/youth/family. Review the summary pages on the comprehensive assessment where barriers to achieving desired outcomes for their physical, behavioral and social health needs have been identified!

Questions to ask the youth/family:

- What is getting in the way of achieving your goal?
- What keeps you from doing _____ tomorrow?

In addition:

- Review items that come back as "2" or "3" on the CANS, that may impede youth/family's progress towards achieving the goal

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- Review these with the child/youth/family. What are some barriers identified that they are ready and willing to address on this plan of care? Are there any that can wait until the next plan? Document these discussions in the member's chart!
- Not everything listed as a "2" or "3" on the CANS needs to be entered in as problems/barriers at this time! You'll need to brainstorm with the family what are problems that need to be addressed through their own objective/interventions on the plan of care vs. what are "barriers" to them achieving their goal
    - For example: If a child enrolled under complex trauma, their CANS output will probably show findings in the trauma symptoms category. If their trauma and associated symptoms are being addressed in the care plan already through objective & intervention(s) linked to the problem identified on their eligibility screen, we wouldn't expect that a separate problem for the identified trauma symptom(s) be added since it's already being addressed unless needed.
    - For example: perhaps there is a finding on the CANS section D #51 school achievement. If the child has a 3 here that means they have a severe school achievement problem. A problem that they're addressing on their care plan could be "Deterioration in school performance". In addition, there is a Sleep disturbance finding on the CANS. This could be a barrier to the child being able to excel in school (perhaps the child is having difficulty getting to bed on time and staying asleep, so they struggle to get up in the morning and stay awake in class) and therefore the barrier surrounding sleep could be addressed in the interventions associated with the school achievement problem.

- Review appropriateness criteria for eligibility
    - Does the member's eligibility screen indicate that they are not linked to a provider and that's part of the reason why they're appropriate for services? A potential barrier to them achieving their desired outcome is that they aren't engaged in routine preventive care. So "Lily isn't connected to a primary care physician" is reflected in your assessments of Lily and is a barrier that you will address within the plan of care.

Examples of some Barriers:

- Since her friend passed away, Lashonda has stopped socializing with anyone at school and often sits in the library by herself during lunch break. She reports being afraid to go outside and be involved in community activities
- She's reported having trouble concentrating during school the past 6 months and has been falling asleep during class because she's not sleeping well at night
- She has not seen her pediatrician, Dr. Jones, in 6 months and says she is forgetting to take her asthma medication as prescribed

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- Difficulty attending Mental Health appointments – Mom (Michelle) doesn't have reliable transportation to appointments and neither of them like taking the bus

History and Risk Factors:

The child/youth's History and Risk Factors as identified in the CANS-NY related to services and treatment, well-being and recovery should be listed.

History should include Past events, and circumstances experienced by youth and/ family that contributed to the need for services.

- Review items in the CANS-NY, that are identified as a "1"

Risk Factors should include the child and/ or family's attributes, and or exposure that could increase the likelihood of them not achieving their desired outcomes without the support of interventions.

- Review appropriateness criteria for eligibility as it relates to the different CANS-NY domains.

Example of History and Risk Factors:

- Mary went to the emergency room twice within the past twelve months due to asthma attacks
- Mary witnesses a friend's murder in her neighborhood six months ago
- Over the past 6 months, Lashonda has suffered from frequent nightmares and consistently loses sleep. She has trouble concentrating class and will often fall asleep which is putting her at risk for failing two classes
- Carl has been diagnosed with asthma since childhood, and he has started smoking up to one pack a day of cigarettes within the past 6 months

Objectives:

Objectives should be milestones along the route toward reaching the goal and reflect the removal/diminishment of barriers. Objectives are much more focused than goals. They are short term, specific outcomes that relate to the person's overall goal. Objectives should be able to answer: "what will the client (not the members of the care team) be able to do or achieve as a result of the identified interventions?"

- Ex: "Mary will [.....]"

To brainstorm objectives, think about asking the member/family:

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- With supports in place, what would you like to be able to do or achieve in regards to your physical health? Your behavioral health? Your social health needs?
- How will he/she know when they've will achieve it?
- When can he/she achieve it by?

Using the comprehensive assessment, CANS-NY and discussions with the member/family, you can help them identify a desired outcome the member wants to achieve in regards to their conditions.

A commonly used prompt says objectives should be **S.M.A.R.T**- Specific/ Simple, Measurable, Attainable, Realistic and Time-Framed.

Objectives indicate the desired, positive result of change in status, abilities, skills or behaviors. Objectives will be linked to problems and are associated to different care plan components in Netsmart CareManager.

- For example, if a member has diabetes and asthma diagnoses they want help with, both of these will be entered in as problems with statuses that indicate the member wants assistance. Both of these are physical health diagnoses and must be linked to the "physical health" category on the plan. You will need to link each problem to an objective. With the family, you can create an objective for the child to achieve that addresses both the asthma and diabetes diagnoses or create an objective (outcome) for each diagnosis separately.
    - Ex: Let's say the member really wants to lose weight, which will help him better control his asthma symptoms *and* manage their diabetes. An outcome statement (objective) that addresses the activities and services put in place to manage their diabetes and asthma could be: "Within the next six months, Gary will achieve a BMI between 25 and 27". This is specific, measurable (we know when he will achieve it), realistic and achievable (based on his current situation) and time framed (this will be achieved within 6 months). This could be inspiring to him to achieve and be in alignment with his overall goal of "I want to feel better and have more energy". By outlining the interventions underneath this objective (exercising, following a nutrition plan, engaging in treatment for asthma and diabetes from his providers, etc.) achieving this outcome could positively affect his asthma and diabetes management.

Examples of Objectives

- By May 2018, Drew will earn passing grades and finish the eighth grade
- Within the next four months, Carrie will be living in a one-bedroom apartment a neighborhood she feels safe in
- Robert will make a new friend within the next three months

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- Sally will better control her asthma symptoms as evidenced by successfully running a half marathon by January 2019
- Joe will engage in at least one conversation with his Care Manager about his alcohol use and its effect on his life within the next six months
- Within the next three months, Alan will be able to identify all of his prescribed medications and explain why he takes them

Interventions:

Interventions are activities, steps, actions, supports and services provided by the members of the care team including the care manager, providers, social supports, community supports and sometimes the person themselves. The interventions will assist the client/family to achieve their goal and objectives.

Interventions should indicate the role of the provider and agency organization providing the service, what they will do, when they'll be doing it, where and how often. Interventions should reflect the Core Care Management Services provided by the Care Manager as well as services provided by other members of the Care Team. The notes will identify the specific person working with the member for the intervention.

- Describe the modality or type of service or activity
- Identify who is responsible for the activity by role, function, discipline AND organization
- Specify the frequency, intensity and duration
- Specify the location when appropriate/known
- State the purpose, intent or impact

Examples of Interventions:

- Guidance counselor at ABC Academy will arrange tutoring for Drew in math, two days a week for the next 3 months
- Primary care physician at Jones Family Medicine will meet monthly with Robert and his mother to discuss on-going treatment for Robert's diabetes
- Mental health therapist at ABC Office will meet with Sally and her family bi-weekly to support the family in repairing and rebuilding relationships, for the next six months
- Care Manager will contact ABC Foundation to see if they have furniture and household supplies available for donation

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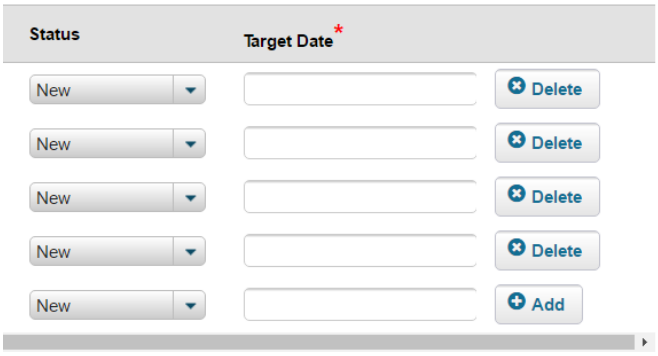
Target Dates:

Target dates in Netsmart CareManager are tied to the interventions. The must initially be entered in on the Plan of Care and can be updated/changed through CareManager Notes.



- Target dates should NOT all be set to six months to a year out. They should instead be an accurate reflection of when you hope to have the intervention completed or the span of time it will cover.
- Target dates should give direction of what you are doing when and in what order. They should identify the progression of work the team will be doing.

Tips to Remember:

- A Plan of Care that does not show steps towards resolution or completion of interventions and objectives should be reevaluated for its success at capturing the member's treatment and service choices along with the level of care needed. The goal and objectives should be reevaluated to ensure they are motivating to the member/family.
- A Plan of Care should be reviewed, at minimum, every six months
- All members of the member's care team should be involved in the creation of the Plan of Care and they should all receive a copy of the completed Plan of Care if they are involved
- Use "initial Plan" for the member's first plan of care, and "New Plan Amendment" when creating subsequent Plans of Care for each member

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