

# Uniform Assessment to Recovery Planning and Care Coordination: Part 2

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Texas Health and Human Services  
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## Overview

- Objectives
- Treatment Recovery Planning
- Treatment Planning
- Planning and Care Coordination
- Care Coordination
- Group Brainstorming
- Importance
- Summary

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## Objectives

This session will discuss:

- Care coordination and care planning, focusing on timely and effective processes to avoid unnecessary delays or care duplication; and
- Care coordination as an activity to help people move from one healthcare system or setting to another smoothly and effectively without delays or care duplication.

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### Treatment Recovery Planning

"A process used to specify, to the greatest extent possible, the application of available treatment resources to meet mutually agreed on individual goals and needs."

Nora E. Noel, (2009). Evidence-Based Treatment Planning for Substance Abuse Therapy. In Peter M. Millerin (Ed.) Evidence-Based Addiction Treatment (pp. 401-416) Elsevier Inc. [http://books.google.com/books?id=9280123743480/Sample\\_Chapters/01-Front\\_Matter.pdf](http://books.google.com/books?id=9280123743480/Sample_Chapters/01-Front_Matter.pdf)

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### Treatment Planning (1 of 3)

Texas Administrative Code (TAC) definition:

- "A collaborative process through which the provider and the person receiving services develop desired treatment outcomes and identify the strategies for achieving them
- At minimum, the plan addresses the identified:
  - ▶ Substance use and mental health disorder(s)
  - ▶ Issues related to treatment progress including relationship, employment, education, spirituality, health concerns, and legal needs"

25 TAC Section 441.101  
26 TAC Section 306.19

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### Treatment Planning (2 of 3)

Treatment plans are developed from the assessments.

- The assessments identify:
  - ▶ Presenting issues
  - ▶ Historical experiences
  - ▶ Past efforts
  - ▶ Supports in place and needed
- The treatment plan recognizes:
  - ▶ Area(s) of concern
  - ▶ Goals or objectives agreed upon
  - ▶ Intervention(s) or methods to be used
  - ▶ Agreement on how change will be measured and recognized

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### Treatment Planning (3 of 3)

Insufficient comprehensive treatment planning after an assessment can interrupt:

- The achievement of desired outcomes;
- The person's care coordination between one caregiver and another; and
- Transition communications between the person and the caregiver, including between one care system and another.

CMS Health Services Advisory Group. (2019). Care Coordination Best-Practice toolkit. <https://www.hsag.com/globalassets/care-coordination/care-coord-toolkit-071319final508.pdf>.

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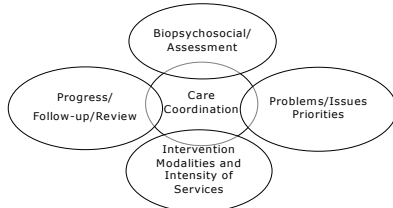
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### Planning and Care Coordination

Aligning resources to identified needs:



Van Hoult, S., Heyman, J., Vanhaecht, K., Sermeus, W., & De Lepelere, J. (2013). An in-depth analysis of theoretical frameworks for the study of care coordination. International journal of integrated care, 13, e024. <https://doi.org/10.5334/ijic-1068>.

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### Care Coordination

Care coordination is:

- An activity, rather than a service; and
- An agreement across services and providers (e.g., Federally Qualified Health Centers, inpatient and acute care), defining accountable treatment teams, health information technology, and care transitions.

Health and Human Services Commission-Substance Use Disorder Program Guide-Definitions

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**Brainstorming Activity  
(1 of 4)**

Required activities in the substance use and mental health service delivery system for care coordination:

- Substance use disorder activities are in Clinical Management for Behavioral Health Services
- Mental health level of care authorizations:
  - ▶ Identify needs
  - ▶ Needs outside the authorization necessitate care coordination

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**Brainstorming Activity  
(2 of 4)**

How are the four elements of purpose-to-practice operationalized:

- Principles or the things participants must do or not do to keep purpose?
- Participants in collaboration is needed to achieve the purpose.
- Structure is needed to practice.
- Practices, activities, and actions supporting the purpose?

Liberating Structures Including and Unleashing Everyone. (2014, February 19). Purpose to Practice. Retrieved June 30, 2023, from <https://www.liberatingstructures.com/33-purpose-to-practice-p2p/>

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**Brainstorming Activity  
(3 of 4)**

In your experience working across systems of care:

- Where are the stuck points with the initiation of care coordination based on assessment and treatment planning processes?
- What opportunities do you see for making progress?
- How would you handle the situation?
- What ideas or actions do you recommend?

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### Brainstorming Activity (4 of 4)

Identifying barriers to initiate care coordination:

- Why is care coordination important to you and the larger community?
- How did you identify the purpose of care coordination?
- Did community stakeholders within a continuum of care contribute to the concept?

<https://www.liberatingstructures.com/33-purpose-to-practice-p2p/>

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### Importance

Why is care coordination important to the community?

- Purpose: What does care coordination provide?
- Principle: What rules must a provider absolutely obey to succeed in implementing care coordination?
- Participants: Who can contribute to initiating care coordination and must be included?
- Structure: How can processes be organized and distributed to achieve the purposes of care coordination?
- Practice:
  - ▶ What does care coordination do?
  - ▶ What does care coordination offer to participants and how do T-CCBHCs do it?
  - ▶ What resources are needed?

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### Summary

Care coordination is an output of conducting uniform assessments and recovery planning:

- Healthcare providers work from a common knowledge base.
- Similar methodologies are applied during screening and assessment activities.
- Increasing compliant exchange of assessment and treatment plan information with community partners strengthens the continuum of care.
- Common processes strengthen a person's experience in recovery.

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**Questions**

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**Thank you**

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