Central Wisconsin Health Partnership (CWHP) Comprehensive Community Services (CCS)

Quality Progress Notes Using TARP

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- Why document?
- Introduction to TARP
- Elements of quality documentation

Before We Get Started

- Download the resources that accompany this video:
  - PowerPoint slides
  - TARP note
  - Service Array Summary
  - Quality Progress Notes Using TARP – Resource Packet

Why Document?

- Record of the service being provided
- Demonstrate progress, satisfaction, and general functioning
- Create alignment with services provided across agencies
- Medicaid requirements

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What Services Are We Documenting?

Screening and Assessment
Service Planning
Service Facilitation
Diagnostic Evaluations
Medication Management
Physical Health Monitoring
Peer Support (WI Certified Peer Specialist)
Individual Skill Development and Enhancement
Employment Related Skill Training
Individual and/or Family Psychoeducation
Wellness Management and Recovery Support Services
Psychotherapy
Substance Abuse Treatment

Services → Activities → Interventions

"Service" – there are 13 allowable services on the CCS Service Array

11. Wellness Management and Recovery

For each Service, there are examples of allowable **"Activities"**

- **psychoeducation**
- **behavioral tailoring**
- **relapse prevention**
- **development of a recovery action plan**
- **recovery and/or resilience training**
- **treatment strategies**
- **social support building**
- **coping skills**

An **"Intervention"** is specific, and indicates how the service and activities will be provided to an individual consumer.

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- Direct Service = In person with the consumer present
- Direct Services CANNOT be provided over the phone or via electronic communication

The TARP Note

http://www.cwhpartnership.org/regional-ccs-forms.html

- **T**reatment Objective Addressed
- **A**ctivity / **A**ssessment
- **R**esponse and progress
- **P**lan

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The Golden Thread – Recovery Plan to TARP Note

TARP Progress Note

Date of Service:
Consumer Name:
Provider Name/Agency:
Type of Contact: ☐ Face to face ☐ Phone with consumer *(billable only by Service Facilitator)*
☐ Collateral contact *(billable only by Service Facilitator)*
☐ Other (specify):
Place of Service: **Round Trip Mileage:**

	Start Time	End Time	Total Minutes	Notes
Service delivery:				*If under or over the authorized service time, please explain:*
Travel:				*If not from office to place of service and return, or if there were extenuating circumstances, please explain:*
Recordkeeping:				

Should all be consistent with what is specified on the Recovery Plan

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The Golden Thread – Recovery Plan to TARP Note

Long-Term Goal from Recovery Plan	**Treatment Goal(s) Addressed:** *(must match current Recovery Plan)*
Service Category listed with the specific Intervention	**Activity / Assessment:** **Please select the service/activity category** ☐ Screening and Assessment ☐ Individual Skill Development and Enhancement ☐ Service Planning ☐ Employment Related Skill Training ☐ Service Facilitation ☐ Individual and/or Family Psychoeducation ☐ Diagnostic Evaluations ☐ Wellness Management and Recovery/Recovery Support Services ☐ Medication Management ☐ Psychotherapy ☐ Physical Health Monitoring ☐ Substance Abuse treatment ☐ Peer Support
Related to the specific activity, service or treatment identified on the Recovery Plan	**Description:** *(Include mental status observations, details of the service/activity you provided, how it related to the goal, how you supported the consumer with the activity)*
Consumer Response and participation	**Response / Progress:** *(describe the consumer's response to/participation in the service/activity)*
Next Steps / follow-up plan	**Plan:** *(describe the plan for the next meeting or next step in services/the intervention)*
Additional activities or notes	**Activities not Included in "Contact Time" above:** *(Activities not billable on an interim basis such as in-person or phone collateral contacts and phone contact with consumer)*

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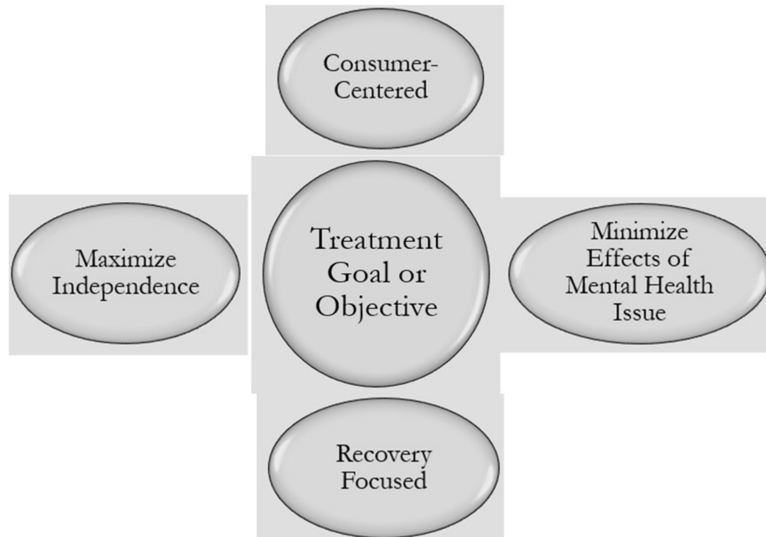
Treatment Goal or Objective



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Bob

Treatment Goal: Bob has coping skills to utilize when experiencing social anxiety, and is connected to community resources.

Service Array 8. Individual Skill Development and Enhancement

Allowable/Billable Activities:

- Training in communication, interpersonal skills, problem solving, decision-making, self-regulation, conflict resolution, and other specific needs identified in the service plan.
- Training in daily living skills related to personal care, household tasks, financial management, transportation, shopping, parenting, accessing and connecting to community resources and services, and other specific daily living needs identified in the service plan.
- Skill training may be provided by various methods, including but not limited to:
  - Modeling
  - Monitoring
  - Mentoring
  - Supervision
  - Assistance
  - Cuing

Bob's Recovery Plan

Service Array	Interventions	Frequency and Intensity	Payment Source	Start date	End date
Individual Skill Development	Worker will teach Bob skills to help him cope with his social anxiety, and will support Bob in practicing the skills in various community settings such as the community center, library, bank, grocery store, or farmer's market.	Weekly, up to 1.5 hours per session	CCS/ Medicaid	**7/1/19**	**7/31/19**

Assessment

- How is the person doing?
  (including mental status observations)

Activity

- Describe the activity / intervention you provided, including how you supported the consumer
- Include how the intervention relates to the consumer's goal

Activity

- Medicaid wants:
  - To know what you as the provider did during the service time
  - To see that you provided skilled interventions that require knowledge and experience
- Medicaid does not pay for:
  - Passive or custodial services. Observing or overseeing an individuals activity is not a Medicaid reimbursable service
  - Providers to "accompany" an individual to an activity. Describe why the person needed you along for the activity
- List the interventions you provided
  - Demonstrated, developed, explained, explored, facilitated, guided, informed, modeled, practiced, prompted, reflected, role played, validated, verbally coached.

What's Missing from the "A" Section of This Note?

A: Writer transported and accompanied Bob to the community center. On the way there we talked about what he likes to eat for breakfast. At the Community Center Bob played cards and picked up an activity calendar. Writer drove Bob to the bank so he could cash a check. Bob was appropriate with the bank teller.

What's Missing?

- Assessment part of the "A"
- Documentation of a service being provided
- Relevance to Bob's Treatment Goal
- Justification for 1.5 hours of service provision

Quality Note Example: Assessment/Activity

Bob was well groomed and in a good mood when writer picked him up at day treatment.
Writer and Bob drove to the Community Center so he could learn about this resource and also practice coping skills in a social setting.
During the drive, writer and Bob discussed what activities are offered today at the Community Center so Bob could have a plan prior to arrival, which would hopefully lessen his anxiety once inside. Writer also explored with Bob possible coping skills (deep breathing, positive self talk, taking a break) he can utilize if he does feel anxious.
Upon arrival at the Community Center, Bob appeared uneasy but went inside without prompting. Once inside, writer prompted Bob one time to follow through with his plan to join a card game with his peers. Writer monitored Bob during the activity, watching for any signs of distress or need for cues. When game ended, writer and Bob explored what the facility had to offer, and writer prompted him to take an activity calendar for the month.
Writer and Bob processed time spent at the Community Center during ride to the bank to cash check. Bob stated "I had a terrific time!". Writer praised Bob for using his coping skills. At the bank, writer assisted Bob in cashing check and adding money to his savings. Writer cued Bob once while he was communicating with teller.

The Consumer's **R**esponse / Progress

- How did the individual respond and how do you know?
- Did the consumer's participation indicate a benefit from your services?
- As the consumer, what did they get out of the contact? How do they think it helped them?
- Check with consumer if they agree with your observations
- What does the consumer think about their progress? How comfortable are they with the skills/task?

What's missing from this "R" Section?

Bob responded well to interventions.

What's Missing?

- Evidence backing up why the worker felt Bob responded well to the intervention
- Bob's response from his perspective
- Progress toward his goal

Quality Note Example: Response / Progress

Bob responded well to interventions. Bob did a nice job remembering the various coping skills that are indicated on his service plan discussed on the way to the Community Center. Bob appropriately followed writer's prompt to ask a group if he could join their card game.

Bob agreed that he should keep a Community Center calendar on his fridge and said "I'll definitely go back but try something different". Bob was able to share that he felt nervous going inside but did some deep breathing and positive thinking, which helped. Bob is also increasing independence with banking and did most of the talking with teller today.

Plan / Next Steps

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What's Missing from the "P" Section of This Note?

P: Worker will accompany Bob to the Community Center next Friday.

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What's Missing?

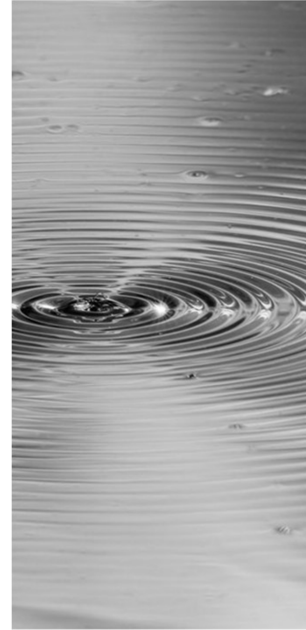
◦ The next step in the intervention

Quality Note Example: Plan

Writer will see Bob again next Friday. Bob would like to continue to practice the skills he's learning in the Community Center setting, with a goal of initiating conversation without prompting.

Helpful Hints:

- Be Specific
- Be Objective
- Include equal amounts of what you as a provider did and how the client responded.
- Use the Recovery Plan and CCS Service Array as tools
- Ensure the intervention is relevant to the consumer's Recovery Plan
- Keep in mind that notes become part of the consumer's clinical record and are available for release if requested by the consumer.
- Notes may also be reviewed by CCS staff, Quality Assurance staff, County and State Government, or Federal Auditors.



www.cwhpartnership.org

Welcome

The Central Wisconsin Health Partnership (CWHP) is a consortium covering a six-county region including Adams, Green Lake, Juneau, Marquette, Waupaca, and Waushara Counties. The partnership includes county human services and public health departments, a Federally Qualified Health Center and other interested healthcare advocates and providers in the region.

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Partnering for a Healthier Central Wisconsin