

# 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



**TARP Progress Note**

Client Name: \_\_\_\_\_  
 Provider Name/Agency: \_\_\_\_\_  
 Type of Contact:  New to Case  Follow-up contact (include only if Service Facilitator)  
 Other Agency: \_\_\_\_\_

Plan of Service: \_\_\_\_\_ Road Trip Mileage: \_\_\_\_\_

Start Time	End Time	Total Minutes	Notes
_____	_____	_____	_____
_____	_____	_____	_____

**Activity Assessment:**

\_\_\_\_\_ Individual Self-Development and Enhancement  
 \_\_\_\_\_ Employment Related Job Training  
 \_\_\_\_\_ Substance Abuse Treatment  
 \_\_\_\_\_ Family Management and Recovery/Recovery Support Services  
 \_\_\_\_\_ Case Management  
 \_\_\_\_\_ Case Support

**Response/Progress:** \_\_\_\_\_

**Plan:** \_\_\_\_\_



**Comprehensive Community Services Service Array Summary**

**I. Screening and Assessment**

- completion of initial and annual functional screens
- completion of the initial comprehensive assessment and ongoing assessments as needed
- the assessment must cover all domains, including substance use, which may include using the uniform Placement Criteria or the American Society of Addiction Medicine Criteria.

**II. Service Planning**

- the development of a written plan of the psychosocial rehabilitation services that will be provided or arranged for the member.
- the service plan must be reviewed and updated based on the needs of the member or at least every six months.
- the service plan review must be facilitated by the service facilitator in collaboration with the member and the relevant team.

**III. Service Facilitation**

- activities that ensure the member receives assessment services, service planning, service delivery, and supportive activities in an appropriate and timely manner.
- ensuring the service plan and service delivery for each member is coordinated, monitored, and reported to leadership according to a manner that helps the member achieve the highest possible level of recovery.
- assisting the member or self-advocates and helping the member obtain other necessary services such as medical, mental health, financial and housing services.
- coordinating a member's crisis services, but not actually providing crisis services.
- for members involved in substance use, assisting the member's family in advocating for the member to obtain necessary services. Service facilitation that is designed to support the family must be directly related to the assessed needs of the member.

**IV. Ongoing Evaluation**

- operational activities needed by the member including, but not limited to: neuropsychological, geriatric/geriatric, specialized trauma, and eating disorder evaluations.
- for members, diagnostic evaluations can also include functional behavior evaluations and adolescent alcohol/drug assessment intervention programs.
- the CCS program does not set expectations for autism, developmental disabilities, or learning disabilities.

### Quality Progress Notes Using TARP – Resource Packet

**Consumer Profile Example "Bob"**

Bob, a CCS Consumer, has been receiving intensive mental health services in an adult day treatment setting for the past 4 weeks. Bob's goal on his service plan includes using coping skills when experiencing social anxiety. Being connected to community resources and learning more about his diagnoses and benefits of medications, your role is to provide "Individual Self-Development and Enhancement" related to his recovery that consist of "Using coping skills when experiencing social anxiety and being connected to community resources." Your plan today is to take Bob into the community to work on coping skills in social situations and connect him to community resources. We typically do this twice weekly.

On the ride to the Community Center, you and Bob talk about what activities will be occurring there today and if Bob still has questions about what to expect when he arrives. You also ask Bob about what coping skills he has tried by the 4th meeting since he's there. Bob also tells you what he had for breakfast that morning and that he likes the food.

You and Bob arrive at the Community Center and he carries out his plan to join a game of cards with his peers. This works from reality, and Bob seems to enjoy the game. He only needs one reminder from you, as to what his plan was once he got inside. Bob went outside for a cigarette once during a break from the game. You helped Bob get an activity calendar for next month.

Upon leaving the Community Center, you and Bob have a plan to go to the bank, as he needs help applying to partners what he needs due to his anxiety. On the way to the bank, you and Bob talk about how things went at the Community Center that day he had a "panic" time, and whether he used any coping skills.

At the bank, you help Bob explain that he needs to cash and add to his savings. Bob seems to be doing better with navigating banking needs, as he does most of the talking with one reminder from you.

## Why Document?

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Record of  
the service  
being  
provided

Demonstrate  
progress,  
satisfaction,  
and general  
functioning

Create alignment  
with services  
provided across  
agencies

Medicaid  
requirements

## 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

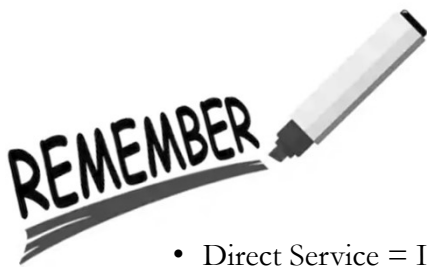
### 11. Wellness Management and Recovery

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>

<b>T</b> reatment Objective Addressed	
<b>A</b> ctivity / <b>A</b> ssessment	
<b>R</b> esponse and progress	
<b>P</b> 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:

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

	Start Time	End Time	Total Minutes	Notes
Service delivery:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<i>If under or over the authorized service time, please explain:</i> <input type="text"/>
Travel:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<i>If not from office to place of service and return, or if there were extenuating circumstances, please explain:</i> <input type="text"/>
Recordkeeping:	<input type="text"/>		<input type="text"/>	

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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**

<input type="checkbox"/> Screening and Assessment	<input type="checkbox"/> Individual Skill Development and Enhancement
<input type="checkbox"/> Service Planning	<input type="checkbox"/> Employment Related Skill Training
<input type="checkbox"/> Service Facilitation	<input type="checkbox"/> Individual and/or Family Psychoeducation
<input type="checkbox"/> Diagnostic Evaluations	<input type="checkbox"/> Wellness Management and Recovery/Recovery Support Services
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Psychotherapy
<input type="checkbox"/> Physical Health Monitoring	<input type="checkbox"/> Substance Abuse treatment
<input type="checkbox"/> 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)*

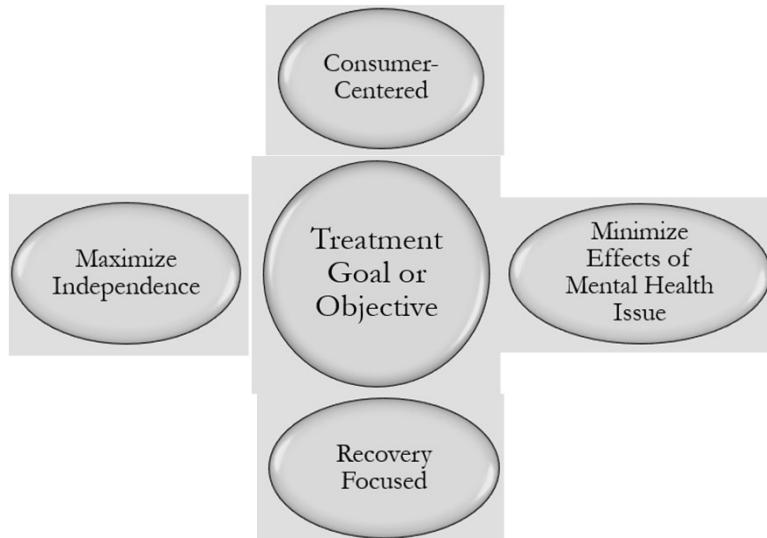
Consumer Response and participation — **Response / Progress:** *(describe the consumer's response to/participation in the service/activity)*

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

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# 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

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ForwardHealth Update 2014-42



## 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

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## 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 individual's 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?



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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



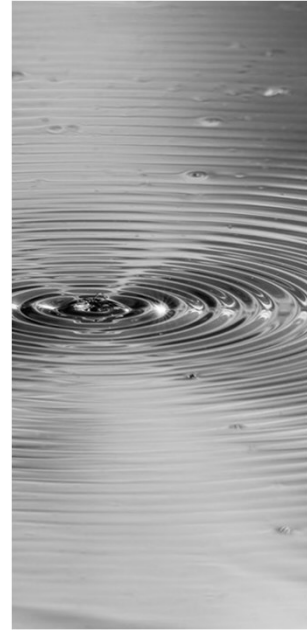
## Quality Note Example: Plan

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.

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## 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](http://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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