



pennsylvania
DEPARTMENT OF DRUG AND
ALCOHOL PROGRAMS



PA WITS

*End User Clinical
Guide*

Applies to:

WITS Version 18.0+

Pennsylvania DDAP
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Pennsylvania DDAP

PA WITS

Intended Audience

This user guide has been prepared for PA WITS Clinical staff members. Topics covered include Client Profile Setup, Client Activities, Consent, Referrals, Notes, Treatment Plan, Recovery Plan, and other important clinical information.

System Requirements

WITS is a web-based application accessed through an Internet (web) browser using Internet connection.

Internet Browsers

PA WITS is compatible with up-to-date versions of most modern Internet browsers such as:

- Mozilla Firefox
- Google Chrome
- Internet Explorer version 10+
- Apple Safari

Pop-up Blocker

Certain features in PA WITS, such as Snapshot and Scheduler, will open in a separate browser window when selected. Make sure your browser allows pop-ups from WITS.

Customer URL Links

Production Site: <https://pa.witsweb.org>

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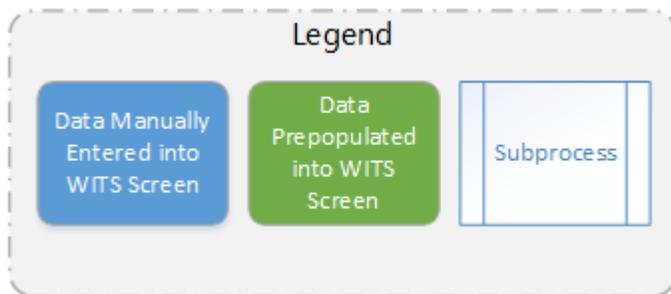
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Part 1: Types of Agency Workflows

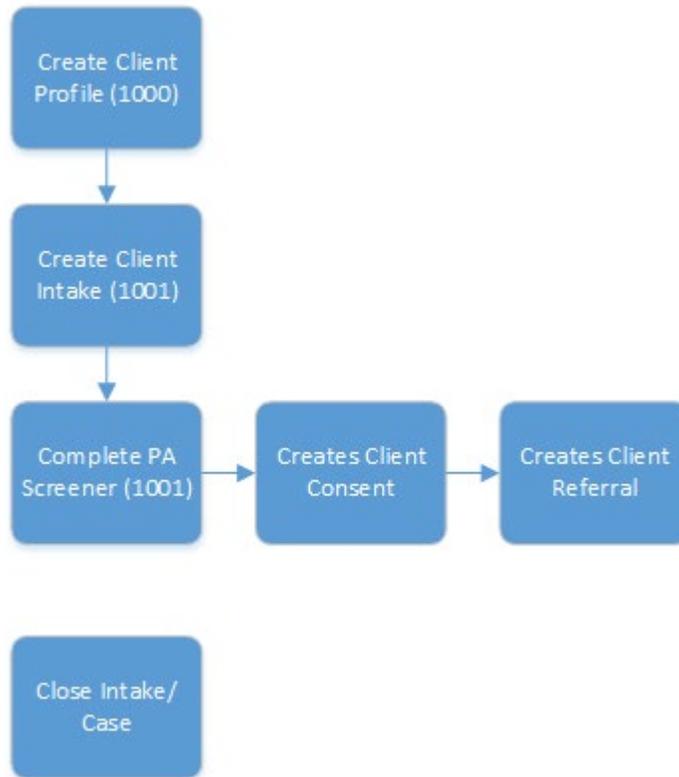
Work Flow Diagrams

The following diagrams illustrate how the data from the user’s agency entered into PA WITS fits into the overall PA WITS workflow. This guide identifies five different types of agencies to illustrate the workflow activities by agency.

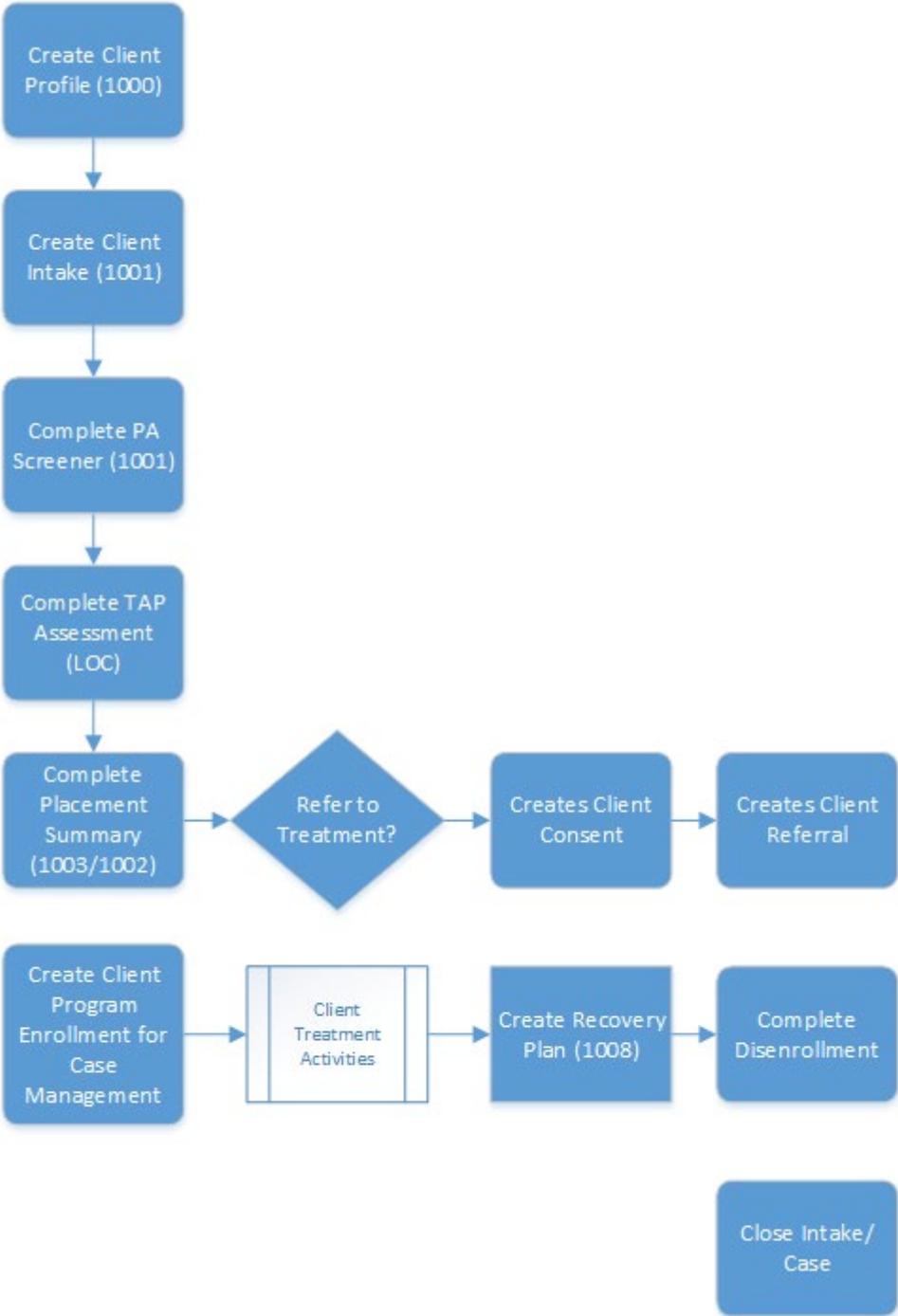
Note: It is also important to understand the workflow activities that happen outside your own agency, especially when consenting and referring clients to other agencies within PA WITS. WITS has been designed to capture specific pieces of information on an individual client level as they move from one agency for the purposes of reporting.



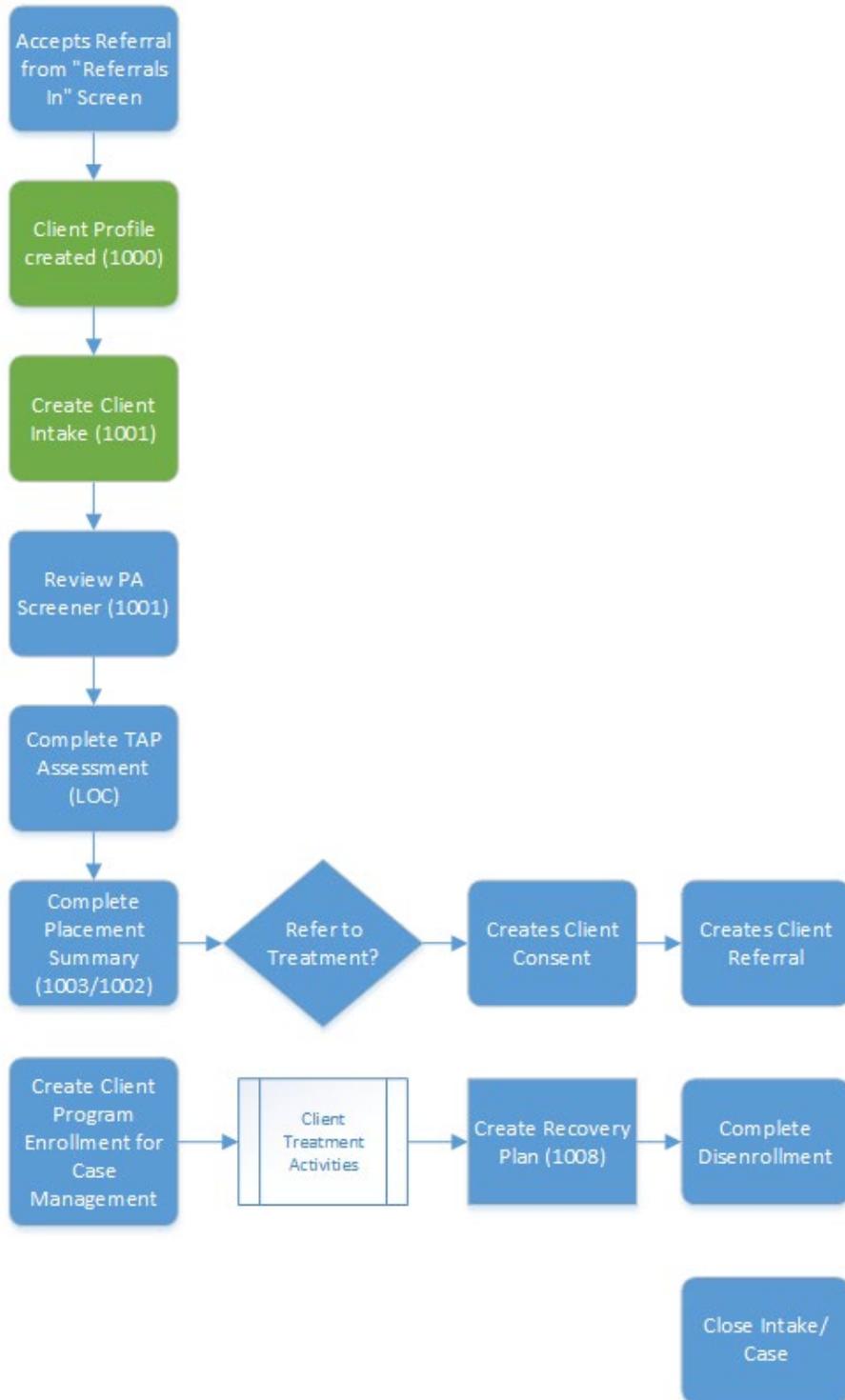
1. Screening Only Agency



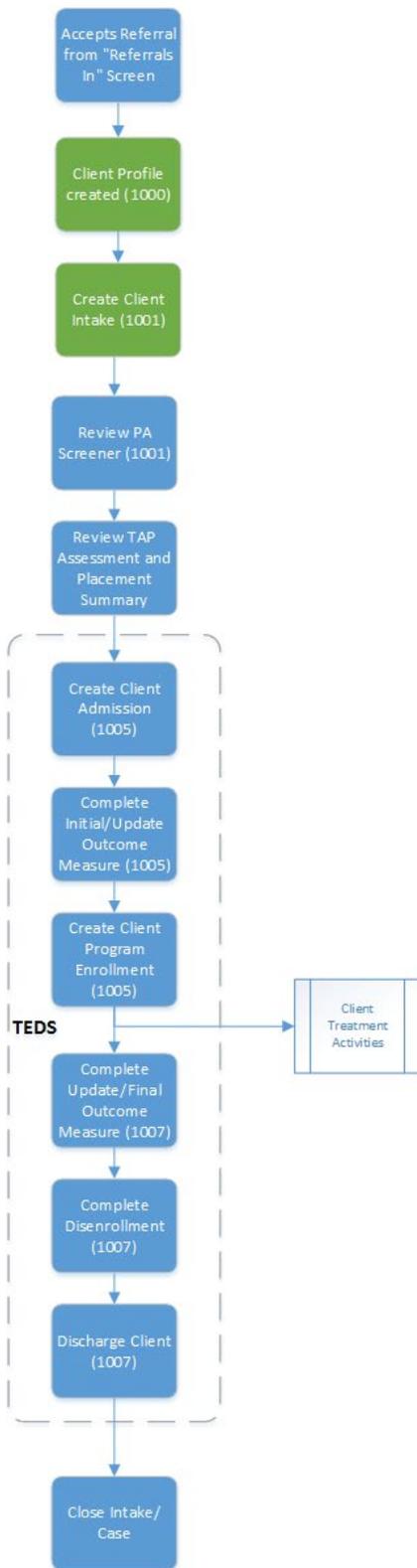
2. Screening Agency with Case Management



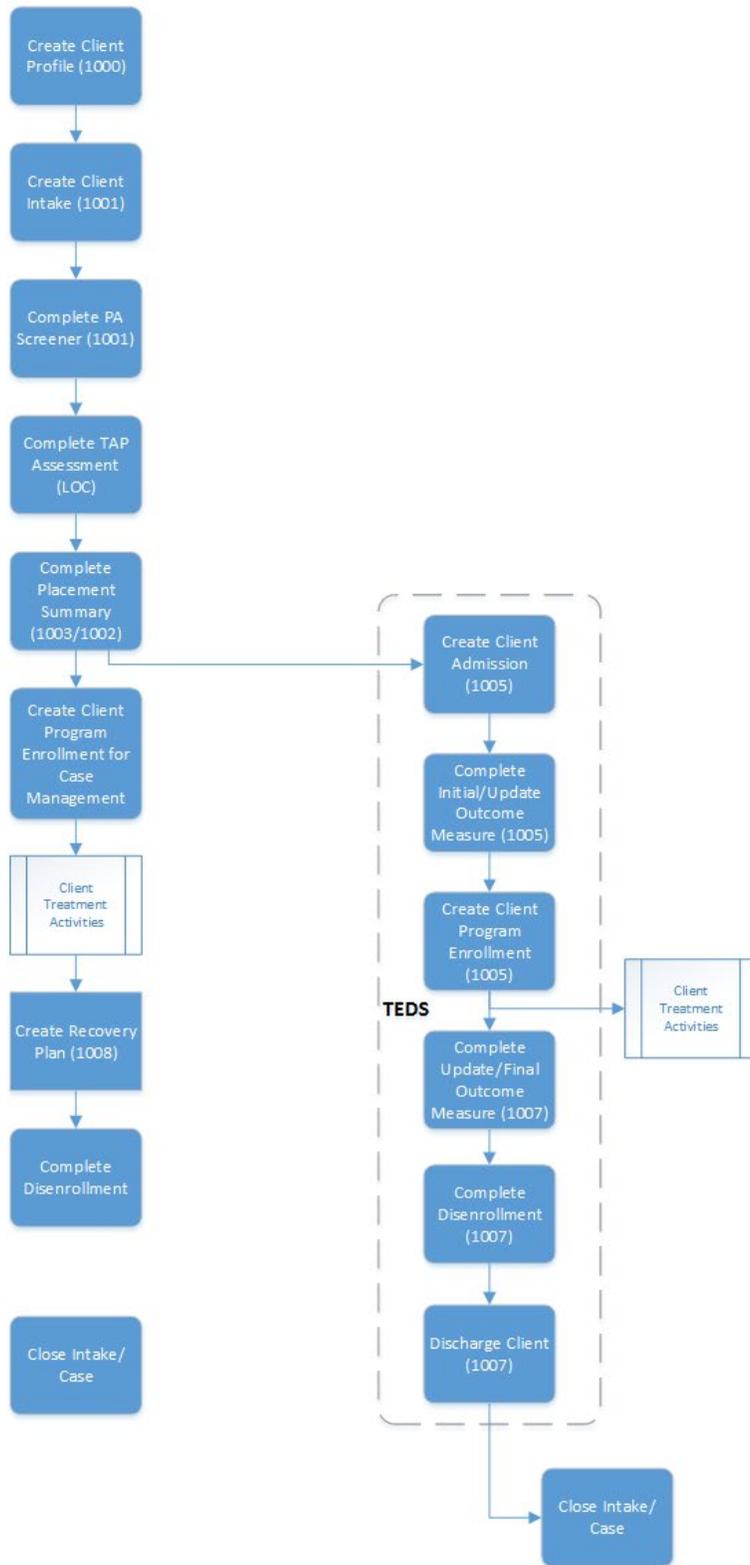
3. Case Management Only Agency



4. Treatment Only Agency



5. Full Functional Agency



Part 2: Client Setup

Search for a Client



Where: [Client List](#) > [Client Search](#)

Before creating a new client record, search for your client to make sure the client is not already in WITS.

1. To view clients within your agency, click on the **Client List** menu item. A blank Client List screen will appear.
2. Use the fields in the **Client Search** section to narrow your results.

NOTE • When searching for a client, try to use unique information, such as birthdates or social security numbers, if possible. You can also enter a partial name (or another field) followed by an asterisk (*). This is called a **wild card search**. For instance, if you search for Last Name of **"Smit*"**, the search results will display people with the last name of "Smith", "Smitty", "Smithson", etc.

3. After entering your search criteria, click **Go** to view the results.

Client Search

Agency: Community Counseling Center of Merc Facility: [Dropdown]

First Name: [Text] Last Name: [Text]

SSN: [Text] DOB: [Text]

PA-WITS Training Client Id: [Text]

Unique Client Number: [Text] Provider Client ID: [Text]

Treatment Staff: [Dropdown] Primary Care Staff: [Text]

Case Status: All Clients [Dropdown] Intake Staff: [Dropdown]

Other Number: [Text] Number Type: [Dropdown]

Include Only Active Consents: Yes [Dropdown]

[Clear](#) [Go](#)

Client List (Export) [Add Client](#)

Actions	Unique Client #	Full Name	DOB	SSN	Gender
	B60011058067890	Bear, Boo Boo	11/5/1980	123-45-6789	Male
	B60009058056460	Bear, Yogi	9/5/1980	987.42-5646	Male
	B10003067500010	Bob, Rob	3/6/1975	000-11-0001	Male
	B50009087069250	Bunny, Bugs	9/8/1970	129-58-6925	Male
	C45309088723630	Client, New	9/8/1987	154-87-2363	Male

Client Actions: Profile | Activity List | Linked Consents

Clients with Consents from Outside Agencies

Actions	Agency	Unique Client #	Client Name	DOB	SSN	Gender

Figure 2-1: Client List screen, Action links

Look for your client in the **Client List**. If you find the right person, hover over the pencil icon in the **Actions** column and click on the **Profile** link. If your client is not displayed in the Client List, you can create a new client record.

Client Search Tips

Client Names

Use a client's nickname or alternate names in the **First Name** or **Last Name** fields.

Use an **asterisk (*)** to perform a wildcard search.

Examples:

- Find clients whose last name starts with "Jon": **Jon***



The screenshot shows the 'Client Search' form with the following fields: Agency (Administrative), Facility (dropdown), First Name (empty), Last Name (Jon*), SSN (empty), and DOB (empty). A red arrow points to the 'Last Name' field.

- Search by the last 4 digits of a client's SSN: ***1123**



The screenshot shows the 'Client Search' form with the following fields: Agency (Administrative), Facility (dropdown), First Name (empty), Last Name (empty), SSN (*1123), and DOB (empty). A red arrow points to the 'SSN' field.

Client Birthday or Age

Search within a timeframe by separating the two dates with a colon (:). Search for clients born after a certain date with a greater than sign (>). Search for clients born before a certain date with a less than sign (<).

Examples:

- Find clients born in the year 1990: **1/1/1990:12/31/1990**



The screenshot shows the 'Client Search' form with the following fields: Agency (Administrative), Facility (dropdown), First Name (empty), Last Name (empty), SSN (empty), and DOB (1/1/1990:12/31/1990). A red arrow points to the 'DOB' field.

- Find clients born after a certain date: **>12/30/1959**



The screenshot shows the 'Client Search' form with the following fields: Agency (Administrative), Facility (dropdown), First Name (empty), Last Name (empty), SSN (empty), and DOB (>12/30/1959). A red arrow points to the 'DOB' field.

Create Client Profile



Where: [Client List](#) > [Client Profile](#)

Note: Please search for each client before creating a new record. See “Search for a Client” for more information. To add a new client to the system, follow the steps below.

1. On the left menu, click **Client List**.
2. On the Client List screen, click **Add Client**.

The screenshot shows the 'Client List' screen. On the left is a navigation menu with 'Client List' selected. The main area contains a 'Client Search' form with fields for Agency (Community Counseling Center of Merc), Facility, First Name, Last Name, SSN, DOB, PA-WITS Training Client Id, Unique Client Number, Provider Client ID, Treatment Staff, Primary Care Staff, Case Status (All Clients), Intake Staff, Other Number, and Number Type. There are 'Clear' and 'Go' buttons. Below the search form is a 'Client List (Export)' table with columns for Actions, Unique Client #, Full Name, DOB, SSN, and Gender. A red arrow points to an 'Add Client' link in the top right corner of the table area.

Figure 2-2: Client List screen, Add Client link

3. On the **Client Profile** screen, enter the required client information.

Table 2-1: Client Profile fields

Field	Description
Current First Name	Type the client’s current first name.
Middle Name	(Optional)
Current Last Name	Type the client’s current last name.
Mother’s Maiden Name	(Optional)
Suffix	(Optional)
Birth First Name	Type the client’s first name at birth.
Birth Last Name	Type the client’s last name at birth.
Gender	Select the client’s gender from the drop-down list.
DOB	Enter the client’s date of birth.
SSN	Type the client’s Social Security Number. If the SSN is unknown, enter all zeroes (000000000).
Driver’s License and State	(Optional) Type the number and then select the State from the drop-down list.
County	Select the client’s county of residence from the drop-down list.
Provider Client ID	(Optional)
Has paper file	(Optional) Select Yes or No. Field defaults to Yes.

NOTE • The **Unique Client Number (UCN)** is created based on information entered on the client's profile. It is important that the client information is entered properly the first time, as this will help to avoid duplicate entry of clients in the future.

The screenshot displays the 'Client Profile' screen. On the left is a navigation menu with options like 'Home Page', 'Agency', 'Clinical Dashboard', 'Client List', 'Client Profile', 'Alternate Names', 'Additional Information', 'Contact Info', 'Collateral Contacts', 'Other Numbers', 'History', 'Linked Consents', 'Non-Episode Contact', 'Activity List', 'Episode List', and 'System Administration'. The main area is titled 'Profile' and contains several input fields: 'Current First Name', 'Middle Name', 'Current Last Name', 'Mother's Maiden Name', 'Suffix', 'Birth First Name', 'Birth Last Name', 'Gender' (dropdown), 'DOB' (calendar icon), 'SSN', 'Provider Client ID', 'Unique Client Number', 'State Client ID', 'Record Created By', 'Last Updated By', 'Created Date', 'Last Updated Date', 'Driver's License', and 'County' (dropdown). There is also a 'Has paper file' dropdown set to 'Yes'. Below the form is an 'Administrative Actions' section with 'Cancel', 'Save', 'Finish', and a right arrow button. At the bottom, there are two tables: 'Alternate Names' with columns 'Actions', 'Last Name', 'First Name', 'Middle Name', and 'Client Alias Type'; and 'Addresses' with columns 'Actions', 'Address Type', 'Address', 'Confidential', 'Created', and 'Updated'. Both tables have an 'Add' button in the top right corner.

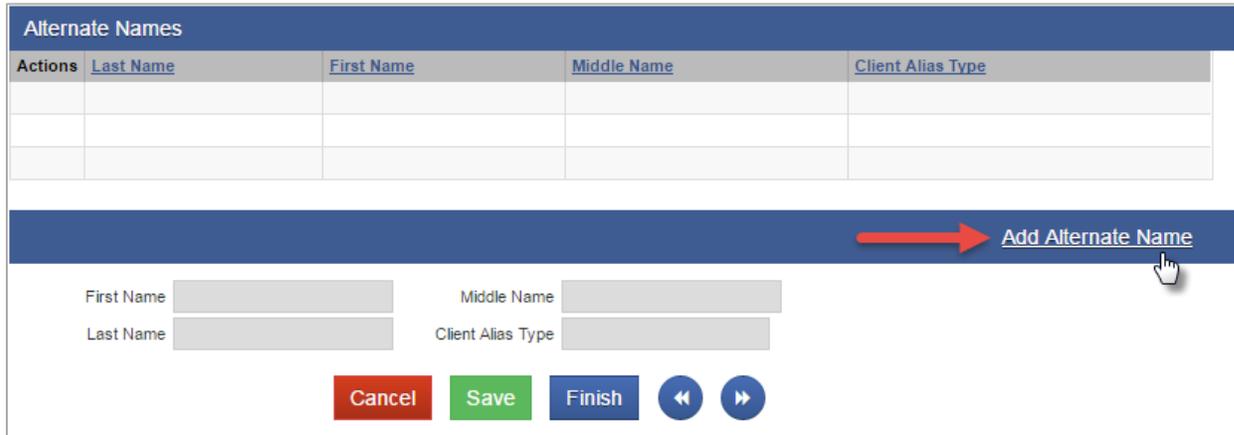
Figure 2-3: Client Profile screen

4. Click **Save**.
5. Click the **right-arrow** to move to the **Alternate Names** screen.

Alternate Names

The client's nickname or street name may be entered here. Use alternate names when searching for a client on the Client List screen.

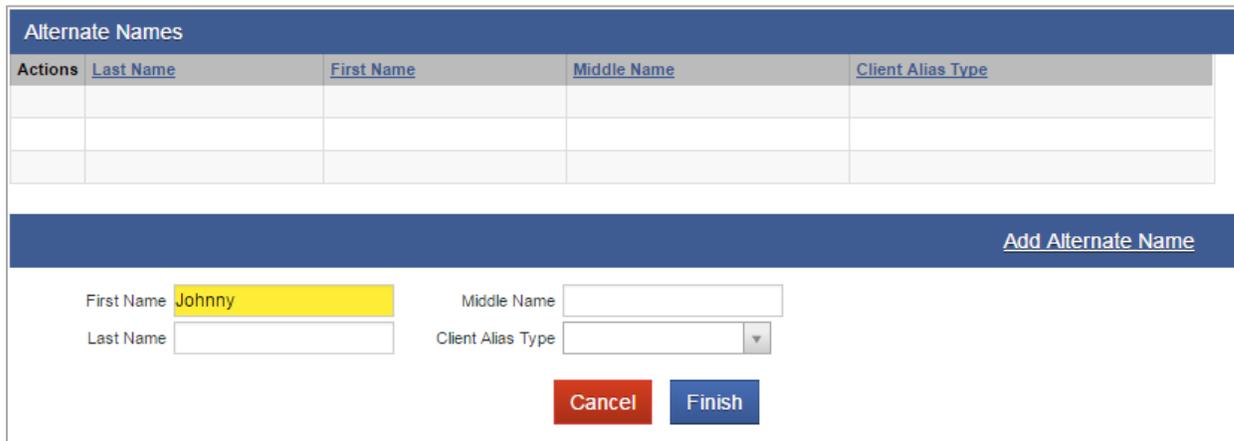
6. On the Alternate Names screen, click **Add Alternate Name**, and the bottom half of the screen becomes editable.



The screenshot shows the 'Alternate Names' screen. At the top is a table with columns: Actions, Last Name, First Name, Middle Name, and Client Alias Type. Below the table is a blue bar with the text 'Add Alternate Name' and a red arrow pointing to it. Underneath are four input fields: First Name, Middle Name, Last Name, and Client Alias Type. At the bottom are buttons for Cancel, Save, Finish, and two navigation arrows.

Figure 2-4: Alternate Names screen

7. Complete at least the **First Name** field.



The screenshot shows the 'Alternate Names' screen with the 'Add Alternate Name' button highlighted. The 'First Name' input field is now filled with the text 'Johnny'. The 'Save' button is no longer visible, and the 'Finish' button is now highlighted in blue. The 'Cancel' button is also visible.

Figure 2-5: Add Alternate Name

8. Click **Finish**. The name will now appear in the list at the top of the screen.
9. From the Alternate Names screen, click the **right-arrow** button to open the **Additional Information** screen.

Additional Information

Note: The light-yellow fields are required for TEDS.

- On the **Additional Information** screen, complete at least the light-yellow fields, as these are required for TEDS reporting and must be completed before creating an Intake.

Table 2-2: Additional Information screen – Required Fields for TEDS Reporting

Field	Description
Ethnicity	Select from the drop-down list.
Selected Races	Select one or more races.
Veteran Status	Select from the drop-down list.

The screenshot shows the 'Additional Information' screen with the following fields and values:

- Ethnicity:** Not Hispanic or Latino (light yellow)
- Races:** Alaska Native, American Indian, Black or African American, Native Hawaiian or Other Pacific Islander, Unknown
- Selected Races:** Asian, Other Race (light yellow)
- Special Needs:** No Response, Developmentally Disabled, Major Difficulty in Ambulating or Nonambulation, Moderate To Severe Medical Problems
- Selected Special Needs:** None
- General Client Comments:** (Text area)
- Sexual Orientation:** Not Collected (light yellow)
- Religious Preference:** Cao Dai
- English Fluency:** Moderate
- Preferred Language:** Mandarin
- Interpreter Needed:** No
- Veteran Status:** Not Collected (light yellow)
- Citizenship:** (Text area)

At the bottom right, there are buttons for **Cancel**, **Save**, **Finish**, and navigation arrows.

Figure 2-6: Additional Information screen

- When complete, click **Save**, then click the **right-arrow** button to open the **Contact Info** screen.

Contact Info

Note: An address is required for PA.

12. On the **Contact Info** screen, enter a phone number for the client, if available, and then click the **Add Address** link to open the **Address Information** screen.

Actions	Address Type	Address	Confidential	Created	Updated

Figure 2-7: Contact Info screen

13. Enter the client's Address Type, Address line 1, City, State, and Zip Code.

NOTE • If the client is **Homeless**, select the Address Type of "**Client Homeless**". The City, State and Zip code fields will then be optional.

Address Type		Confidential	No
Address Line 1			
Address Line 2			
City		State	Zip

Figure 2-8: Address Information screen

14. When complete, click **Finish**, and the client's address information will show up on the Contact Info screen. Add an additional address if needed.
15. From the **Contact Info** screen, click the **right-arrow** button to open the **Collateral Contacts** screen.

NOTE • If a client has a new address, update the Address Type of the current address record to “Previous”, and then create a new address.

NOTE • WITS uses the USPS Address Standardization Web Tool to validate the client’s address. If USPS detects any errors in the street address, WITS will display the results from USPS. You can then decide to select the original address entered or the suggested address from USPS.

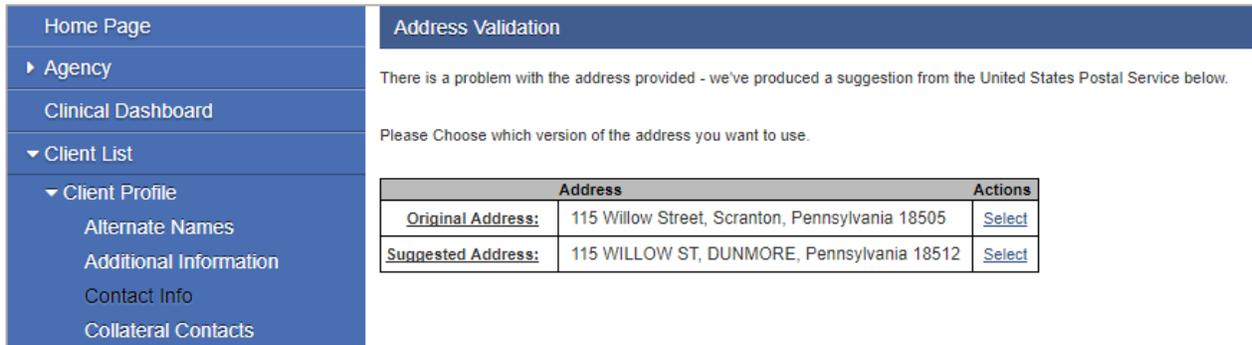
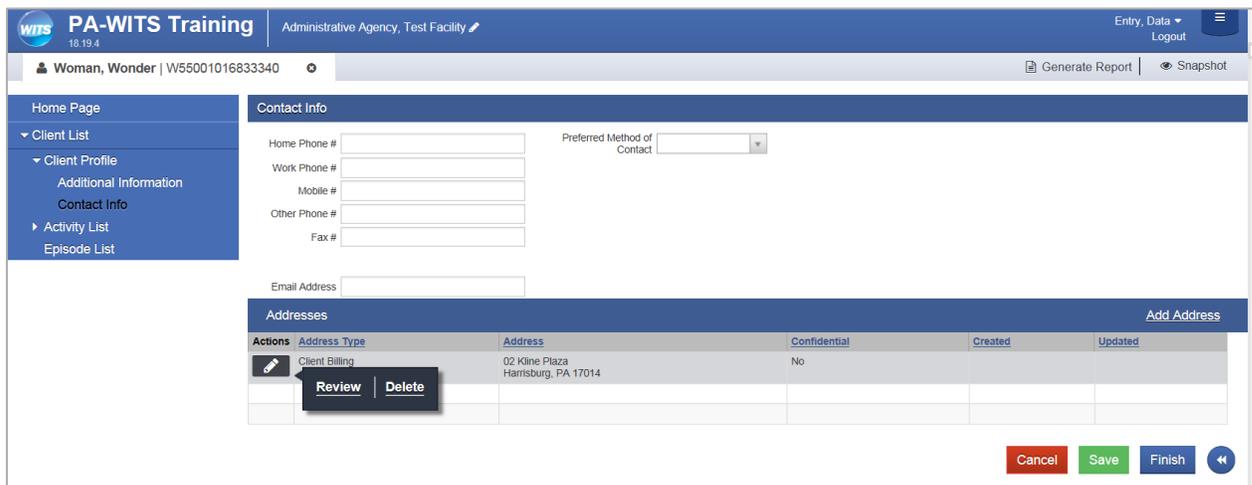


Figure 2-9: Address Validation screen

If you need to edit the address, you can revise the address from the Address Information screen. Click Select for the original address.

You will be returned to the Contact Info screen. Hover your cursor over the Pencil icon next to the address you wish to edit, then click Review.



After you have edited the address, click Finish and you will be directed back to the Contact Info screen.

Collateral Contacts

Adding Collateral Contacts is optional.

- On the **Collateral Contacts** screen, note the fields below are grey, and click the **Add Contact** link.

Collateral Contacts					
Actions	First Name	Last Name	Relation	Phone Numbers	Can Contact?

 [Add Contact](#)

Table 2-3: Collateral Contacts Fields

Field	Description
First Name	Type the contact's first name.
Last Name	Type the contact's last name.
Relation	Select the collateral contact's relation to the client from the drop-down menu.
Address, City, State	Type the contact's address information
Can Contact	Select Yes or No.
Consent On File	Select Yes or No.

Collateral Contacts					
Actions	First Name	Last Name	Relation	Phone Numbers	Can Contact?

[Add Contact](#)

First Name

Last Name

Relation

Gender

Home Phone

Work Phone

Mobile

Fax

Other

Legal Guardian

Active Date 

Inactive Date 

Address 1

Address 2

City State Zip

Email

Can Contact

Consent On File

Notes

Created

Last Update

Figure 2-9: Add Collateral Contacts screen

- When complete, click **Finish**. The names now show up in the table on top of the screen.
- From the **Collateral Contacts** screen, click the **right-arrow** button to open the **Other Numbers** screen.

Other Numbers

In this section, users can add additional identifying numbers for a client, such as a court case number. This section is **OPTIONAL** and does not need to be completed for the profile to be considered complete.

19. On the Other Numbers screen, click the **Add Other Number** link. The bottom half of the screen now becomes editable. Fill in information such as, Number Type, Number, Start Date and Status.

The screenshot shows the 'Other Numbers' screen. At the top is a table with columns: Actions, Number Type, #, Start, End, Contact Name, and Status. Below the table is a blue bar with the text 'Add Other Number'. The form below contains the following fields: Number Type (dropdown), Number (text input), Start Date (calendar icon, value: 11/26/2014), End Date (calendar icon), Status (dropdown, value: Active), Contact (dropdown), and Comments (text area). At the bottom right are 'Cancel' and 'Finish' buttons.

Figure 2-10: Other Numbers screen

20. The **Contact** drop-down box will display the names of any saved Collateral Contacts from the previous screen. If the name of the Collateral Contact is not present, click on the **Collateral Contacts** screen to add a new record.

This screenshot shows the 'Add Other Number' form with the 'Contact' dropdown menu open. The dropdown list displays 'Smith, Jane'. The other fields are: Number Type (dropdown), Number (text input), Start Date (calendar icon, value: 12/11/2014), End Date (calendar icon), Status (dropdown, value: Active), and Comments (text area). 'Cancel' and 'Finish' buttons are at the bottom right.

Figure 2-11: Other Numbers screen, saved collateral contact

21. When complete, click **Finish**. The numbers now show up in the table on top of the screen.
22. Click **Save**, then click the right arrow to move to the Client Group Enrollment.

Client Group Enrollment

A client group enrollment (CGE) must be entered for each client. This will identify the funding source for the client. If the client is not being funded by an SCA, there is a "No SCA" option that can be selected. The CGE can be updated as funding sources change.

1. Click **Add Government Contract Enrollment**

Payor List							
Actions	Priority	Plan	Group	Subscriber/ Acct#	Subscriber/ Resp Party	Start Date	End Date

Add Government Contract Enrollment

2. Select the Contract, or funding source, from the drop-down menu. The options will be an SCA that the provider contracts with or No SCA.

The Plan-Group field will auto populate with the appropriate information based on the Contract selected.

The Subscriber # will auto populate with the client's UCN.

Government Contract Billing Information

Plan Type: Government Contract
Contract: [Yellow]
Plan-Group: [Yellow]
Subscriber #: W42502019158130

Payor Priority Order: 1
Start Date: [Yellow]
End Date: []

Administrative Actions: []

Cancel Save

3. Enter the Start Date, which is the date the selected funding source will begin covering services.
4. Click **Save**
5. On the Payor List, click **Finish**, and you will be returned to the Client Search.

Update Funding Source

If a client's funding source changes, you can update the previous funding source and add the new funding source.

1. From the Payor List, hover over the pencil icon next to the source and click **Edit**.

Payor List							Add Government Contract Enrollment	
Actions	Priority	Plan	Group	Subscriber/ Acct#	Subscriber/ Resp Party	Start Date	End Date	
	1	Philadelphia S	Oversight	W42502019158130		7/1/2018		
Edit	Remove							

2. Enter the end date for the funding source.
3. Click **Save**.

The new funding source can then be added by following the steps listed on the previous page of this user guide.

History

The History sub-menu displays a list of all changes that have been made to the client information as well as any access to this client's record. It lists the date, staff person, and a description of the access or change.

Date Changed	System Account	Description of Changes
10/12/2017 12:19 PM	Jones, Ashley	• Accessed Client Profile Screen
10/12/2017 12:19 PM	Jones, Ashley	• Accessed Client Record: "Mouse, Minnie, Client ID: M20007030036580"
7/7/2017 9:38 AM	Saul, Michele	• Discharge was added.
7/7/2017 9:38 AM	Saul, Michele	• Accessed Discharge Screen for Case: 1
7/7/2017 9:37 AM	Saul, Michele	• Client Program Enrollment was changed.
7/7/2017 8:33 AM	Saul, Michele	• Accessed Admission Screen for Case: 1
7/7/2017 8:33 AM	Saul, Michele	• Accessed Client Record: "Mouse, Minnie, Client ID: M20007030036580"
7/6/2017 3:01 PM	dataentry, michele	• Accessed Client Profile Screen
7/6/2017 2:43 PM	dataentry, michele	• Client Program Enrollment was added.
7/6/2017 2:42 PM	dataentry, michele	• Outcome Measure was changed.
7/6/2017 2:39 PM	dataentry, michele	• Client Diagnosis was changed.
7/6/2017 2:38 PM	dataentry, michele	• Accessed Outcome Measures - Client Diagnosis for Case: 1
7/6/2017 2:38 PM	dataentry, michele	• Outcome Measure was added.
7/6/2017 2:38 PM	dataentry, michele	• Outcome Measure was added.
7/6/2017 2:37 PM	dataentry, michele	• Accessed Outcome Measures - Client Status for Case: 1
7/6/2017 2:37 PM	dataentry, michele	• Accessed Outcome Measures for Case: 1
7/6/2017 2:37 PM	dataentry, michele	• Admission was added.
7/6/2017 2:36 PM	dataentry, michele	• Accessed Admission Screen for Case: 1
7/6/2017 2:36 PM	dataentry, michele	• Client Intake Record was created.
7/6/2017 2:36 PM	dataentry, michele	• Accessed Intake Screen
7/6/2017 2:36 PM	dataentry, michele	• Address 'PO BOX 678' added.
7/6/2017 2:35 PM	dataentry, michele	• Veteran Status changed from " " to 'No' • Ethnicity changed from " " to 'Not of Hispanic Origin'. • Race 'Black or African American' added.
7/6/2017 2:35 PM	dataentry, michele	• Accessed Client Record: "Mouse, Minnie, Client ID: M20007030036580"
7/6/2017 2:35 PM	dataentry, michele	• Client 'Mouse, Minnie' added.

Figure 2-12: Client History screen

Linked Consents



Where: **Client List** > **Clients with Consents from Outside Agencies**

Each time another agency consents client information to your agency, a row will be displayed on the “**Clients with Consents from Outside Agencies**” section of the **Client List** screen. Always look at the linked consents first to make sure you don’t already have that client entered.

If the consent is sent along with a referral and the referral is accepted at the referred to agency, users with a Clinical Supervisor role may manually link and unlink consents. This action is available when it is clear that a client with consented information is in fact the same person as a client that exists in the agency. They may not have been automatically linked because the names or other identifying information may have been different in the sending agency than they are in the receiving agency.

The screenshot shows the PA-WITS Training interface. At the top, there's a navigation bar with the WITS logo, 'PA-WITS Training', and user information 'Jones, Ashley'. Below the navigation bar is a sidebar menu with options like 'Home Page', 'Agency', 'Clinical Dashboard', 'Client List', 'Client Profile', 'Linked Consents', 'Non-Episode Contact', 'Activity List', 'Episode List', and 'System Administration'. The main content area is titled 'Client Search' and contains various search filters. Below the search form is a 'Client List' table with columns for 'Actions', 'Unique Client #', 'Full Name', 'DOB', 'SSN', and 'Gender'. A red box highlights a section titled 'Clients with Consents from Outside Agencies' which contains a table with one row: 'GREENBRIAR TREATMENT CENTER', 'F62308138722220', 'Forrest, Bobby', '8/13/1987', '121-11-2222', and 'Male'. A red arrow points to this section.

For example:

A client named “Bobby” is referred into your agency from an outside agency. Your agency already has a record for a client named “Robert”. The Linked Consents screen allows you to compare the New/Referred Client Information (Bobby) with the Existing Client Information (Robert). Using this screen, you can tell that Robert and Bobby are the same person and these two profiles can be linked together so the same client won’t have two different client profiles within the same agency.

Link to Consented Client

1. On the left menu, click **Client List** and then click **Go**.
2. In the **Clients with Consents from Outside Agencies** section, hover over the Actions column and click **Link**.

The screenshot shows the 'Client List' interface. On the left is a navigation menu with 'Client List' selected. The main area is titled 'Client Search' and contains various search filters. Below this is a table of clients. A section titled 'Clients with Consents from Outside Agencies' is highlighted, containing one client entry: 'GREENBRIAR TREATMENT CENTER'. A red arrow points to the 'Link' button in the 'Actions' column for this client.

Actions	Unique Client #	Full Name	DOB	SSN	Gender
	200006018756780	2, Deeksha Test	6/1/1987	213-12-5678	Female
	A23608019956780	Asteraceae, Zinnia	8/1/1999	012-34-5678	Female
	B00009078465980	Bee, New	9/7/1984	852-31-6598	Male
	B60007108274830	Berry, Blue	7/10/1982	090-44-7483	Male
	B60007107298760	Berry, Straw	7/10/1972	173-84-9876	Male
	B00007020355550	Boy, Teen	7/2/1972	123-12-5555	Male

Actions	Agency	Unique Client #	Client Name	DOB	SSN	Gender
Activity List Link Remove	GREENBRIAR TREATMENT CENTER	F62308138722220	Forrest, Bobby	8/13/1987	121-11-2222	Male

Figure 2-13: Client List screen, Clients with Consents from Outside Agencies section, Link action item

3. The **Link Client Search** screen will appear and the Consented Client information is displayed as read-only fields.

The screenshot shows the 'Link to Consented Client' screen. At the top, the client's information is displayed in read-only fields: Full Name (Forrest, Bobby), Client Number (F62308138722220), and DOB (8/13/1987). Below this is the 'Link Client Search' form, which includes search filters for Agency, Facility, First Name, Last Name, SSN, DOB, Unique Client Number, Provider Client ID, and Number Type. The 'Go' button is highlighted.

Actions	Unique Client #	Full Name	DOB	SSN	Gender

Figure 2-14: Link Client Search screen

- Use the search fields to find a client with similar information. It is helpful to copy and paste some of the consented client's information into the search fields. The example in Figure 2-15 uses the Consented Client's Unique Client Number in the search field.

WITS PA-WITS Training 18.25.7 Administrative Agency, Administrative Unit Jones, Ashley Logout Snapshot

Home Page Link to Consented Client

Agency Clinical Dashboard

Client List

Client Profile
Linked Consents
Non-Episode Contact
Activity List
Episode List
System Administration

Full Name Forrest, Bobby DOB 8/13/1987
Client Number F6230813872220 SSN 121-11-2222

Link Client Search

Agency Administrative Agency Facility
First Name Last Name
SSN DOB
Unique Client Number F6230813872220 Provider Client ID
Other Number Number Type
Clear Cancel Go

Actions	Unique Client #	Full Name	DOB	SSN	Gender

Figure 2-15: Link Client Search screen, search by Unique Client Number

- After filling out one or more search fields, click **Go** and then review the search results.

WITS PA-WITS Training 18.25.7 Administrative Agency, Administrative Unit Jones, Ashley Logout Snapshot

Home Page Link to Consented Client

Agency Clinical Dashboard

Client List

Client Profile
Linked Consents
Non-Episode Contact
Activity List
Episode List
System Administration

Full Name Forrest, Bobby DOB 8/13/1987
Client Number F6230813872220 SSN 121-11-2222

Link Client Search

Agency Administrative Agency Facility
First Name Last Name
SSN DOB
Unique Client Number F6230813872220 Provider Client ID
Other Number Number Type
Clear Cancel Go

Actions	Unique Client #	Full Name	DOB	SSN	Gender
	F6230813872220	Forrest, Robert	8/13/1987	121-11-2222	Male

Figure 2-16: Link Client Search screen with search results

- If the information in the search results matches the Consented Client information, hover over the Actions column and then click **Link**.

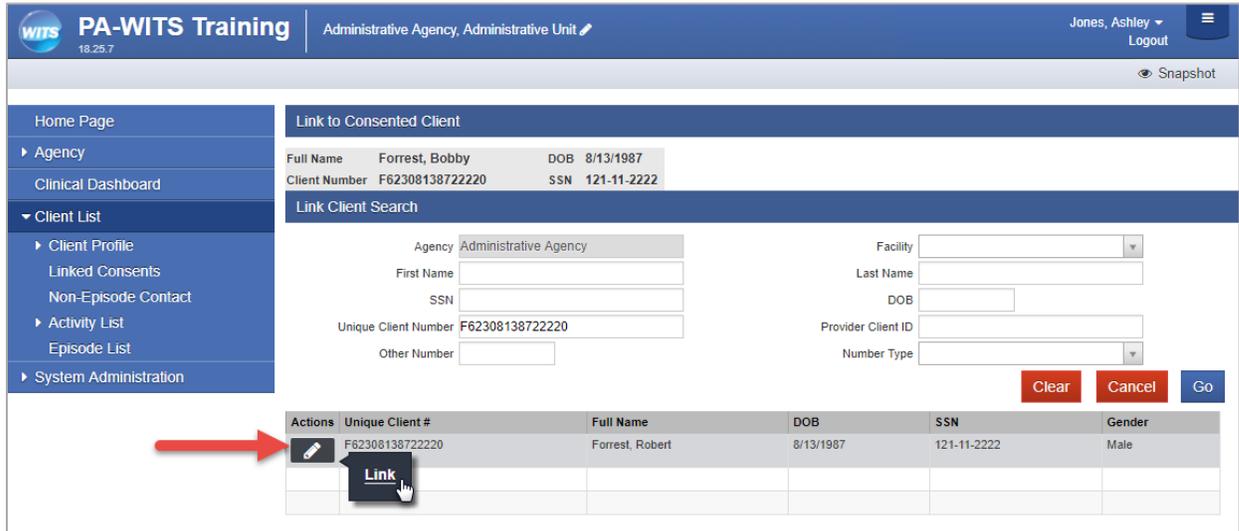


Figure 2-17: Link Client Search screen, Link Consent record

- Click **Yes**.



Figure 2-18: Are you sure you want to link current consented client to the consent client

- The client's Linked Consent screen will now display the consent record from the other agency.



Figure 2-19: Linked Consents screen

Non-Episode Contact



Where: [Client List](#) > [Non-Episode Contact](#)

The Non-Episode Contact screen provides a place within the client’s record to document something that happens outside or unrelated to the client’s episode of care. Once the client’s profile information is entered, a Non-Episode Contact record can be created.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Profile**.
3. On the left menu, click **Non-Episode Contact**.
4. Click the **Add New Non-Episode Contact Record** link.

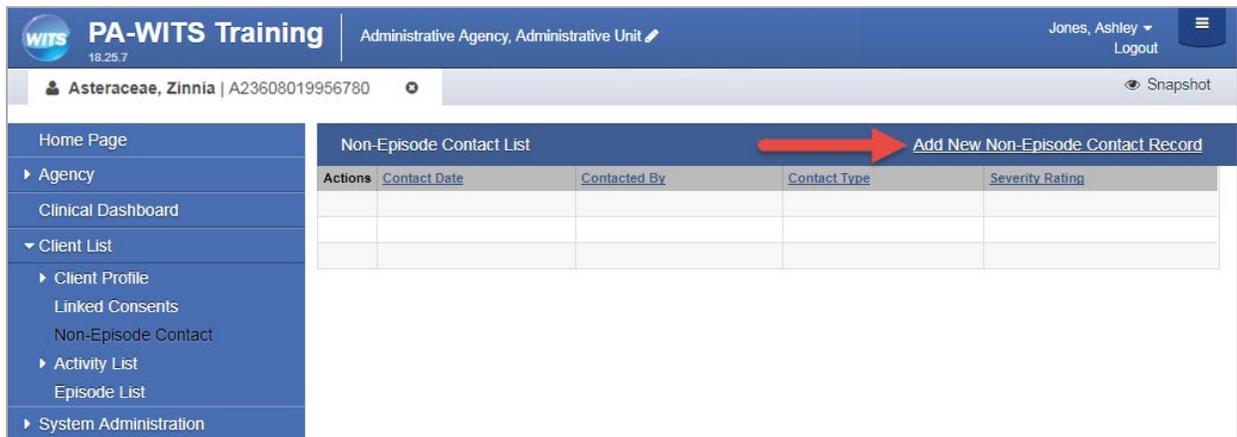


Figure 2-20: Non-Episode Contact List

5. Complete the fields on the Non-Episode Contact Note screen.

Table 2-4: Non-Episode Contact Note fields

Field	Description
Contact Date	Enter the date when the client contacted.
Start Time	Enter the start time including AM or PM.
End Time	Enter the end time including AM or PM.
Duration	The duration fields will auto calculate based on the Start Time and End Time fields.
Contacted By	Defaults to the staff member name currently signed in.
Contact Reason	Select from the drop-down list.
If Other, Specify	Read-only field unless “Other” is selected in the Contact Reason field.
Location	Select from the drop-down list.
Contact Type	Select from the drop-down list.
Referral	(Optional) Select “Formal”, “Informal”, or “None”.
Referring Agency	(Optional)
Referred By - First Name	(Optional)

Field	Description
Referred By - Last Name	(Optional)
Referred By - Phone	(Optional)
Severity Rating	(Optional)
Created Date	Read-only field displaying the date and time the Non-Episode Contact Note was created.
Signed Notes	Read-only field.
Unsigned Notes	Type notes about the event.
Outcome	(Optional) Select from the drop-down list.
Reason for ineligibility	(Optional)
Follow-Up Steps Selected	Select one or more options. Note: These values are controlled by the "Followup Step" code table.

Figure 2-21: Non-Episode Contact Note Profile screen

- Click **Save** and then click **Sign Note**.

Figure 2-22: Sign Note

- The signed note will now be displayed in the read-only field. Click **Finish**.

Figure 2-23: Signed Notes

Duplicate Client Check

The duplicate client panel screen will appear when either a new client is being entered into an agency or a client is being referred from another agency. The following criteria are used to identify potential duplicate clients:

- The generated UCN;
- The current first name and current last name;
- The current last name, first initial, date of birth, and gender matches;
- The current last name, street address, date of birth, and gender; or
- The current last name, date of birth, gender, and zip code.

If a possible duplicate client is identified based on the UCN, the following message will be displayed: "This client results in a Unique Client Number (display the UCN) that already exists or a client by this name already exists. Please review the following information and select the appropriate action:"

The screenshot shows the PA-WITS Training interface. At the top, there is a header with the WITS logo, the text 'PA-WITS Training 18.25.7', and user information 'Administrative Agency, Administrative Unit' and 'Jones, Sarah A., CCS Logout'. A navigation menu on the left includes 'Home Page', 'Agency', 'Clinical Dashboard', 'Client List', and 'System Administration'. The main content area features a message box: 'This client results in a Unique Client Number (R20006309000120) that already exists or a client by this name already exists. Please review the following information and select the appropriate action.' Below this are two tables. The first table, 'New/Referred Client Information', has columns for Name, Date of Birth, Address, Phone, and Alternate Names, with one row for 'Rose, Margaret' (DOB: 6/30/1990, Address: 115 WILLOW ST). The second table, 'Existing Client(s) Information', has columns for Actions, Name, Date of Birth, Address, Phone, Unique Client #, and Alternate Names, with one row for 'Rose, Daisy' (DOB: 6/30/1990, Address: 115 WILLOW ST, Unique Client #: R20006309000120). A 'Cancel' button is located at the bottom right.

Figure 2-24: New/Referred Client Information with Existing Client Information

If a possible duplicate client is identified from any other criteria, the following message will be displayed: "This client results in matching demographics for a client that already exists. Please review the following information and select the appropriate action."

The screenshot shows a message box with the text: "This client results in matching demographics for a client that already exists. Please review the following information and select the appropriate action." The message box has a close button (X) in the top right corner.

Review the client information provided. If the referred client is the same as the existing client, hover over the Actions column, and click Same Client. If the referred client is different than the existing client, click Different Client.

WITS PA-WITS Training 18.25.7 Administrative Agency, Administrative Unit Jones, Sarah A., CCS Logout

Snapshot

Home Page
 Agency
 Clinical Dashboard
 Client List
 System Administration

This client results in a Unique Client Number (R20006309000120) that already exists or a client by this name already exists. Please review the following information and select the appropriate action.

New/Referred Client Information [Different Client](#)

Name	Date of Birth	Address	Phone	Alternate Names
Rose, Margaret	6/30/1990	115 WILLOW ST		

Existing Client(s) Information

Actions	Name	Date of Birth	Address	Phone	Unique Client #	Alternate Names
	Rose, Daisy	6/30/1990	115 WILLOW ST		R20006309000120	

Same Client

Cancel

Figure 2-25: Existing Client Information, Same Client link

Part 3: Activity List

It is important to understand that data collection in WITS happens within a Client's Activity List. The Case, or Episode of Care, is the container that holds all client activities. The beginning and end of a client's Episode of Care are recorded on the Intake transaction, where the Intake Date starts the Episode and the "Date Closed" marks the end of the Episode (these fields are shown in *Figure 3-6: Intake Case Information screen* on page 34).

The concept diagram below illustrates how this data collection is structured within the client Activity List. This Activity List is comprised of three (3) primary nested containers: Episode (e.g., Case, or Intake), Admission, and Program. The double lines connecting the Program container represent multiple program enrollments, which are allowed within a single Admission. In the diagram, arrows denote the sequence of progressing through each container.

When an Episode of Care ends for a client, this signifies that the client is no longer receiving services. It's possible for that client to return at a later time

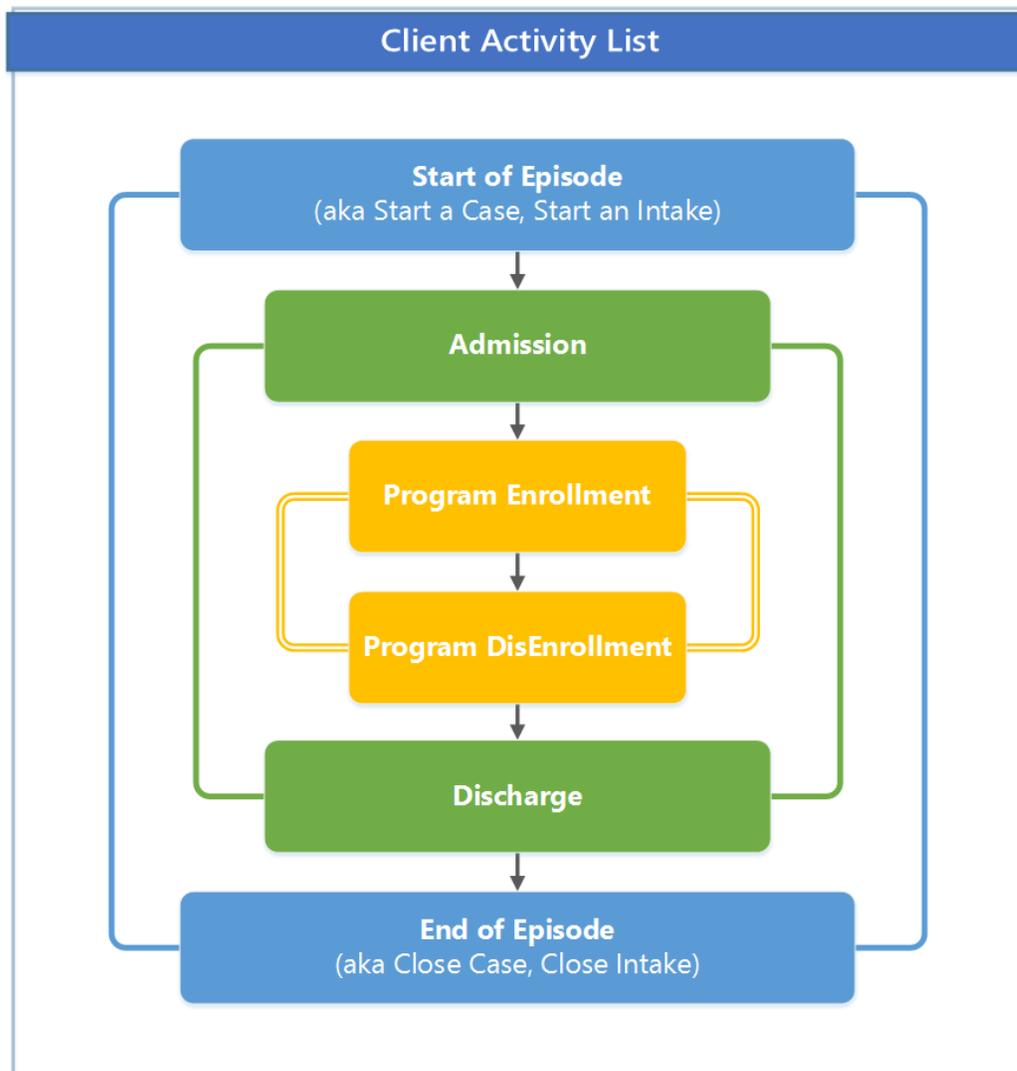


Figure 3-1: Concept Diagram of Data Collection Structure within Client Activity List

When client activities are recorded in WITS, the Client Activity List screen serves as a “dashboard” view for

Note: To access items within the Activity List, a client must be selected first.

The Activity List can serve as the “dashboard” view for the information that has been collected for a given client within an Episode. Each Activity on the Activity List has a status to help the end user determine if that activity is “Complete” or “In Progress”. When an activity is “In Progress”, a Details link is available which displays the information needed to complete the activity.

Certain client activities must be complete before you can proceed to a following activity. Validation rules will guide you throughout the workflow as you enter new data.

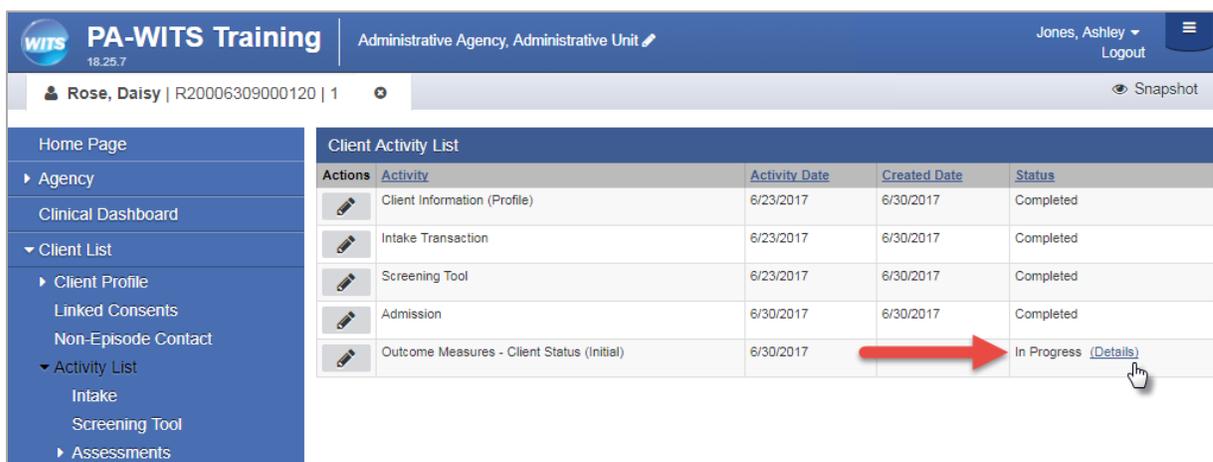


Figure 3-2: Client Activity List, Details link

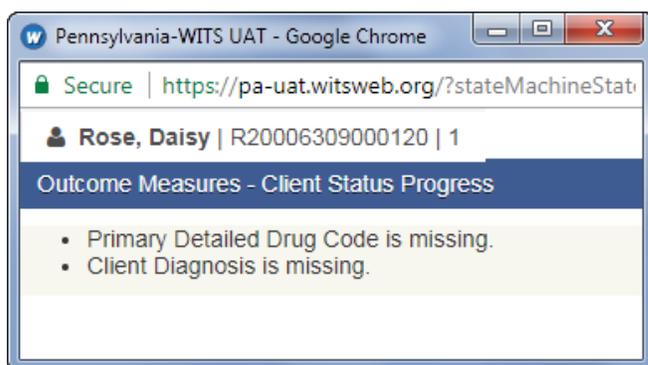


Figure 3-3: Details link, list of missing information

Note: Some Client Activities do not have a concept of being complete. For those activities, the Status will be listed as Not Applicable.

Start New Episode (New Clients)



Where: [Client List](#) > [Activity List](#) > [Episode List](#)

In WITS, all items located in a client’s Activity List are based upon an active Episode of Care, which is started by creating an Intake. You must complete an Intake to perform any client activities within the system.

1. On the left menu, click **Episode List**.
2. Click the **Start New Episode** link.

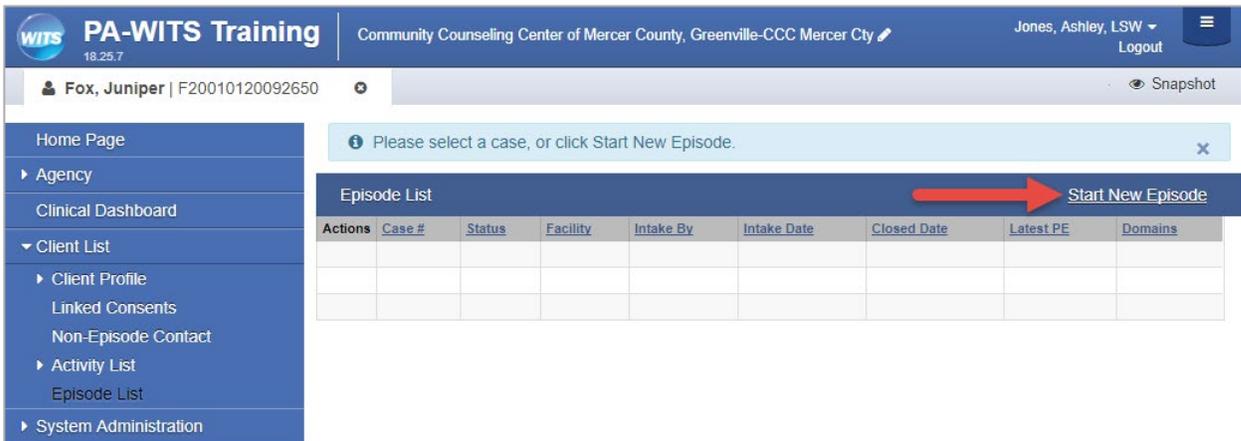


Figure 3-4: Episode List screen, Start New Episode link

3. If the client profile is missing certain information, such as an Address or fields on the Additional Information screen, a New Episode cannot be created and an error message will appear, as shown in Figure 3-5.



Figure 3-5: Episode List screen, Error Message

4. If the client profile is complete, clicking **Start New Episode** will open the Intake Case Information screen, as shown in Figure 3-6: Intake Case Information screen.



Where: *Client List > Activity List > Intake*

Note: When completing the client’s first Intake, click Finish, and system will take you to the Screening Tool (Formerly collected on the PA Form 1001).

1. Complete the fields on the Intake Case Information screen.

Table 3-1: Intake Case Information Fields

Field	Description
Intake Facility	Pre-populates with the current facility location.
Intake Staff	Pre-populates with the current staff member name.
Initial Contact	Select from the drop-down list.
Case Status	Defaults to “Open Active”.
Initial Contact Date	The date when the Client first reached out for treatment. For the clients first intake in PA-WITS this field will be editable. When a client is referred from one agency to another, the Initial Date of Contact will be in a Read-Only mode. This field is used in calculations for the Case Management Resource Report.
Intake Date	Enter the client’s intake date, (which also marks the beginning of the client’s Episode). This field is used in calculations for the Case Management Resource Report.
Is Client Public Funded?	(Optional)
Funding SCA	Select from the drop-down list.
Source of Referral	Select from the drop-down list. Note: The Source of Referral should be the original/initial referral source.
Referral Contact	(Optional) Select from a list of the client’s collateral contacts.
Pregnant	Is the client pregnant at the time of admission? Complete if applicable.
Prenatal Treatment	(Optional) Is the client also receiving prenatal treatment? Select Yes/No if applicable.
Injection Drug User	Select Yes or No.
Problem Area	(Optional)
Presenting Problem (In Client’s Own Words)	(Optional)
Scheduled Assessment Date	This field is used in calculations for the Case Management Resource Report. Note: Changing the value of this field will cause the screen to be refreshed.
Assessment Date	This field is used in calculations for the Case Management Resource Report. Note: Changing the value of this field will cause the screen to be refreshed.
If assessment cannot be scheduled within 7 days, why?	This field is used in or the Case Management Resource Report. Note: Changing the value of this field will cause the screen to be refreshed.

Field	Description
Did client complete scheduled assessment?	This field is used in or the Case Management Resource Report. Note: Changing the value of this field will cause the screen to be refreshed.
Why was scheduled assessment missed?	This field is used in or the Case Management Resource Report. Note: Changing the value of this field will cause the screen to be refreshed.
Scheduled Admission Date	This field is used in or the Case Management Resource Report. Note: Changing the value of this field will cause the screen to be refreshed.
Special Initiatives/Populations Selected	Select one or more options. If client is not part of a Special Initiative or Population, select None.
Inter-Agency Service Selected	(Optional)
Selected Domains	This field will be pre-populated and read-only if there is only one domain associated with the agency. If the agency has multiple domains, select the appropriate domain(s) for the client.
Date Closed Date Closed <input data-bbox="370 856 483 894" type="text"/>  Save & Close the Case	The Date Closed field is used to mark the end of the client's Episode.

Intake Case Information

Intake Facility: Administrative Unit
 Intake Staff: O'Reilly, Kristyn
 Initial Contact: By Appointment
 Is Client Public Funded?
 Funding SCA: Adams
 Source of Referral: SCA

Case #: 1
 Case Status: Open Active
 Initial Contact Date: 5/6/2017
 Intake Date: 5/7/2017
 Pregnant: Not Applicable Due Date

Referral Contact: [Add Collateral Contact](#)
 Prenatal Treatment
 Injection Drug User: No
 Problem Area
 Presenting Problem (In Client's Own Words)

Scheduled Assessment Date: 6/7/2017
 Assessment Date: 6/16/2017
 If assessment cannot be scheduled within 7 days, why? Client Choice
 Did client complete scheduled assessment? Yes
 Why was scheduled assessment missed?
 Scheduled Admission Date: 6/13/2017

Special Initiatives/Populations
 Acquired Brain Disorders
 Adult with Organic Disorder w/o SED
 Adult with Severe and Persistent Mental Illness
 Adult with Severe Emotional Disturbance

Special Initiatives/Populations Selected
 None

Inter-Agency Service
 Child Protective Services (OCS)
 Court/Legal Interface
 DCSF
 Developmental Disabilities

Inter-Agency Service Selected

Domains
 Selected Domains
 Substance Abuse

Date Closed: [Save & Close the Case](#)

Cancel Save Finish

Figure 3-6: Intake Case Information screen

5. Click **Finish**. When you click Finish, the Screening Tool will appear.

Screening Tool



Where: [Client List](#) > [Activity List](#) > [Screening Tool](#)

Note: If you've just completed the client's Intake, the system will automatically bring you to this screen and you can skip to step number 4.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Screening Tool**.
4. Complete the Screening Tool fields as shown in the table below.

Table 3-2: Screening Tool Fields

Field	Description
Screening Date	This field defaults to the Intake Date, which was entered on the client's Intake screen.
Interviewer	Defaults to the staff member currently signed in.
Health Insurance	Select from the drop-down list.
Substance Abuse	
For the following fields marked with an asterisk*, select options for Primary, Secondary, and Tertiary, as applicable. When a screening tool is consented, this information can be pulled forward into the client's continuing case in another agency.	
*Substance	
*Severity	(Optional)
*Frequency	
*Method	
*Detailed Drug Code	
*# of DAYS since LAST use of the substance indicated above	
Are you experiencing any of the following symptoms? (If yes, he/she must be transferred to a clinical staff person)	
Selected Symptoms	Select one or more symptoms.
Other (specify)	Only required if symptoms selected above.
Have you recently been treated by medical personnel for an overdose?	Select Yes/No.
Date of last overdose?	Only required if Yes is answered to previous question
Psychiatric	
Are you having any current thoughts of harming yourself or others? (If yes, he/she must be transferred to clinical staff person who will make arrangements for a crisis intervention handoff)	Select Yes/No.
Prenatal/Perinatal	

Field	Description
Are you experiencing any pregnancy complication that you feel may require emergency care?	Select Yes/No.
If yes, explain:	
Outcome	
Screening Outcome	
Notes	(Optional)

Screening Tool

Screening Date: 6/3/2017  Interviewer: Jones, Sarah A., CCS 
 Health Insurance: SCA 

Substance Abuse

Rank	Substance	Severity	Frequency	Method	Detailed Drug Code
Primary:	Alcohol		Daily	Oral	Alcohol/Spirits
Secondary:	Marijuana/Hashish		1-3 Times/Month	Smoking	Marijuana/Hashish
Tertiary:	None	N/A	N/A	N/A	Not Applicable

of DAYS since LAST use of the substance indicated above: Primary: 1 Secondary: 3 Tertiary:

Are you experiencing any of the following symptoms? (If yes, he/she must be transferred to a clinical staff person)

Symptoms	Selected Symptoms
Hallucinations	Nausea/Vomiting
Seizures	Uncontrollable Shaking
Severe Cramps	Other
None	

Other (specify): Headache, dizziness

Have you recently been treated by medical personnel for an overdose? Yes No Date of last overdose? 5/29/2017 

Psychiatric

Are you having any current thoughts of harming yourself or others? (If yes, he/she must be transferred to clinical staff person who will make arrangements for a crisis intervention handoff) No Yes

Prenatal/Perinatal

Are you experiencing any pregnancy complication that you feel may require emergency care? Yes No If yes, explain: I might be pregnant.

Outcome

Screening Outcome: Referred to detox 
 Notes:

Figure 3-7: Screening Tool

- Click **Finish**. When you click Finish, the **Client Activity List** appears.

Tx Team (Treatment Team)



Where: [Client List](#) > [Activity List](#) > [Treatment Team](#)

Each client should have a Treatment Team created to ensure the appropriate staff have access to each client record.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Tx Team**.

Add Team Member

4. Click the **Add Team Member** link.

The screenshot shows the 'Treatment Team' interface. At the top, there is a table with columns: Actions, Team Member Name, Is Primary Care Member?, Review Member, Role/Relation, Start Date, and End Date. Below the table is a blue bar labeled 'Assign Group' with a red arrow pointing to the 'Add Team Member' link. The form below contains several input fields: Staff Name, Non Staff Name, Add Collateral Contact, Role/Relation, Review Member, Primary Care Staff, Deny Access to Client Records, Start Date, End Date, and Notes. At the bottom, there are two dropdown menus for 'Treatment Sub-Teams' (with 'Recovery' selected) and 'Selected Sub-Teams', along with a 'Finish' button.

Figure 3-8: Treatment Team screen, Add Team Member link

5. Complete the team member fields.

Table 3-3: Treatment Team Member fields

Field	Description
Staff Name	Select available agency Staff Members from the drop-down list.

Field	Description
Non Staff Name	This drop-down list includes collateral contacts previously entered for the client. Select a contact who is part of the client's treatment team. If the drop-down list is missing a contact, click the Add Collateral Contact link to enter that contact for the client.
Role/Relation	Select an option from the drop-down list.
Review Member	Will the team member review the client's record, including the treatment plan? Select Yes/No.
Primary Care Staff	Is the team member primarily responsible for the client's treatment? Select Yes/No.
Deny Access to Client Records	Will the client's records be hidden from this team member? Select Yes/No. If this is set as "Yes", then the selected staff will not be able to see that Client record in the Agency Client List screen.
Selected Sub-Teams	"Recovery" must be selected for this Team Member to appear on the Recovery Plan.
Start Date	Defaults to today's date. May need to be updated for each Tx Team Member.
End Date	
Notes	(Optional)

Treatment Team

Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date

Assign Group
[Add Team Member](#)

Staff Name:

Non Staff Name:

[Add Collateral Contact](#)

Role/Relation:

Review Member:

Primary Care Staff:

Deny Access to Client Records:

Start Date:

End Date:

Notes:

Treatment Sub-Teams:

Selected Sub-Teams:

Figure 3-9: Treatment Team screen, Add New Team Member

- Click **Save**. Add additional team members as needed.

Assign Group

Treatment Team Groups are created by your Agency Administrator. If a group is not available, please see your supervisor.

7. Click Assign Group.

The screenshot shows the 'Treatment Team' interface. At the top, there is a table with the following data:

Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
	Jones, Sarah A., CCS	No	Yes	Case Manager	6/10/2017	

Below the table, there are two buttons: 'Assign Group' (highlighted with a red arrow) and 'Add Team Member'. The 'Assign Group' button leads to a form with the following fields:

- Staff Name:
- Non Staff Name:
- Add Collateral Contact:
- Role/Relation:
- Review Member:
- Primary Care Staff:
- Deny Access to Client Records:
- Start Date:
- End Date:
- Notes:
- Treatment Sub-Teams:
- Selected Sub-Teams:

A 'Finish' button is located at the bottom right of the form.

Figure 3-10: Treatment Team screen, Assign Group link

8. Select the appropriate treatment team group(s), if available.

The screenshot shows the 'Select Groups to Add to Treatment Team' interface. It features two dropdown menus:

- Available Groups:
- Selected Groups:

Navigation arrows are located between the two dropdowns. At the bottom right, there are two buttons: 'Cancel' (red) and 'Assign' (blue).

Figure 3-11: Select Groups to Add to Treatment Team

- Click **Assign**. Staff members who are included in the selected Group will then be listed in the client's Treatment Team.

Treatment Team						
Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
	Jones, Sarah A., CCS	No	Yes	Case Manager	6/10/2017	
	Jones, Ashley	No	No	Team Lead	7/10/2017	
	OReilly, Kristyn	No	No	Counselor	7/10/2017	
	Amadi, Uche	No	No	Neurologist	7/10/2017	
	Riegel, Amber	No	No	Psychologist	7/10/2017	

Assign Group		Add Team Member
Staff Name <input type="text"/>	Start Date <input type="text"/>	End Date <input type="text"/>
Non Staff Name <input type="text"/>	Notes <input type="text"/>	
Add Collateral Contact <input type="text"/>		
Role/Relation <input type="text"/>		
Review Member <input type="text"/>		
Primary Care Staff <input type="text"/>		
Deny Access to Client Records <input type="text"/>		
Treatment Sub-Teams Recovery <input type="text"/>	Selected Sub-Teams <input type="text"/>	
Finish		

Figure 3-12: Treatment Team with team members added to list

- To update information for an individual team member, hover over the **Actions** column, and then click **Review**.

Treatment Team						
Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
	Jones, Sarah A., CCS	No	Yes	Case Manager	6/10/2017	
	Jones, Ashley	No	No	Team Lead	7/10/2017	
	OReilly, Kristyn	No	No	Counselor	7/10/2017	
	Amadi, Uche	No	No	Neurologist	7/10/2017	
	Riegel, Amber	No	No	Psychologist	7/10/2017	

A red arrow points to the pencil icon in the Actions column for the row "OReilly, Kristyn". A tooltip with the text "Review" is visible over the icon.

Figure 3-13: Treatment Team screen, Review Team Member link

Assessments

TAP (Treatment Assignment Protocol)



Where: [Client List](#) > [Activity List](#) > [Assessments](#) > [TAP](#)

Note: An Intake TAP assessment cannot be added after the client is admitted; otherwise, the following error message will appear as shown below in Figure 3-15. Once an Admission record is entered, users can only add a Follow-up TAP.



Figure 3-15: Intake TAP Assessment Error Message

Add New Intake TAP

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Assessments**, and then click **TAP**.
4. Click the **Add New Intake TAP** link.

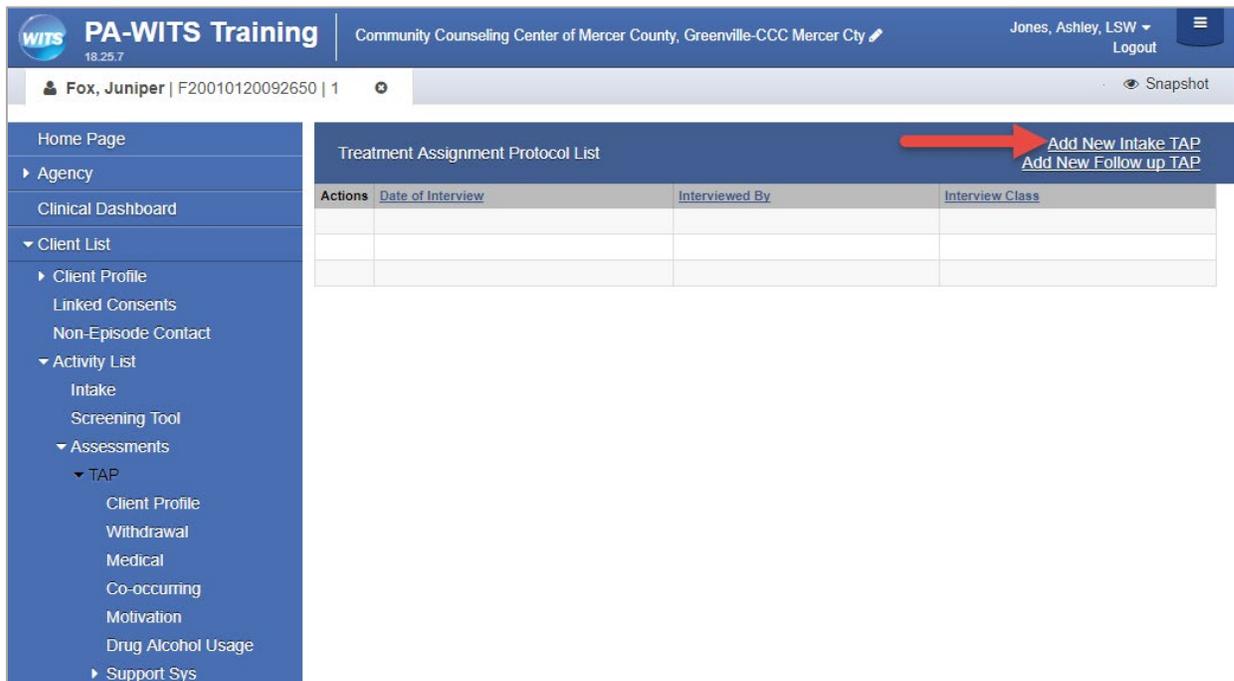


Figure 3-16: Treatment Assignment Protocol: Add New Intake TAP

5. Enter the **Interview Date**, then click **Save**.

TAP Interview Date

Interview Date

Cancel
Save

TAP: Client Profile

6. Complete the fields on the Treatment Assignment Protocol Assessment: Client Profile.

Table 3-4: Treatment Assignment Protocol Assessment: Client Profile fields

Field	Description
Class	Read-only field; displays "Intake".
Interview Date	Populates with date entered on previous screen.
Contact Code	Read-only field; displays "In person".
Source of Referral	Read-only field. Displays selection entered on the Intake screen. If the Source of Referral information is updated on the Intake screen, this read-only field (on the TAP) will also be updated automatically.
Primary Payment Source	(Optional)
Interviewer	Defaults to the staff member currently signed in.
Special Code	(Optional)
Military Status:	Read-only field. Displays selection entered on the Client Profile Additional Information screen.
Pregnant	Read-only field. Displays selection entered on the Intake screen.
Race:	Read-only field. Displays selection entered on the Client Profile Additional Information screen.
Ethnicity:	Read-only field. Displays selection entered on the Client Profile Additional Information screen.
Religious Preference	(Optional)
How Long at Current Address	(Optional)
Is the Residence Owned by You or Family	(Optional)
County of Residence:	Read-only field. Displays selection entered on the Client Profile screen.
Controlled Environment in Last 30 Days?	(Optional)
How Many Days in Controlled Environment	(Optional)
Days Attended AA/NA/Similar Meetings in Last 30 Days	(Optional)
Months Since Discharged from Last Admission	(Optional)
Is This a TAP for Concerned Person	(Optional) Select Yes/No.

Treatment Assignment Protocol Assessment: Client Profile		
Intake ID: 1086	Client Name: Asteraceae, Zinnia	Unique Client Number: A23608019956780
SSN: 012-34-5678	DOB: 8/1/1999	Gender: Female
Class: Intake		
Interview Date: 6/4/2017		How Long at Current Address: 5 / 0 Yrs/Mo
Contact Code: In person		Is the Residence Owned by You or Family: Yes
Source of Referral: Family/Friend		County of Residence: Forest
Primary Payment Source: SCA		Controlled Environment in Last 30 Days?: Psychiatric TX
Interviewer: Jones, Sarah A., CCS		How Many Days in Controlled Environment: 2
Special Code: N/A, Interview Compl...		Days Attended AA/NA/Similar Meetings in Last 30 Days:
Military Status: No		Months Since Discharged from Last Admission:
Pregnant: Yes		Is This a TAP for Concerned Person: No
Race: Two or More Races		
Ethnicity: Unknown		
Religious Preference: Other		
<input type="button" value="Cancel"/> <input type="button" value="Save"/> <input type="button" value="Finish"/> <input type="button" value="Next"/>		

Figure 3-17: Treatment Assignment Protocol Assessment: Client Profile screen

7. Click **Save**.
8. Click the **right-arrow** button.

TAP: Withdrawal

9. Complete the fields on the TAP Withdrawal screen.

Treatment Assignment Protocol Assessment: Withdrawal

Intake ID: 1073	Client Name: Rose, Lavender	Unique Client Number: W3620629904440
SSN: 333-22-4444	DOB: 6/29/1990	Gender: Female

1. What is the longest # of days in a row that you have gone without using alcohol and/or drugs:

a. In the last 30 days?

b. In the last 6 months?

2. Is the client reporting or exhibiting any of the following symptoms:

Withdrawal Symptoms

Abdominal cramps/diarrhea

Anxiety, Depression

Back spasms

Excessive sweating

Selected Withdrawal Symptoms

3. How many times in your life have you been treated for:

a. Alcohol abuse?

b. Drug abuse?

4. How many of these were for:

a. Alcohol detox only?

b. Drug detox only?

5. How many days in the last 30 days have you been treated for alcohol and/or drugs as an:

a. In-patient?

b. Out-patient?

6. How many times in the last 30 days have you used:

a. Alcohol?

b. Drugs?

7. How many days in the last 30 have you experienced:

a. Alcohol problems?

b. Drug problems?

8. How many times have you had:

a. Alcohol DTs?

b. A drug overdose?

9. Do you sometimes use prescription, over the counter medication, alcohol, or an illicit drug to relieve withdrawal symptoms?

10. Have you noticed the need to increase the amount you use to achieve the same effect or high, or sometimes feel less effect or high, after using your usual amount?

11. Would you say that you often use more than you initially intended to over a longer period of time?

12. Have you ever had blackouts while drinking or using; drank or used enough that you could not remember what you said or did the next day?

13. Would you say that you spend a great deal of time obtaining the substance(s) you use, using them, and/or recovering from their effects?

14. IV drug use in the past?

15. What kind of tobacco do you currently use?

16. If cigarettes, indicate daily amount.

17. Would there be adequate support at home for you if you needed help while detoxing?

18. Do you have significant problems with other possible addictions such as sex, eating disorders, or gambling?

Interviewer Rating:

19. How would you rate the client's need for detox treatment?

Notes

Figure 3-18: Treatment Assignment Protocol Assessment: Withdrawal screen

10. Click **Save**.

11. Click the **right-arrow** button.

TAP: Medical

12. Complete the fields on the TAP Medical screen.

Treatment Assignment Protocol Assessment: Medical

Intake ID: 1073	Client Name: Rose, Lavender	Unique Client Number: W36206299044440
SSN: 333-22-4444	DOB: 6/29/1990	Gender: Female

- How many times in your life have you been hospitalized for medical treatment?
- How long ago was your last hospitalization for a physical problem? / Yrs/Mo
- Do you have a history of or current diagnosis of any of the following:

Abscess	▶	<input type="text"/>
Arthritis		
Cardiac		
Cirrhosis or liver problems		
- Do you have chronic medical problems which continue to interfere with your life?
- Are you taking any prescribed medication on a regular basis for a physical problem?
Please list:
- How many days in the last 30 have you experienced medical problems?
- How troubled have you been in the last 30 days by these medical problems?
- How many times in the last 30 days have you visited an ER?
- Have you ever been diagnosed with TB?
- Are you currently using birth control?
- What is your weight? lbs
- Have you noticed a recent weight loss?
- How many times in the last 6 months have you been hospitalized due to a non-TX drug and/or non-alcohol related problem?

Interviewer Rating:

- How would you rate the client's need for medical treatment?

Notes

Figure 3-19: Treatment Assignment Protocol Assessment: Medical

13. Click **Save**.

14. Click the **right-arrow** button.

TAP: Co-occurring

15. Complete the fields on the TAP Co-occurring screen.

Treatment Assignment Protocol Assessment: Co-occurring

Intake ID: 1073	Client Name: Rose, Lavender	Unique Client Number: W36206299044440
SSN: 333-22-4444	DOB: 6/29/1990	Gender: Female

1. How many times have you been treated for any psychological or emotional problems in a hospital or in-patient setting?

Have you had a significant period, that was not a direct result of alcohol/drug use, in which you have:

	Part 30 Days	Lifetime
2. Experienced serious depression, sadness, hopelessness, lack of interest?	<input type="text"/>	<input type="text"/>
3. Experienced serious anxiety, tension, inability to relax, unreasonable worry?	<input type="text"/>	<input type="text"/>
4. Experienced hallucinations or saw/heard things that did not exist?	<input type="text"/>	<input type="text"/>
5. Experienced trouble understanding, concentrating, remembering?	<input type="text"/>	<input type="text"/>
6. Experienced trouble controlling violent behavior including rage or violence?	<input type="text"/>	<input type="text"/>
7. Experienced serious thoughts of suicide?	<input type="text"/>	<input type="text"/>
8. Attempted suicide?	<input type="text"/>	<input type="text"/>
9. Been prescribed meds for psychological or emotional problems? Please specify: <input type="text"/>	<input type="text"/>	<input type="text"/>

10. How many days in the last 30 have you experienced psychological or emotional problems?

11. How troubled have you been in the last 30 days by these emotional problems?

12. Psychiatric problem in addition to alcohol/drug problem?

Interviewer Rating:
At the time of the interview was the client:

13. Obviously withdrawn/depressed?	<input type="text"/>
14. Obviously hostile?	<input type="text"/>
15. Obviously anxious/nervous?	<input type="text"/>
16. Having trouble with reality testing, thought disorders, paranoid thinking?	<input type="text"/>
17. Having trouble comprehending, concentrating, remembering?	<input type="text"/>
18. Having suicidal thoughts?	<input type="text"/>
19. How would you rate the client's need for treatment for emotional problems?	<input type="text"/>

Notes

Figure 3-20: Treatment Assignment Protocol Assessment: Co-occurring

16. Click **Save**.

17. Click the **right-arrow** button.

TAP: Motivation

18. Complete the fields on the TAP Motivation screen.

Treatment Assignment Protocol Assessment: Motivation

Intake ID: 1073 Client Name: Rose, Lavender Unique Client Number: W36206299044440
SSN: 333-22-4444 DOB: 6/29/1990 Gender: Female

1. Is the client motivated to change his/her alcohol/drug use?

2. Are there any medical conditions which interfere with the client's treatment needs?

Please Specify

3. How important now to the client is treatment for these medical problems?

4. Are there any psychological conditions which interfere with the client's treatment needs?

5. How important now to the client is treatment for these psychological problems?

Interviewer Rating:

6. How would you rate the client's readiness to change?

Notes

Cancel **Save** **Finish**

Figure 3-21: Treatment Assignment Protocol Assessment: Motivation

19. Click **Save**.

20. Click the **right-arrow** button.

TAP: Alcohol/Drug Usage

21. Complete the fields on the TAP Alcohol/Drug Usage screen.

Treatment Assignment Protocol Assessment: Alcohol/Drug Usage

Intake ID: 1073 Client Name: Rose, Lavender Unique Client Number: W36206299044440
SSN: 333-22-4444 DOB: 6/29/1990 Gender: Female

1. Which substance do you consider to be the client's:

a. Primary problem?

b. Secondary problem?

c. Tertiary problem?

	Primary	Secondary	Tertiary
2. Was the substance prescribed to the client?	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. What was the age of first use? (if unknown, enter "97"; if not applicable, enter "96"):	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. What is the severity of use?	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. What is the frequency of use?	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. What are the methods of use?	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. Have you ever tried to reduce or control use of this substance?	<input type="text"/>	<input type="text"/>	<input type="text"/>
8. Has anyone ever asked you to stop using this substance?	<input type="text"/>	<input type="text"/>	<input type="text"/>
9. What was the date of last use?	<input type="text"/>	<input type="text"/>	<input type="text"/>

10. Methadone Maintenance Planned?

11. Ever attended a self-help/support group (AA/NA, R/R, church, etc.)?

Other Additions: Selected Other Additions:

12. Last substance admission environment in the last 10 years

13. Number of prior substance abuse admissions

Interviewer Rating:

14. How would you rate the client's potential for continued use?

Notes:

Cancel **Save** **Finish** **◀** **▶**

Figure 3-22: Treatment Assignment Protocol Assessment: Alcohol/Drug Usage

22. Click **Save**.

23. Click the **right-arrow** button.

Support Sys (Systems)

TAP: Employment

24. Complete the fields on the TAP Employment screen.

Treatment Assignment Protocol Assessment: Employment

Intake ID: 1073 Client Name: Rose, Lavender Unique Client Number: W36206299044440
SSN: 333-22-4444 DOB: 6/29/1990 Gender: Female

Employment

1. Education completed?

2. Training or technical ed? / Yrs/Mo

3. Do you have a profession, trade, or skill?

Please specify:

4. Do you have a valid driver's license?

5. Do you have an automobile available for use?

6. Longest full time job? / Yrs/Mo

7. Usual or last occupation?

8. Does someone contribute to your support in any way?

9. Does this constitute the majority of your support?

10. Employment status?

11. Employer

12. How many days in the last 30 were you paid for work? include under the table

How much money did you receive from the following resources in the last 30 days:

13. Employment (gross)? 16. Pension, SS, benefits?

14. Unemployment comp? 17. Mate, family, friends?

15. Welfare? 18. Illegal?

* Current gross/taxable individual monthly income?

19. What is your primary source of income?

19a. Other Income Sources Other Income Sources Selected

Disability

None

Other

Public Assistance

20. How many months have you been employed during the last 6 months?

21. How many days in the last 30 have you experienced employment problems?

22. How many days of work and/or school have you missed in the last 6 months due to substance abuse related problems?

23. Do you have current health insurance?

24. If yes, does it cover substance abuse treatment?

Interviewer Rating:

25. How would you rate the client's need for employment services?

Notes

Cancel Save Finish <>

Figure 3-23: Treatment Assignment Protocol Assessment: Employment

25. Click **Save**.

26. Click the **right-arrow** button.

TAP: Social

27. Complete the fields on the TAP Social screen.

Treatment Assignment Protocol Assessment: Social

Intake ID: 1073	Client Name: Rose, Lavender	Unique Client Number: W36206299044440
SSN: 333-22-4444	DOB: 6/29/1990	Gender: Female

Family/Social Relationships

1. What is your current relationship status?
2. Are you satisfied with this situation?
- If no, please specify:
3. What has been your usual living arrangement?
4. How long have you lived in these arrangements? Yrs Mo
5. Are you satisfied with these arrangements?
6. Do you live with anyone who:
 - a. Has a current alcohol problem?
 - b. Uses non-prescribed drugs?
7. With whom do you spend most of your free time?
8. Are you satisfied spending your free time this way?
9. How many close friends do you have?
10. List the people with whom you have had a close, long lasting relationship:

Brother/Sister	▶	
Children		
Father	◀	
Friends		
11. Have you had significant periods in the last 30 days or in your lifetime in which you have experienced serious problems getting along with your:

	Past 30 Days			Lifetime		
Mother?	<input type="text"/>					
Father?	<input type="text"/>					
Brother/sister?	<input type="text"/>					
Sexual partner/spouse?	<input type="text"/>					
Children?	<input type="text"/>					
Other significant family?	<input type="text"/>					
Close friends?	<input type="text"/>					
Neighbors?	<input type="text"/>					
Co-workers?	<input type="text"/>					
12. Have any of these people abused you? If so, how and when?

	Past 30 Days			Lifetime		
	Emotionally	Physically	Sexually	Emotionally	Physically	Sexually
Mother	<input type="text"/>					
Father	<input type="text"/>					
Brother/sister	<input type="text"/>					
Sexual partner/spouse	<input type="text"/>					
Children	<input type="text"/>					
Other significant family	<input type="text"/>					
Close friends	<input type="text"/>					
Neighbors	<input type="text"/>					
Co-workers	<input type="text"/>					
13. How many children do you have age 17 or less (birth, adopted, or stepchildren) whether they live with you or not?
14. How many of these children spent the last 6 months living with you?
15. Are any of your children living with someone else because of a child protection order?
16. Does your substance use cause problems at home with your partner, children, or home obligations?
17. Do you have a DHS case worker?
18. How troubled have you been in the last 30 days by:
 - a. Family problems?
 - b. Social problems?
19. Have you given up or reduced your involvement in important social or recreational activities that did NOT include drinking or using?
20. Is there a family history of substance abuse or dependency?
- Interviewer Rating:
 21. How would you rate the client's need for family or social counseling?

Cancel
Save
Finish
◀
▶

Figure 3-24: Treatment Assignment Protocol Assessment: Social

28. Click **Save**.

29. Click the **right-arrow** button.

TAP: Legal

30. Complete the fields on the TAP Legal screen.

Treatment Assignment Protocol Assessment: Legal

Intake ID: 1086 Client Name: Asteraceae, Zinnia Unique Client Number: A23608019956780
SSN: 012-34-5678 DOB: 8/1/1999 Gender: Female

Legal

1. Was this admission prompted by the criminal justice system?

2. Are you on parole or probation?

How many times have you been arrested and/or charged and/or convicted for the following:

	Arrested	Charged	Convicted
3. Shoplifting/vandalism?	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. parole/probation violation?	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. Drug charges?	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. Forgery?	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. Weapons offense?	<input type="text"/>	<input type="text"/>	<input type="text"/>
8. Burglary, larceny, B&E?	<input type="text"/>	<input type="text"/>	<input type="text"/>
9. Robbery?	<input type="text"/>	<input type="text"/>	<input type="text"/>
10. Assault?	<input type="text"/>	<input type="text"/>	<input type="text"/>
11. Arson?	<input type="text"/>	<input type="text"/>	<input type="text"/>
12. Rape?	<input type="text"/>	<input type="text"/>	<input type="text"/>
13. Homicide/manslaughter?	<input type="text"/>	<input type="text"/>	<input type="text"/>
14. Prostitution?	<input type="text"/>	<input type="text"/>	<input type="text"/>
15. Contempt of court?	<input type="text"/>	<input type="text"/>	<input type="text"/>
16. OWI in the last 12 months?	<input type="text"/>	<input type="text"/>	<input type="text"/>
17. Non-drug or alcohol-related crime while under the influence in the last 12 months?	<input type="text"/>	<input type="text"/>	<input type="text"/>
18. Non-drug or alcohol-related crime while not under the influence in the last 12 months?	<input type="text"/>	<input type="text"/>	<input type="text"/>
19. Drug or alcohol-related crime in the last 12 months?	<input type="text"/>	<input type="text"/>	<input type="text"/>
20. Other?	<input type="text"/>	<input type="text"/>	<input type="text"/>
21. How many times have you been arrested in the past 12 months?	<input type="text"/>		
22. How many times have you been arrested in the past 30 days?	<input type="text"/>		
23. How long were you incarcerated in your life?	<input type="text"/> / <input type="text"/> / <input type="text"/> Yrs/Mo/Days		
24. How long was your last incarceration?	<input type="text"/> / <input type="text"/> / <input type="text"/> Yrs/Mo/Days		
25. What was it for?	<input type="text"/>		
26. Are you presently awaiting charges, trial, or sentence?	<input type="text" value="No"/>		
27. What for?	<input type="text"/>		
28. How many days in the last 30 were you detained or incarcerated?	<input type="text"/>		
29. How many days in the last 30 have you engaged in illegal activities for profit?	<input type="text"/>		
30. How serious do you feel your current legal problems are?	<input type="text"/>		
Interviewer Rating:			
31. How would you rate the client's need for legal services?	<input type="text"/>		
Notes	<input type="text"/>		

Figure 3-25: Treatment Assignment Protocol Assessment: Legal

31. Click **Save**.

32. Click the **right-arrow** button.

TAP: Summary

33. Complete the fields on the TAP Summary screen.

Treatment Assignment Protocol Assessment: Summary

Intake ID: 1073 Client Name: Rose, Lavender Unique Client Number: W36206299044440
SSN: 333-22-4444 DOB: 6/29/1990 Gender: Female

Interviewer Confidence Rating:

1. In your opinion, is the information in this assessment significantly distorted due to client's misrepresentation?

2. In your opinion, is the information in this assessment significantly distorted due to client's ability to understand?

Comments:

Assessment Duration

Interview Start Date: 6/29/2017 * The date will be set to the same as Interview Date.

End Date: 6/29/2017

Total Interview Time:

Cancel **Save** **Finish**

Figure 3-26: Treatment Assignment Protocol Assessment: Summary

34. Click **Save**.

35. Click the **right-arrow** button.

TAP: Narrative

36. Review the information on the TAP Narrative screen.

Intake ID: 1086 SSN: 012-34-5678	Client Name: Asteraceae, Zinnia DOB: 8/1/1999	Unique Client Number: A23608019956780 Gender: Female
Withdrawal		
Client reports and/or exhibits the following withdrawal symptoms (Anxiety, Depression, Insomnia, Sleep disturbance, Runny nose). Client reports 0 lifetime treatments for alcohol abuse and 0 treatments for drug abuse. Client denies using alcohol in the past month. Client denies using drugs in the past month. Client denies experiencing alcohol problems in the 30 days prior to the assessment. Client denies experiencing drug problems in the 30 days prior to the assessment. Client denies a history of alcohol DT's. Client denies a history of drug overdose. Client denies ever experiencing blackouts. She/he denies having experienced a preoccupation with substance use. Client denies a past history of IV drug use. She/he denies using tobacco. S/he acknowledges other possible addictions detailed further in the Comments section. This interviewer rates the client's need for detoxification services as Not at all.		
Medical		
She reports a history or current diagnosis of the following: (Vision). She states s/he uses birth control. Client reports weighing 100 and has noticed a recent weight loss. Client denies any hospitalizations in the past 6 months due to a non-alcohol or non-drug related problem. This interviewer rates the client's need for medical treatment as being Not at all.		
Co-occurring		
Client denies any treatments in a hospital/inpatient setting for psychological or emotional problems. Client acknowledges experiencing serious depression, sadness, hopelessness, loss of interest, or difficulty with daily function in the past 30 days. Client acknowledges experiencing serious unreasonable worry, or feel relaxed in the past 30 days. Client denies experiencing hallucinations or saw/heard things that did not exist during his/her lifetime. Client acknowledges experiencing trouble understanding, concentrating, remembering in the past 30 days. Client denies experiencing trouble controlling violent behavior including rage or violence during his/her lifetime. Client denies experiencing serious thoughts of suicide during his/her lifetime. Client denies attempting suicide during his/her lifetime. Client reports a history of having been prescribed medication for psychological or emotional problems. Client acknowledges experiencing psychological or emotional problems in the past 30 days. She reports being Extremely bothered by these problems in the past 30 days. The interviewer finds that the client does not appear to have a psychiatric problem in addition to possible alcohol/drug problem. At the time of the interview, the client seemed obviously depressed/withdrawn; did not appear obviously hostile; was obviously anxious/nervous. The interviewer noted no indicators that the client was having trouble with reality testing, thought disorders and/or paranoid thinking. The client appeared to be having trouble comprehending, concentrating, remembering; S/he denied suicidal thoughts at present. The interviewer rates the client's level of needs for mental health treatment as being High.		
Motivation		
This interviewer rates client's overall readiness to change as being in the Contemplation stage.		
Alcohol/Drug Usage		
The assessment information suggests that the client's primary problem substance is None. The assessment information suggests that the client's secondary problem substance is None. The assessment information suggests that the client's tertiary problem substance is None. The interviewer has assessed the client's severity of use as being N/A. The client reported her/his frequency of use of the primary substance as N/A. Method of administration is reported as N/A. The client reports no evidence of other addictions.		
Employment		
The client reports that s/he does have a valid driver's license. S/he has no automobile available for use. The client reported his/her usual or last occupation as being Sales. The client reports his/her employment status as Not in labor force (Student). He/she reports having health insurance that does not cover substance abuse treatment. Based on the above information, the interviewer rates the client's need for employment services as Low.		
Social		
The client describes her/his current relationship status as Never Married. The client states that s/he is not satisfied with this situation. The client's usual living arrangement has been Dependent Living. S/he states that free time is spent mostly Friends. S/he describes being indifferent to spending free time this way. The client reports that s/he lives with a person who has an active alcohol problem and/or uses non-prescription drugs. The client describes having 3 close friends. S/he describes long-lasting relationships with the following people: Brother/Sister, Friends. The client states that s/he has had significant period of time in which s/he had serious problem getting along with her/his: Mother, Father. The client states s/he has been emotionally abused by: Mother, Father. The client reports being Extremely troubled by family problems in the last 30 days. The client reports being Considerably troubled by social problems in the last 30 days. The client reports a family history of substance abuse or dependency. This interviewer rates the client's need for family or social counseling as Critical.		
Legal		
The client states that this admission was not prompted by the criminal justice system. S/he reports not being on probation or parole. Client denies any history of arrests.		
Comments		
In the interviewer's opinion, the assessment was Slightly distorted by the client's misrepresentations. In the interviewer's opinion, the information in this assessment was Not at all distorted by the client's ability to understand.		
<div style="text-align: right;">Cancel Save Finish ⏪</div>		

Figure 3-27: Treatment Assignment Protocol Assessment: Narrative

37. Click **Finish**.

If miscellaneous notes have not already been entered for the Gambling and TB Screening questions, a new screen will appear with a prompt stating, "Miscellaneous Notes should be entered for Gambling and TB Screening, would you like to collect the information at this time?" Select Yes. Selecting "Yes" will open the Notes screen, and steps for adding these miscellaneous notes are included in Part 4 of this guide.

If the Gambling and TB Screening notes have already been entered, this screen will not appear, and clicking Finish will return the user to the Treatment Assessment Protocol List.

Add New Follow up TAP

Once an Admission record is entered, users can only add a Follow-up TAP. If users try to enter an Initial TAP Assessment after an Admission record has been added, they will see the following error message:



Users should create a Follow-up TAP, instead of making changes to an Initial TAP, if one was created prior to Admission.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Assessments**, and then click **TAP**.
4. Click the **Add New Follow up TAP** link.

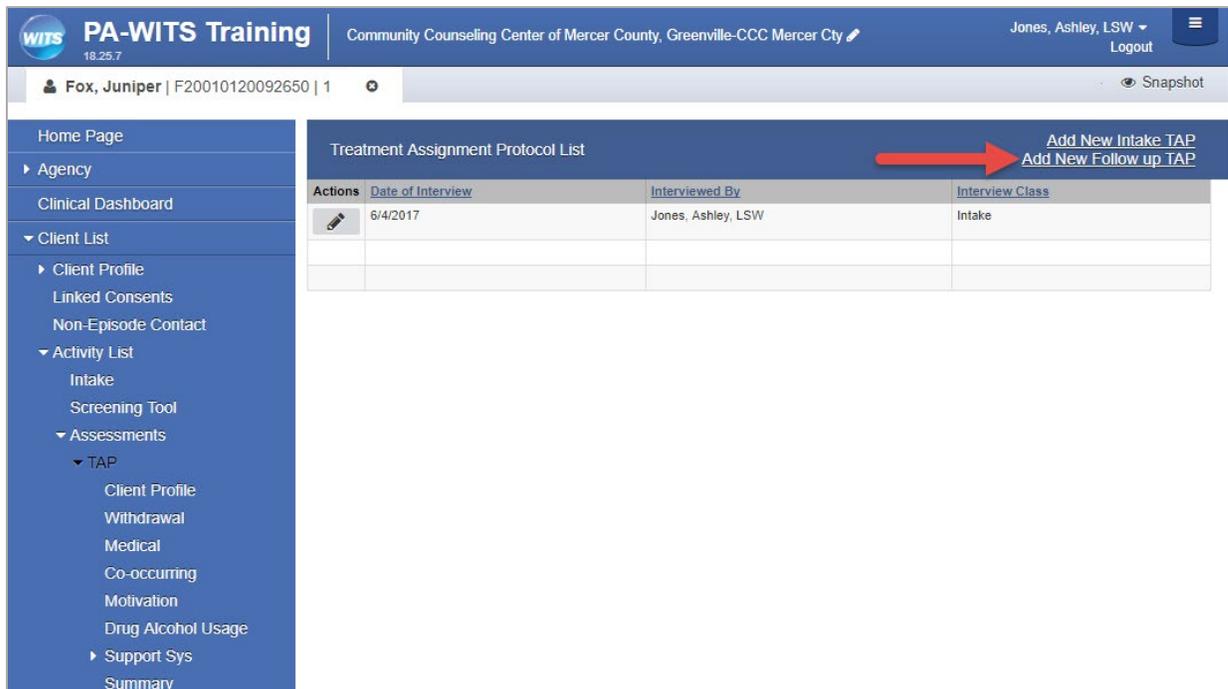


Figure 3-28: Add New Follow up TAP

5. Enter the **Interview Date**, then click **Save**.

6. If a TAP was completed within the last 6 months, you will be given the option to pull forward that information into the Follow-up TAP. You can then edit the previously entered information. Select **Yes** or **No**.

7. Complete the fields on the TAP Client Profile screen as shown in the table below.

Table 3-5: Follow-up TAP Client Profile fields

Field	Description
Class	Read-only field; displays "Follow-up".
Interview Date	Populates with the date entered on the previous screen.
Contact Code	Select "In person" or "Telephone".
Source of Referral	Read-only field. Displays selection entered on the Intake screen. If the Source of Referral information is updated on the Intake screen, this read-only field (on the TAP) will also be updated automatically.
Primary Payment Source	(Optional)
Interviewer	Defaults to the staff member currently signed in.
Special Code	(Optional)
Military Status:	Read-only field. Displays selection entered on the Client Profile Additional Information screen.
Pregnant	Read-only field. Displays selection entered on the Intake screen.
Race:	Read-only field. Displays selection entered on the Client Profile Additional Information screen.
Ethnicity:	Read-only field. Displays selection entered on the Client Profile Additional Information screen.
Religious Preference	(Optional)
How Long at Current Address	(Optional)
Is the Residence Owned by You or Family	(Optional)

Field	Description
County of Residence:	Read-only field. Displays selection entered on the Client Profile screen.
Controlled Environment in Last 30 Days?	(Optional)
How Many Days in Controlled Environment	(Optional)
Days Attended AA/NA/Similar Meetings in Last 30 Days	(Optional)
Months Since Discharged from Last Admission	(Optional)
Is This a TAP for Concerned Person	(Optional) Select Yes/No.

Figure 3-29: Follow-up TAP Client Profile screen

- Complete the Follow-up TAP by reviewing and updating the client’s answers to the nine questionnaires in the following topics: Withdrawal, Medical, Co-Occurring, Motivation, Drug Alcohol Usage, Employment, Social, Legal, and Summary. Use the left and right arrows to move between screens, and click Save to save the client’s responses.
- Review the information on the Narrative screen, then click **Finish**.

If miscellaneous notes have not already been entered for the Gambling and TB Screening questions, a new screen will appear with a prompt stating, “Miscellaneous Notes should be entered for Gambling and TB Screening, would you like to collect the information at this time?” Select Yes. Selecting “Yes” will open the Notes screen, and steps for adding these miscellaneous notes are included in Part 4 of this guide.

If the Gambling and TB Screening notes have already been entered, this screen will not appear, and clicking Finish will return the user to the Treatment Assessment Protocol List.

Placement Summary

ASAM



Where: [Client List](#) > [Activity List](#) > [ASAM](#)

1. On the left menu, click **Client List** and search for a client.
2. Hover over the **Actions** column, and click **Activity List**.
3. On the left menu, click **ASAM**.
4. Click **Add ASAM**.

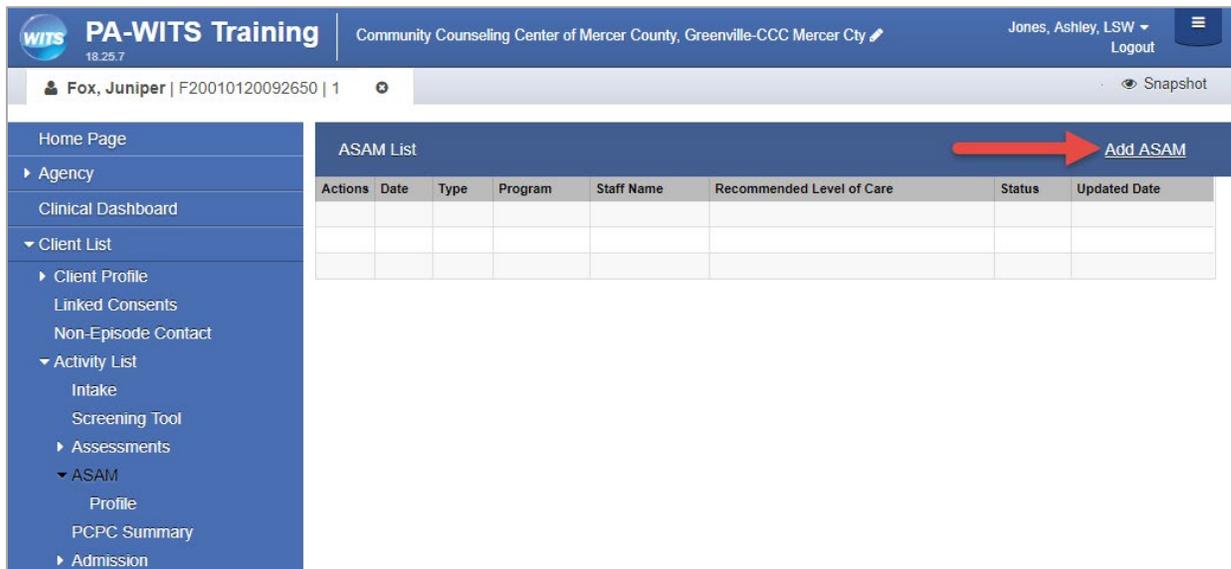


Figure 3-30: ASAM List screen, Add ASAM

5. Complete the fields on the ASAM screen as shown in the table below.

Table 3-6: ASAM Fields

Field	Description
Type	In the drop-down list, select "Admission", "Continued Stay", or "Discharge".
Dimensions For each of the following six (6) dimensions, complete these three (3) fields: <ul style="list-style-type: none"> • Level of Risk (optional) – select a number from the drop-down list • Level of Care – select an option from the drop-down list. • Criteria Included/Comments – type applicable comments 	
*Dimension 1 - Acute Intoxication and/or Withdrawal Potential	Select the Level of Risk (optional), Level of Care , and complete the Criteria Included/Comments field.
*Dimension 2 - Biomedical Conditions and *Complications	Select the Level of Risk (optional), Level of Care , and complete the Criteria Included/Comments field.
*Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and Complications	Select the Level of Risk (optional), Level of Care , and complete the Criteria Included/Comments field.

Field	Description
*Dimension 4 - Readiness to Change	Select the Level of Risk (optional), Level of Care , and complete the Criteria Included/Comments field.
*Dimension 5 - Relapse, Continued Use, or Continued Problem Potential	Select the Level of Risk (optional), Level of Care , and complete the Criteria Included/Comments field.
*Dimension 6 - Recovery / Living Environment	Select the Level of Risk (optional), Level of Care , and complete the Criteria Included/Comments field.
Recommended Level of Care	Select from the drop-down list.
Actual Level of Care	Select from the drop-down list.
Clinical Override	This field becomes required when the Recommended Level of Care and the Actual Level of Care fields do not match.
Comments	Type any applicable comments.
Date	Enter the date when the ASAM was administered.
Program	This field will be empty unless a client has a program enrollment.

The screenshot displays the ASAM Placement screen in the PA-WITS Training system. The interface includes a navigation sidebar on the left with categories like Agency, Client List, and ASAM. The main content area is titled 'ASAM' and features a 'Type' dropdown menu. Below this, there are six dimensions for assessment, each with a 'Level of Risk' and 'Level of Care' dropdown menu, and a 'Criteria Included/Comments' text area. At the bottom of the form, there are fields for 'Recommended Level of Care', 'Actual Level of Care', 'Clinical Override', 'Date', 'Program', and 'Comments'. The 'Date' field includes a calendar icon. At the bottom right, there are three buttons: 'Cancel' (red), 'Save' (green), and 'Finish' (blue). An 'Administrative Actions' section at the bottom left contains a 'Sign ASAM' link.

Figure 3-31: ASAM Placement screen

6. Click **Save**.

- In the Administrative Actions box, click **Sign ASAM**. Once the ASAM Summary has been signed, the summary will become read-only.

Please note that only users who have completed the required ASAM Criteria trainings are authorized to sign ASAM Summaries. Users who have not completed the trainings will be required to have their supervisor review the assessment and sign the ASAM Summary.

Administrative Actions

[Sign ASAM](#)

ASAM

	Type	Admission	
Dimension			
1 - Acute Intoxication and/or Withdrawal Potential	Level of Risk	4	Level of Care 3.5 - Clinically Managed Medium-Intensity Residential
	Criteria Included/Comments	N/A	
2 - Biomedical Conditions and Complications	Level of Risk	0	Level of Care N/A
	Criteria Included/Comments	N/A	
3 - Emotional, Behavioral, or Cognitive Conditions and Complications	Level of Risk	4	Level of Care 3.1 - Clinically Managed Low-Intensity Residential
	Criteria Included/Comments	N/A	
4 - Readiness to Change	Level of Risk	3	Level of Care N/A
	Criteria Included/Comments	N/A	
5 - Relapse, Continued Use, or Continued Problem Potential	Level of Risk	0	Level of Care N/A
	Criteria Included/Comments	N/A	
6 - Recovery / Living Environment	Level of Risk	3	Level of Care 3.5 - Clinically Managed Medium-Intensity Residential
	Criteria Included/Comments	Unsafe home environment	
Recommended Level of Care	3.5 - Clinically Managed Medium-Intensity Residential		Clinical Override
Actual Level of Care	3.5 - Clinically Managed Medium-Intensity Residential		
	Comments		
Date	6/4/2017	Program	

Administrative Actions

Signed by: Jones, Sarah A., CCS Signed on: 7/18/2017 9:52 AM

Cancel
Save
Finish

Figure 3-32: Signed ASAM screen

- Click **Finish**.

Admission



Where: [Client List](#) > [Activity List](#) > [Admission](#)

The Admission Screen in WITS denotes the date when a client has been admitted into Treatment, but does not always represent the date when a level of care has been assigned. The admission process may not be completed in one visit.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Admission**.
4. Complete the fields on the Admission Profile.

Table 3-7: Admission Profile Fields

Field	Description
Admission Type	Defaults to Initial Admission.
Admission Staff	Defaults to the staff member currently signed in.
Admission Date	
Selected Administrative Checklist Items	(Optional)

The screenshot shows the 'Admission Profile' screen in the WITS PA-WITS Training system. The client is Rose, Lavender (R20010129011110 | 1). The admission type is 'Initial Admission', the staff member is 'Jones, Ashley, LSW', and the admission date is '10/12/2017'. The administrative checklist includes 'Assessed individual for any special needs' and 'Completed PCPC'. Buttons for 'Cancel', 'Save', 'Finish', and a right arrow are visible at the bottom.

Figure 3-33: Admission Profile screen

5. Click **Save** and then click **Finish**.

NOTE • Optional information can be entered by clicking the right-arrow button. Please see the following page.

Admission Youth screens are available to capture specific information about youth clients. This information is not required as a part of TEDS data collection or the DDAP Treatment Manual.

The screenshot shows the 'Youth Admission' screen for client Fox, Juniper (ID: F20010120092650 | 1). The interface includes a navigation menu on the left with options like 'Home Page', 'Agency', 'Client List', 'Activity List', 'Assessments', 'ASAM', 'PCPC Summary', 'Admission', 'Profile', 'Youth', and 'Assmt Scores'. The main content area is titled 'Admission' and contains two sections: 'Youth Admission' and 'POSIT Scores'.
 The 'Youth Admission' section includes fields for 'Client is a Student' (Yes), 'Client is a Gang Member' (No), 'Guardian Name' (Fox, Fig), 'Guardian Type' (Other relative(s)), 'School Name', 'School Contact', 'Attending Grade', 'Days Suspended in Last 30 Days', 'Current GPA', and 'Days Absent in Last 30 Days'.
 The 'POSIT Scores' section includes input fields for: Substance Abuse Score, Peer Score, Leisure Recreational Score, Physical Health Score, Education Status Score, Aggression Score, Mental Health Score, Vocational Status Score, HIV Risk Score, POSIT Family Score, and Social Skill Score. At the bottom of the form are buttons for 'Cancel', 'Save', 'Finish', and navigation arrows.

Figure 3-34: Admission, Youth Admission screen

The screenshot shows the 'Assessment Scores' screen for client Rose, Lavender (ID: R20010129011110 | 1). The interface includes a navigation menu on the left with options like 'Home Page', 'Agency', 'Client List', 'Activity List', 'Assessments', 'ASAM', 'PCPC Summary', 'Admission', 'Profile', 'Youth', 'Assmt Scores', and 'Outcome Measures'. The main content area is titled 'Admission' and contains an 'Assessment Scores' section.
 The 'Assessment Scores' section includes input fields for: Medical, Employment, Drug, Alcohol, Legal, Family, Psychiatric, and Controlled Environment. Below these fields are links for 'Load Latest Assessment Scores' and 'Clear Assessment Scores'. At the bottom of the form are buttons for 'Cancel', 'Save', 'Finish', and a navigation arrow.

Figure 3-35: Admission, Assessment Scores screen

Outcome Measures (Initial)



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#)

The Outcome Measures module in WITS is used to collect data needed for the NOMS extract, which is reported to SAMHSA. Be sure to complete all the steps on the Outcome Measure screens to ensure accurate and complete TEDS information is collected.

Note: When the client is ready to be disenrolled from a treatment program, or if the client needs to be moved to a different level of care, an **Update** or **Final** Outcome Measure will be required. Please ensure your Outcome Measure data is collected within one (1) day of program disenrollment.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Outcome Measures**.
4. Click **Add New**.

The screenshot shows the PA-WITS Training interface. The top navigation bar includes the WITS logo, the text 'PA-WITS Training 18.25.7', the user's name 'Jones, Ashley, LSW', and a 'Logout' button. Below the navigation bar, the user's current client is identified as 'Fox, Juniper | F20010120092650 | 1'. The left-hand navigation menu is expanded to show 'Outcome Measures' with sub-options: 'Client Status', 'Diagnosis', and 'Program Enroll'. The main content area is titled 'Outcome Measures List' and contains a table with the following structure:

Actions	Type	Date	Domain(s)

A red arrow points to the 'Add New' link located in the top right corner of the table area.

Figure 3-36: Outcome Measure screen, Add New link

Client Status

5. Complete the fields on the Outcome Measures – Client Status screen.

Table 3-8: Outcome Measures – Client Status (Initial) fields

Field	Description
Date	Pre-populates with the Admission Date.
Type	Defaults to “Initial” when adding first Outcome Measure.
Pregnant	Pre-populates with the selection entered on the Intake screen. Select Yes or No, if applicable.
Due Date	Pre-populates with the selection entered on the Intake screen. Enter client’s Due Date, if applicable.
Profile	
Codependent/Collateral	Select Yes/No.
Co-Occurring SA and MH Problem	
Medication Assisted Tx	
SMI/SED Status	Not required
# of Prior SA Tx Episodes	
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	
Education	
Education Status	
Financial/Household	
Employment Status	
Source of Income	
Primary Payment Source	
Health Insurance	
Marital Status	
Living Situation	
# of People Living With Client, Including the Client	Not required
# of Children Under 18 Living/Not Living w/Client	Not required
Legal	
# of Arrests in Past 30 Days	
Mental Health Legal Status	
Add Selected Legal History	
Remove Selected Legal History	
Selected Legal History	

Field	Description
Substance Abuse	
For the following fields marked with an asterisk*, select options for Primary, Secondary, and Tertiary as applicable.	
For the following fields marked with two asterisks**, these fields will pre-populate with information entered on the most recent Screening Tool. This includes Screening Tool records that the client consented to share, and records created within the context agency.	
**Substance	
**Severity	
**Frequency	
**Method	
**Detailed Drug Code	
*At what age did the client FIRST use the substances indicated above (if unknown, enter '97')	
*# of DAYS since LAST use of the substances indicated above:	
Tobacco/Nicotine	
Have you ever used Tobacco/Nicotine products?	Select Yes, No, or Unknown. If Yes is selected, the following fields will become editable.
Smoker Status?	
Age of First Use	
In the past 30 days, what tobacco/nicotine product did you use most frequently?	
Other (Please Describe)	
In the past 30 days, how often did you use tobacco/nicotine product(s)?	

Outcome Measures - Client Status

Date: 6/4/2017 Type: Initial
 Pregnant: Yes Due Date: 2/5/2018

Domains: Selected Domains: Substance Abuse

Profile

Codependent/Collateral: No Co-Occurring SA and MH Problem: Yes
 Medication Assisted Tx: No SMI/SED Status: # of Prior SA Tx Episodes: 0
 # of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.
 No attendance in the past month

Education

Education Status: Grade 11

Financial/Household

Employment Status: Not in labor force (Student) Source of Income: None
 Primary Payment Source: SCA Health Insurance: SCA
 Marital Status: Never Married Living Situation: Dependent Living
 # of People Living With Client, Including the Client: 3 # of Children Under 18 Living/Not Living w/Client:

Legal

of Arrests in Past 30 Days: 0 Mental Health Legal Status:

Legal History: Selected Legal History: None/No Involvement

Substance Abuse

Rank	Substance	Severity	Frequency	Method	Detailed Drug Code
Primary:	Alcohol		Daily	Oral	Alcohol/Spirits
Secondary:	Marijuana/Hashish		1-3 Times/Month	Smoking	Marijuana/Hashish
Tertiary:	None	N/A	N/A	N/A	Not Applicable

At what age did the client FIRST use the substances indicated above (if unknown, enter '97')
 Primary: 13 Secondary: 16 Tertiary: 96
 # of DAYS since LAST use of the substances indicated above: Primary: 1 Secondary: 3 Tertiary:

Tobacco/Nicotine

Have you ever used Tobacco/Nicotine products? Yes
 Smoker Status? Former smoker
 Age of First Use: 16
 In the past 30 days, what tobacco/nicotine product did you use most frequently? None
 Other (Please Describe):
 In the past 30 days, how often did you use tobacco/nicotine product(s)? NA

Cancel Save Finish

Figure 3-37: Outcome Measures – Client Status screen, Initial Outcome Measure

- Click **Save**.
- Click the **right-arrow** button.

Diagnosis

- Complete the fields on the **Client Diagnosis** screen.

Note: Required TEDS does not include Secondary and Tertiary diagnoses. DDAP also does not require Medical or Psychological diagnoses to be entered.

Table 3-9: Client Diagnosis fields

Field	Description
Effective Date	Pre-populates to the Outcome Measure date.
Time	Pre-populates to 12:00 AM.
Diagnosing Clinician	In the drop-down list, select the staff member who diagnosed the client. Note: this field will only display staff members with the Client Diagnosis role.
GAF Score	(Optional)

- Click **Edit Diagnosis** to add one or more diagnoses for the client. This link can also be used to edit a previously entered diagnosis.

The screenshot shows the 'Client Diagnosis' screen. At the top right, there is a blue header bar with the text 'Client Diagnosis' and a red arrow pointing to a link labeled 'Edit Diagnosis'. Below the header, there are several input fields: 'Primary', 'Secondary', and 'Tertiary' (all dropdown menus); 'Effective Date' (set to 6/4/2017), 'Expiration Date', 'Time' (set to 12:00 AM); 'Diagnosing Clinician' (dropdown menu); and 'GAF Score' (text input). Below these fields are three tables for 'Behavioral Diagnosis', 'Medical Diagnosis', and 'Psychosocial Diagnosis'. Each table has columns for 'Code', 'Description', 'Comments', and 'Principal'. At the bottom right, there are buttons for 'Cancel', 'Save', 'Finish', and navigation arrows. At the bottom left, there is an 'Actions' field.

Figure 3-38: Outcome Measures - Client Diagnosis screen, Edit Diagnosis link

10. On the **Edit Diagnosis** screen, enter the following information, as listed in Table 3-11 below.

Table 3-10: Client Diagnosis, Edit Diagnoses fields

Field	Description
Type	Select "Behavioral" from the drop-down list.
Diagnosis	Type at least two (2) characters for options to appear in the drop-down list. Select an option. Please note that only ICD 10 codes are available in PA WITS. If the diagnosis, either the exact code or wording that is on your form, is not listed, select Unknown.
Principal Diagnosis	Select "Yes". Note: At least one diagnosis must be marked "Yes" as the Principal Diagnosis.
Comments	Type any comments if applicable.

Client Diagnosis

Type

Diagnosis Principal Diagnosis

Comments

Behavioral Diagnosis

Actions	Code	Description	Comments	Principal

Medical Diagnosis

Actions	Code	Description	Comments	Principal

Psychosocial Diagnosis

Actions	Code	Description	Comments	Principal

Figure 3-39: Outcome Measures - Client Diagnosis, Edit Diagnosis screen



Figure 3-40: Client Diagnosis, Edit Diagnosis screen, select Type of diagnosis

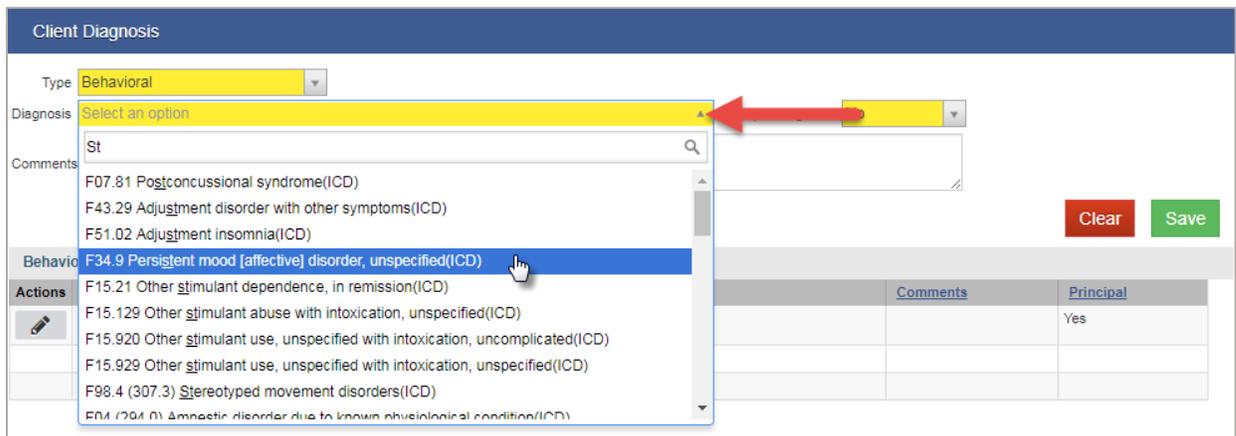


Figure 3-41: Client Diagnosis, Edit Diagnosis screen, select client's diagnosis

11. Click **Save**. The Diagnosis information will update in the Behavioral Diagnosis section of the screen.
12. Enter the Secondary Diagnosis and/or Tertiary Diagnosis, if applicable and time permits.
Note: TEDS does not collect Secondary and Tertiary diagnoses.

Client Diagnosis

Type ▼

Diagnosis Select an option ▼ Principal Diagnosis No ▼

Comments

Clear Save

Behavioral Diagnosis

Actions	Code	Description	Comments	Principal
	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder		Yes
	F34.9	Persistent mood [affective] disorder, unspecified		No

Medical Diagnosis

Actions	Code	Description	Comments	Principal
	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No

Psychosocial Diagnosis

Actions	Code	Description	Comments	Principal
	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Finish

Figure 3-42: Client Diagnosis, Edit Diagnosis screen with multiple diagnoses

13. Click **Finish**. You are redirected to the main Client Diagnosis screen.

Client Diagnosis [Edit Diagnosis](#)

Primary: F10.94-Alcohol use, unspecified with alcohol-induced mood disorder(ICD) Effective Date: 6/4/2017 Time: 12:00 AM
 Secondary: Expiration Date: Time:
 Tertiary:

Diagnosing Clinician: Jones, Sarah A., CCS GAF Score:

	Code	Description	Comments	Principal
Behavioral Diagnosis	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder		Yes
	F34.9	Persistent mood [affective] disorder, unspecified		No
Medical Diagnosis	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No
Psychosocial Diagnosis	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Actions:

Figure 3-43: Client Diagnosis screen with list of client's diagnoses

14. Select the client's **Secondary** diagnosis, if applicable and time permits. **Note:** TEDS does not collect Secondary and Tertiary diagnoses.

Client Diagnosis [Edit Diagnosis](#)

Primary: F10.94-Alcohol use, unspecified with alcohol-induced mood disorder(ICD) Effective Date: 6/4/2017 Time: 12:00 AM
 Secondary: Expiration Date: Time:
 Tertiary:

Diagnosing Clinician: Jones, Sarah A., CCS GAF Score:

	Code	Description	Comments	Principal
Behavioral Diagnosis	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder		Yes
	F34.9	Persistent mood [affective] disorder, unspecified		No
Medical Diagnosis	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No
Psychosocial Diagnosis	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Figure 3-44: Client Diagnosis screen, select Secondary diagnosis

- Select the client's **Tertiary** diagnosis, if applicable and time permits. **Note:** TEDS does not collect Secondary and Tertiary diagnoses.

Client Diagnosis [Edit Diagnosis](#)

Primary F10.94-Alcohol use, unspecified with alcohol-induced mood disorder(ICD) Effective Date 6/4/2017 Time 12:00 AM

Secondary F34.9-Persistent mood [affective] disorder, unspecified(ICD) Expiration Date Time

Tertiary Assigning Clinician Jones, Sarah A., CCS

GAF Score

Beha
Diag

- O09.91-Supervision of high risk pregnancy, unspecified, first trimester(ICD)
- O26.11-Low weight gain in pregnancy, first trimester(ICD)
- O99.311-Alcohol use complicating pregnancy, first trimester(ICD)
- Z63.79-Other stressful life events affecting family and household(ICD)
- Z81.1-Family history of alcohol abuse and dependence(ICD)

	Code	Description	Comments	Principal
Medical Diagnosis	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No
Psychosocial Diagnosis	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Figure 3-45: Client Diagnosis screen, select Tertiary diagnosis

- Click **Save**.
- Click the **right-arrow** button.

Program Enroll

18. On the Program Enrollment screen, click **Add Enrollment**.

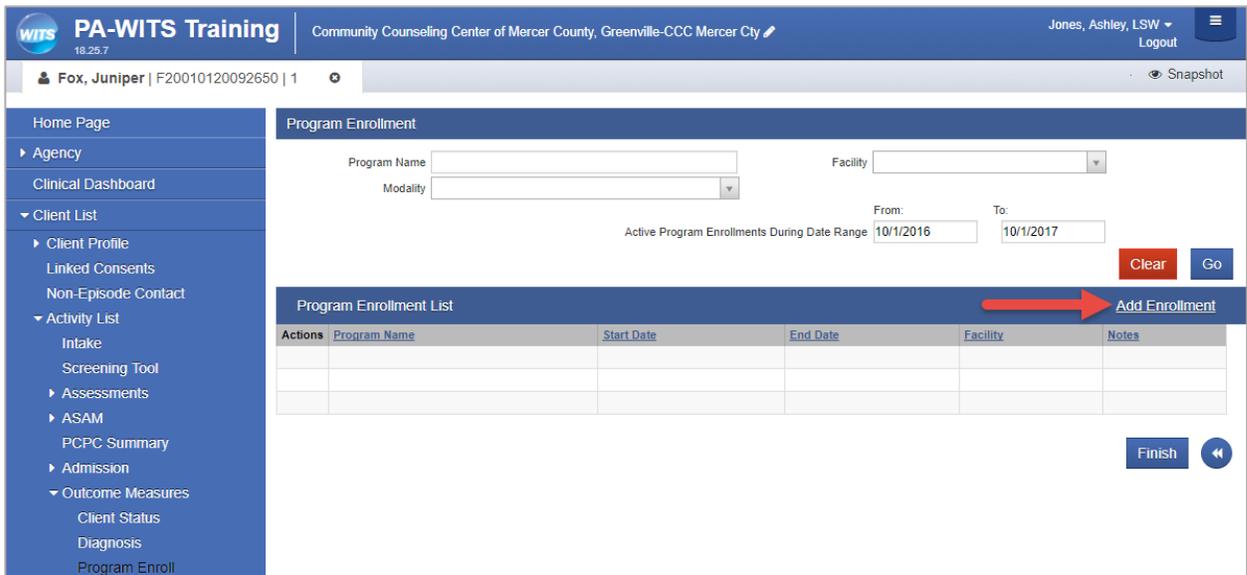


Figure 3-46: Outcome Measures – Program Enrollment screen

19. Complete fields on the Program Enrollment Profile as shown in the table below.

Table 3-11: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the currently Facility name.
Program Name	Select from the programs available.
Program Staff	Pre-populates with the current staff member name.
Start Date	Pre-populates with the Outcome Measure date.
Days on Wait List	
Reason for waiting?	<p>If the client had to wait longer than two weeks to access the recommended level of care, select the reason from the drop-down list.</p> <p>This field will be required if:</p> <ul style="list-style-type: none"> The program enrollment start date is more than 14 days from the most recent ASAM or Placement Summary date. The LOC associated with the program is different than the Recommended LOC of the most recent ASAM or Placement Summary (consented or client activity).
Notes	Type any notes as needed.

The enrollment admission status values are collected on Outcome Measure screens.

Program Enrollment Profile

Facility	Administrative Unit	Days on Wait List	6	Start Date	8/10/2017
Program Name	TEDS	Reason for waiting?	Client Choice	End Date	
Program Staff	Jones, Sarah A., CCS				
Termination Reason					
Notes					

Cancel Save Finish

Figure 3-47: Program Enrollment Profile screen

20. On the Program Enrollment Profile screen, click **Finish**.

21. On the Program Enrollment screen, click **Finish**.

Note: A client cannot be enrolled in more than one TEDS or treatment program at a time. For example, if a client is discharged from detox at 11:00pm and immediately transferred to rehab, the program enrollment Start Date for rehab must be the following day. The Start Date for the new program enrollment cannot be the same as the End Date for the previous program enrollment.

Outcome Measures (Update and Final)

Note: When the client is ready to be disenrolled from a treatment program, or if the client needs to be moved to a different level of care, an **Update** or **Final** Outcome Measure will be required. Please ensure your Outcome Measure data is collected within one day of program disenrollment.

DDAP will be utilizing the Update Outcome Measure when a client is transferring from one level of care to another within the same facility. A Final Outcome Measure will be completed when transferring from one facility to another, or when the client is no longer in treatment at your facility. It is possible that you may not enter an Update Outcome Measure, and would proceed directly to the Final Outcome Measure.

1. From the Outcome Measures List, click **Add New**.

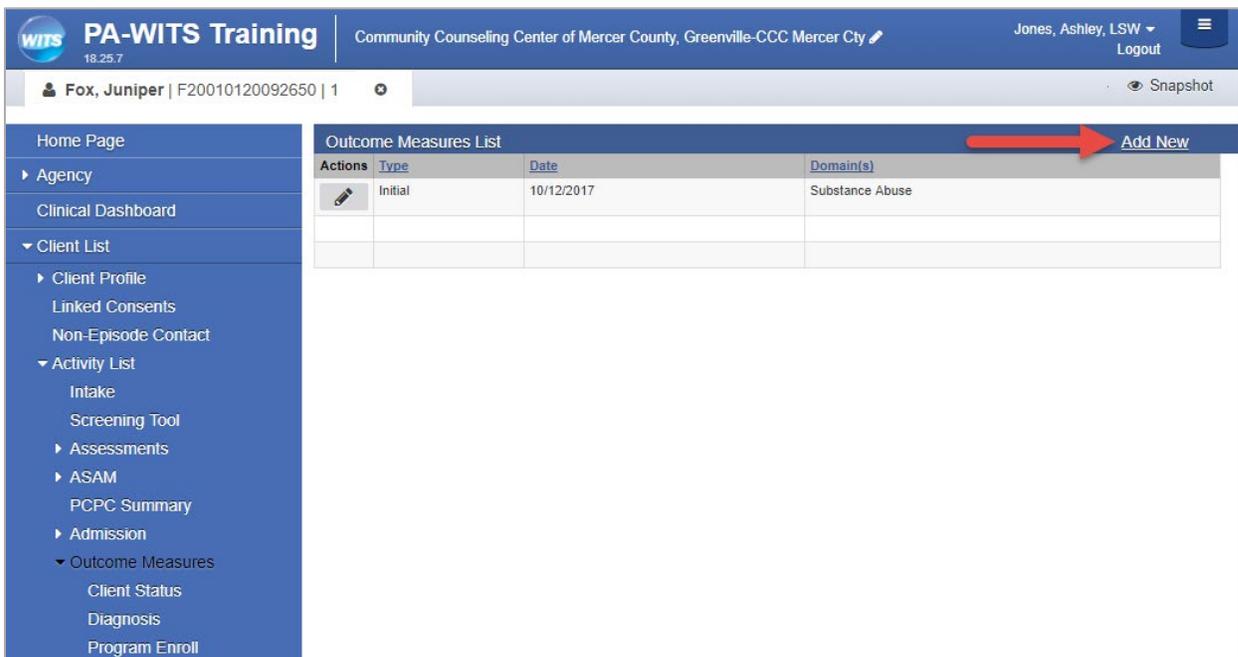


Figure 3-48: Add New Outcome Measure

2. On the Outcome Measures Client Status screen, complete the following information:

Field	Description
Date	Enter the date of discharge from the current level of care
Type	Select Update or Final
Date of Last Contact	Enter the last date when treatment occurred
Profile	

Field	Description
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	
Legal	
# of Arrests in Past 30 Days	
Substance Abuse	
Frequency	Select the updated Frequency from the drop-down menu.

- Click **Save**, then click the **Right Arrow**.
- On the Diagnosis screen, you only need to update information if the Diagnosis has changed. If no changes are needed, click the **Right Arrow**.

On the Program Enrollment screen, you will complete two tasks: unenroll the client from the current level of care, and enroll them in the new level of care.

- Hover** over the pencil icon of the current program. Click **Review**.

Actions	Program Name	Start Date	End Date	Facility	Notes
	821 Inpt Non-Hosp Detox 3A	5/3/2018		DDAP Training 01	

- Enter the **End Date**, which is the date of discharge from the program and the Outcome Measure Date that was entered on the Client Status screen. This date should not be confused with the Date of Last Contact.
- Select the **Termination Reason**.

- Click **Finish**.

Next you will complete the enrollment into the new level of care. **NOTE:** This will not be done if completing a Final Outcome Measure.

9. On the Program Enrollment screen, click **Add Enrollment**.

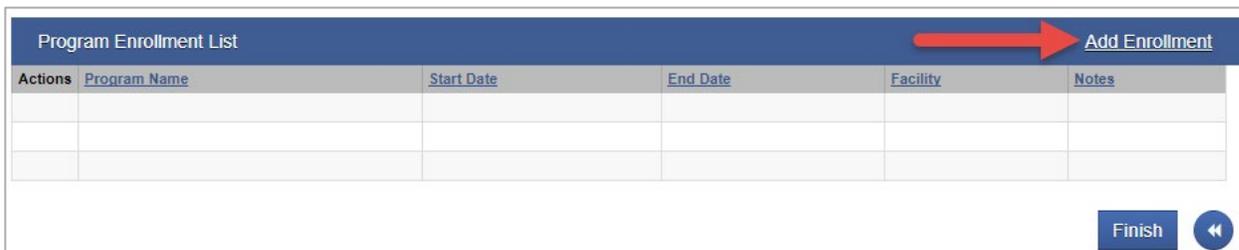


Figure 3-49: Outcome Measures – Program Enrollment screen

22. Complete fields on the Program Enrollment Profile as shown in the table below.

Table 3-12: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the currently Facility name.
Program Name	Select from the programs available.
Program Staff	Pre-populates with the current staff member name.
Start Date	Pre-populates with the Outcome Measure date.
Days on Wait List	
Reason for waiting?	<p>If the client had to wait longer than two weeks to access the recommended level of care, select the reason from the drop-down list.</p> <p>This field will be required if:</p> <ul style="list-style-type: none"> The program enrollment start date is more than 14 days from the most recent ASAM or Placement Summary date. The LOC associated with the program is different than the Recommended LOC of the most recent ASAM or Placement Summary (consented or client activity).
Notes	Type any notes as needed.

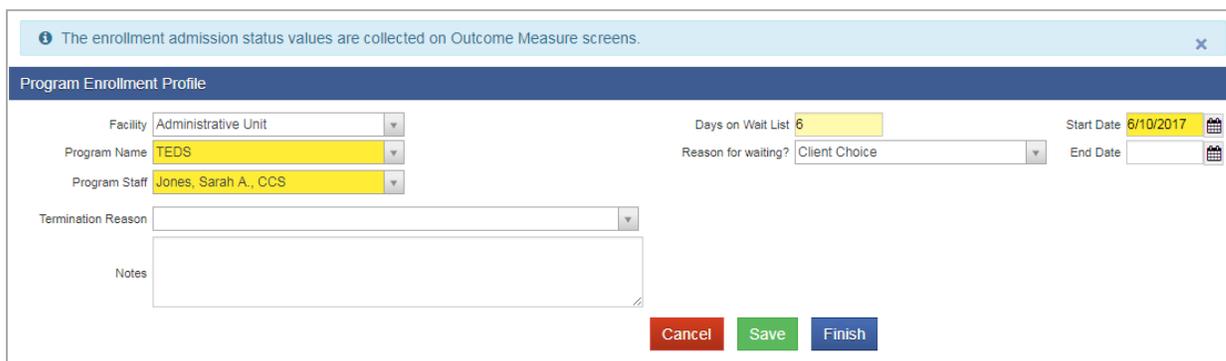


Figure 3-50: Program Enrollment Profile screen

23. On the Program Enrollment Profile screen, click **Finish**.

24. On the Program Enrollment screen, click **Finish**.

Note: A client cannot be enrolled in more than one TEDS or treatment program at a time. For example, if a client is discharged from detox at 11:00pm and immediately transferred to rehab, the program enrollment Start Date for rehab must be the following day. The Start Date for the new program enrollment cannot be the same as the End Date for the previous program enrollment.

Consent

Create Client Consent Record

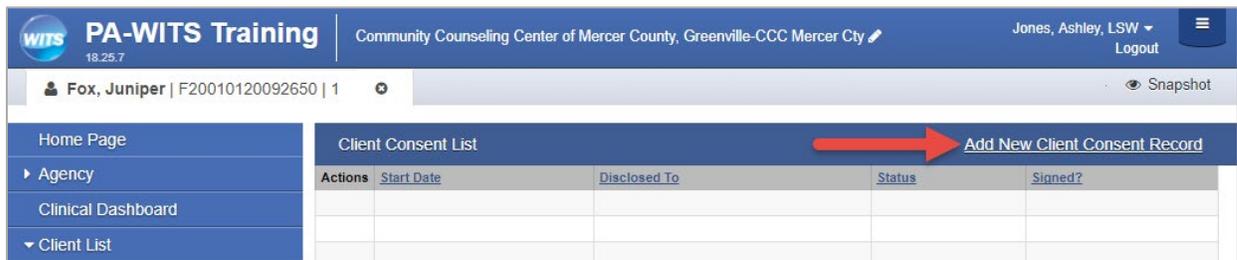


Where: [Client List](#) > [Activity List](#) > [Consent](#)

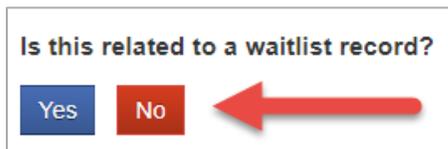
The consent is a formal process adhering to 42 CFR Part 2, which governs the sharing of client information between agencies and facilities using WITS. A consent may also be used to record the sharing of information (on paper) with agencies who do not use WITS, making the consent part of the electronic health record.

It is also important to note that redisclosure of information is not possible in PA WITS, even with client consent. For example, if Agency A discloses information to Agency B, such as the client's Intake or Screening, then the client transfers to Agency C, the Intake or Screening cannot be sent from Agency B's records. Agency C would need to contact Agency A to have those records disclosed, which will involve a new Client Consent Record being created at Agency A.

1. On the left menu, click **Client List** and search for a client.
2. Locate the client, hover over the Actions column, and then click **Activity List**.
3. On the left menu, click **Consent**.
4. Click the **Add New Client Consent Record** link.



5. Select **No**.



6. On the Client Disclosure Agreement screen, complete the following fields.

Table 3-13: Client Disclosure Agreement fields

Field	Description
Entities with Disclosure Agreements	Select from the drop-down list. This field will display a list of agencies that have previously created a Disclosure template. This will prepopulate fields in the "Client Information To Be Consented" section, which can then be modified if needed.
System Agency	Select "Yes" if the agency uses WITS.
Disclosed to Agency	Select the agency that will be receiving the client's information.

Field	Description
Facility	Select the facility within the selected Agency that will be receiving the client's information. Select All Facilities, or an individual facility.
Purpose for Disclosure	Type the reason for creating the Consent record.
Earliest date of services to be consented	Select the date.
Has the client signed the paper agreement form	Select "No" to save the screen and have the client sign the paper form (see below), after client has signed, select "Yes".
Date client signed consent	This field will become editable when "Yes" is selected in the previous field.

Client Disclosure Agreement

Note: Consented information may not be redisclosed.

Client Name: poppins, mary
Unique Client Number: P15206017665430
Disclosed From Agency: Administrative Agency

Entities with Disclosure Agreements

System Agency

Disclosed To Agency Facility

Disclosed To Entity (Non System Agency)

Purpose for disclosure

Earliest date of services to be consented

Has the client signed the paper agreement form Date client signed consent

Client Information To Be Consented

Expiration Type + Days

*Expiration type is required for disclosure activities.

Client Information Options

- Admission
- ASAM
- ATR Eligibility Screen
- Behavioral Health Assessment
- CAGE-AID Screening
- CONTINUUM Triage™ Assessment
- CONTINUUM™
- DENS ASI Assessment
- DENS ASI Lite
- Diagnosis List

Disclosure Selection

- Client Information (Profile) (UD, +3)
- Client Screening (UD, +30)
- Consent (UD, +30)
- Intake Transaction (UD, +30)
- TAP Assessment (UD, +30)

Comments

Other Disclosures

Figure 3-51: Client Disclosure Agreement screen

- If additional consent information needs to be added or removed from the client’s disclosure agreement, update the options from the “Client Information To Be Consented” section. Your agency administrator may have set up templates for the disclosure agreement.

Table 3-14: Client Information To Be Consented fields

Field	Description
Expiration Type and + Days	Select either “Discharge (UD)” or “Date Signed (DS)”, then when the yellow field appears, enter the number of days the consent will expire.
Client Information Options/Disclosure Selection	Select options from the box and use the mover buttons to add or remove the desired consent options.

If any items have different expiration dates, a separate Client Consent Record must be created for each expiration date. For example, if the Intake expires 30 days after Discharge, but the Screener expires 30 days after Date Signed, these items must be consented separately.

- When all required fields are complete, click **Save**.

Note: When consenting a TAP assessment, the Misc Notes that include the gambling screener and TB screener must also be consented.

Print the Client Consent Form

- After saving the Client Disclosure Agreement screen, click the **Generate Report** link to print the Client Consent Form to get the client's signature on the paper copy. The printed consent form includes items from the Client Information Options box along with the Consent Expires information.

The screenshot shows the PA-WITS Training interface. The top navigation bar includes the WITS logo, the user name 'Jones, Ashley, LSW', and a 'Logout' button. Below the navigation bar, the user's name 'Fox, Juniper' and ID 'F20010120092650' are displayed. A red arrow points to the 'Generate Report' link in the top right corner. The main content area is titled 'Client Disclosure Agreement' and contains the following information:

- Note: Consented information may not be redisclosed.
- Client Name: Fox, Juniper
- Unique Client Number: F20010120092650
- Disclosed From Agency: Community Counseling Center of Mercer County
- Entities with Disclosure Agreements: All Other Agencies
- System Agency: Yes
- Disclosed To Agency: Administrative Agency
- Facility: Administrative Unit
- Disclosed To Entity (Non System Agency):
- Purpose for disclosure: Client's level of care has changed and needs services fr

Figure 3-52: Client Disclosure Agreement screen, Generate Report

- Once the client has signed the paper form, update these fields:

- Has client signed the paper agreement form:** select "Yes"
- Date client signed consent:** defaults to current date

- Click **Save** and stay on this screen (notice the fields are now grayed out).

- After saving the client consent, a link to add a Client Referral for this consent will be available. This will open the client referral screen, and will pre-populate the signed consent and Agency fields of the Referred to section.

- Click the link, **Create Referral Using this Disclosure Agreement**, and continue to the section.

The screenshot shows a printable version of the Client Consent Form. The title is 'CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS'. The form contains the following text:

The confidentiality of client records maintained by an ATR service provider ("program") is protected by Federal law and regulations. Generally, the program may not say to a person outside the program that a client is enrolled in ATR, or disclose any information identifying a client as a person with a problem with alcohol or other drugs unless:

- The client consents in writing; OR
- The disclosure is allowed by a court order; OR
- The disclosure is made to medical personnel in a medical emergency or to a qualified personnel for research, audit, or program evaluation; OR
- The client consents or threatens to commit a crime either at the program or against any person who works for the program.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

See 42 U.S.C. Sec. 2906d-2 for federal law and 42 CFR Part 2 for federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records.

Source: "A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA", Legal Action Center (1998).

CONSENT FOR TWO-WAY RELEASE OF CONFIDENTIAL INFORMATION

I, Donald Abare, authorize the ATR4 Coordinator Agency to communicate with and disclose to West Care Coordination Inc. the following information:

The purpose of the disclosure authorized herein is:

- to verify my eligibility to receive and to pay West Care Coordination Inc. for the following ATR services:
- needed for other facility

I also authorize West Care Coordination Inc. to communicate with and disclose to the ATR4 Coordinator Agency all information related to the services I received from West Care Coordination Inc. for purposes of payment and care coordination.

This authorization expires six months from today's date.

I understand that my records are protected under federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. I understand that authorizing disclosure of the information identified above is voluntary. However I understand that lack of consent to share information may prevent ATR Coordinator and the ATR Service Provider from providing ATR services and/or authorizing payment for services, and I may be denied referral for MA consent form.

Printable Consent Form

next

The screenshot shows the PA-WITS Training interface, similar to Figure 3-52. The 'Generate Report' link is now grayed out, and a new link, 'Create Referral Using this Disclosure Agreement', is highlighted with a red arrow. The main content area is titled 'Client Disclosure Agreement' and contains the same information as in Figure 3-52.

Figure 3-53: Create Referral Using this Disclosure Agreement link

Referrals

Create a Client Referral



Where: Client List > Activity List > Referrals

Continuing from previous section...

Once the Client Consent is complete, create the Client Referral Record. A referral is used when the receiving agency (another WITS agency) will be providing services for the client. Referrals may also be done from one facility to another facility within the same agency.

- After clicking the **Create Referral Using this Disclosure Agreement** link, the Referral screen will open.

The screenshot shows the 'Referral' screen with two main sections: 'Referred By' and 'Referred To'.
Referred By: Agency (Administrative Agency), Facility (Administrative Unit), Staff Member (Jones, Ashley), Program (dropdown), State Reporting Category (dropdown), Reason (dropdown), If Other (text field), Is Consent Verification Required? (dropdown), Is Consent Verified? (dropdown), Continue This Episode of Care? (No dropdown), Comments (text area), Referral Status (Referral Created/Pending dropdown), Projected End Date (calendar icon), Created Date (7/24/2017 2:20 PM).
Referred To: Signed Consents (ALCOHOL AND DRUG ABUSE SERVICES dropdown), Agency (ALCOHOL AND DRUG ABUSE SERVICES), Facility (CHESTNUT ST-A&D ABUSE SRVCS), Staff Member (dropdown), Program (dropdown), State Reporting Category (dropdown), Non-System Agency (dropdown), Non-System Modality (dropdown), Non-System Specifier (dropdown), Appt Date (calendar icon, Undetermined).
Consents Granted: Consent Date: 6/30/2017, Disclosure Domains: Admission (UD, +30), ASAM (UD, +30), Client Information (Profile) (UD, +30), Client Screening (UD, +30), Intake Transaction (UD, +30).
 Buttons: Cancel, Save, Finish.

Figure 3-54: Referral screen

- On the Client Referral screen, complete the required fields in the **Referred By** section, including:

Table 3-15: Referred By fields

Field	Description
Program	Select the Program, if available.
Reason	In the drop-down field, select the reason why this client is being referred.
Is Consent Verification Required?	Select Yes.
Is Consent Verified?	Select Yes.
Continue Episode of Care?	Select Yes or No.
Referral Status	State of the referral (this should be "Referral Created/Pending").
Created Date	Date client is referred.

16. Next, in the **Referred To** section, complete all the required fields, including:

Table 3-16: Referred To fields

Field	Description
Signed Consents	Select the consent from list of available consents.
Agency	This field will auto populate based on the "Consent" selected.
Facility	The facility the client is being referred to.
Program	The program the client is being referred to.

17. When complete, click **Finish**.

Client Discharge

After the client has completed treatment in a facility, or has been referred to another facility to continue their treatment, they can be discharged and the case can be closed.

1. On the left menu, click **Discharge**.
2. Enter the date of **Discharge**.
3. Select the **Discharge Staff** from the drop-down box.
4. Click **Finish**.

Discharge Profile

Discharged 2/10/2017

Discharge Staff AgencyAdmin, DDAP Discharge Referral

Disposition

Cancel
Save
Finish

Note: There are additional screens that can be completed if the client is an adolescent. These screens are not required by DDAP, but may be used if your agency chooses to.

5. In the upper left corner of the page, above the words "Home Page" click on the small **x** to close the client profile.

Woman, Wonder | W55001016833330 | 1
Snapshot

Home Page

▼ Client List

▶ Client Profile

▼ Activity List

▶ Admission

▶ Outcome Measures

▶ Discharge

Episode List

Client Activity List

Actions	Activity	Activity Date	Created Date	Status
	Client Information (Profile)	9/1/2017	9/20/2017	Completed
	Intake Transaction	9/1/2017	9/20/2017	Completed
	Admission	9/1/2017	9/20/2017	Completed
	Client Program Enrollment (Test Program)	9/1/2017	9/20/2017	Completed
	Outcome Measures - Client Status (Initial)	9/1/2017	9/20/2017	Completed
	Outcome Measures - Client Status (Update)	9/7/2017	9/20/2017	Completed
	Client Program Enrollment (Test Program)	9/8/2017	9/20/2017	Completed
	Outcome Measures - Client Status (Update)	9/8/2017	9/20/2017	Completed
	Discharge	9/19/2017	9/20/2017	Completed
	Outcome Measures - Client Status (Final)	9/19/2017	9/20/2017	Completed
	Diagnosis Summary	9/20/2017	9/20/2017	Not Applicable

Part 4: Case Management/Treatment Planning

Program Enroll (Case Management or Non-TEDS Program)



Where: [Client List](#) > [Activity List](#) > [Program Enroll](#)

Clients enrolled in treatment programs will already have a program enrollment, which was entered as part of an Outcome Measure. If you are providing Case Management or non-TEDS services for a client and the client does not have a program enrollment in your agency, you will need to create a program enrollment.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Program Enroll**.
4. Click the **Add Enrollment** link.

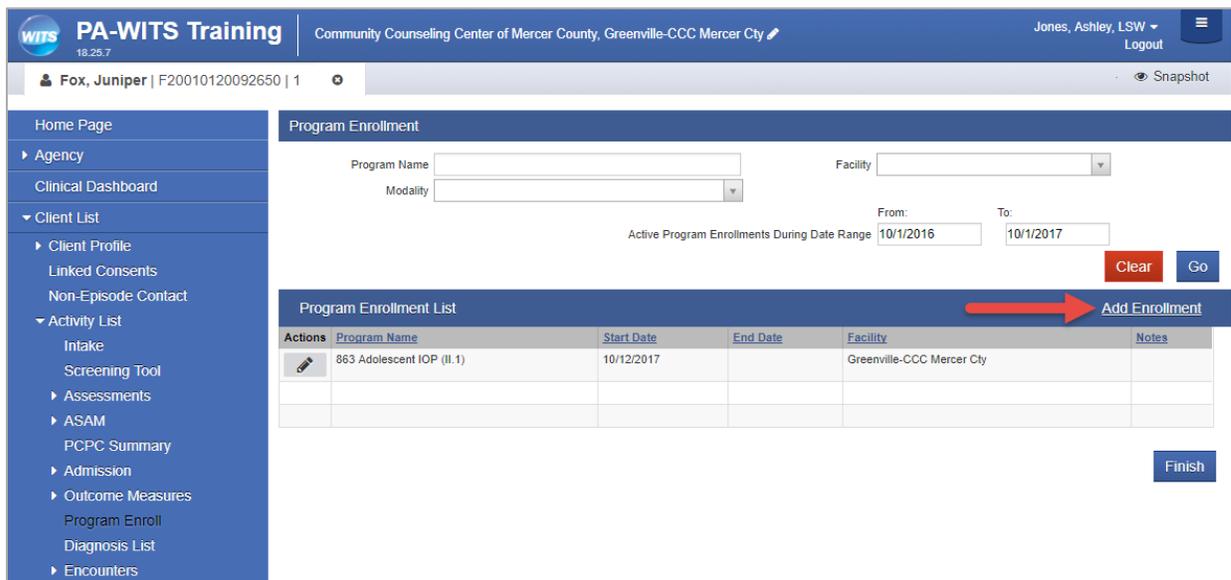


Figure 4-1: Program Enrollment screen

5. Complete fields on the Program Enrollment Profile.

Table 4-1: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the current Facility name.
Program Name	Select the appropriate program for the client
Program Staff	Pre-populates with the current staff member name.
Start Date	Defaults to the current date.
Days on Wait List (TEDS Only)	
Reason for waiting? (TEDS Only)	
Notes	Type any notes as needed.

Figure 4-2: Program Enrollment Profile screen

6. Click **Finish**.
7. On the Program Enrollment screen, click **Finish**.

When the client is no longer receiving Case Management or Non-TEDS services, they can be disenrolled from the program.

8. **Hover** over the pencil icon of the current program. Click **Review**.

Actions	Program Name	Start Date	End Date	Facility	Notes
	821 Inpt Non-Hosp Detox 3A	5/3/2018		DDAP Training 01	

9. Enter the **End Date**, which is the date of discharge from the program and the Outcome Measure Date that was entered on the Client Status screen. This date should not be confused with the Date of Last Contact.

10. Select the **Termination Reason**.

11. Click **Finish**.
12. On the Program Enrollment Screen, click **Finish**.

Recovery Plan



Where: [Client List](#) > [Activity List](#) > [Recovery Plan](#)

Role(s) Needed:

- Recovery Plan (Full Access) or Recovery Plan (Read Only) role

Note: PA Form 1008 = Life Domains/Goals screen

The first step in creating the Recovery Plan is to add the Recovery Team Members, which is done through the Treatment Team module.

Add Recovery Team Members

The first step in creating the Recovery Plan is to add the Recovery Team Members, which is done through the Treatment Team module.

- Click **Tx Team** in the left menu.
- If the staff member is already a member of the client's treatment team, locate their name in the list, **hover** over the pencil icon, and click **Review**.
- Locate the Treatment Sub-Teams mover box. Select **Recovery**, then click the **right arrow**.

- Click **Save**.

If the staff member is not a member of the client's treatment team, please review those steps in Part 3 of this user guide.

New Recovery Plan Profile

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Recovery Plan**.
4. Click **Add New Recovery Plan Record**.



Figure 4-9: Recovery Plan List screen

5. Complete the Recovery Plan Profile fields.

Table 4-2: Recovery Plan Profile fields

Field	Description
Plan Name	Type a name for the client’s plan.
Plan Start Date	Defaults to today’s date.
Plan End Date	Defaults to the date 60 days from today’s date.
Plan Period (Days)	This field defaults to 60 days.
Plan Status	Read-only field.
Next Review Date	Defaults to the date 60 days from today’s date.
Client Participated in Recovery Plan Development	Select Yes or No.

Recovery Plan Profile

Created By: <input type="text"/>	Updated By: <input type="text"/>
Created Date: <input type="text"/>	Last Updated Date: <input type="text"/>
Plan Name: <input type="text" value="Recovery Plan"/>	Plan Start Date: <input type="text" value="6/15/2018"/> <input type="text" value=""/>
Plan Period (Days): <input type="text" value="60"/>	Plan End Date: <input type="text" value="8/14/2018"/> <input type="text" value=""/>
Plan Status: <input type="text" value="Active - Not Signed Off"/>	Next Review Date: <input type="text" value="8/14/2018"/> <input type="text" value=""/>
Client Participated in Recovery Plan Development <input type="text" value="Yes"/>	

Administrative Actions

Create New Version
Sign Off

Figure 4-10: Recovery Plan Profile screen

NOTE • If you change the Start Date, the remaining dates do not auto-calculate based on this change. You will need to manually change the End Date and Next Review Date, as well.

6. Click **Save**.
7. Click the **right-arrow** button or on the left menu, click **Overview**.

Life Domains/Goals (PA Form 1008)

Note: this screen is prepopulated with the Life Domains from PA form 1008.

- A Recovery Plan may have one or several **Life Domains**. Each life domain can be associated with one or multiple **Goals**.

Recovery Plan Summary			Add New Life Domain
Actions #	Life Domains	Client Resources	Client Barriers
 1	Healthcare Coverage		
 2	Basic Needs		
 3	Physical Health	I have health insurance.	Fear of doctors offices. I'm not sure what to do to help improve my overall physical health.
 4	Emotional/Mental Health	My sister is supportive; my medication has been helping.	Triggers that cause panic attacks/anxiety.
 5	Family	My closest family member is my sister.	I have trouble talking with my parents sometimes.
 6	Child Care	N/A	N/A
 7	Legal Status	N/A	N/A
 8	Education/Vocation		
 9	Life Skills	My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.	My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.
 10	Social	I'm not sure.	It's hard making new friends with similar interests.
 11	Employment		Stressful work environment; long commute with lots of traffic.

Finish
⏪
⏩

9. Hover over the Actions column, and click Review.

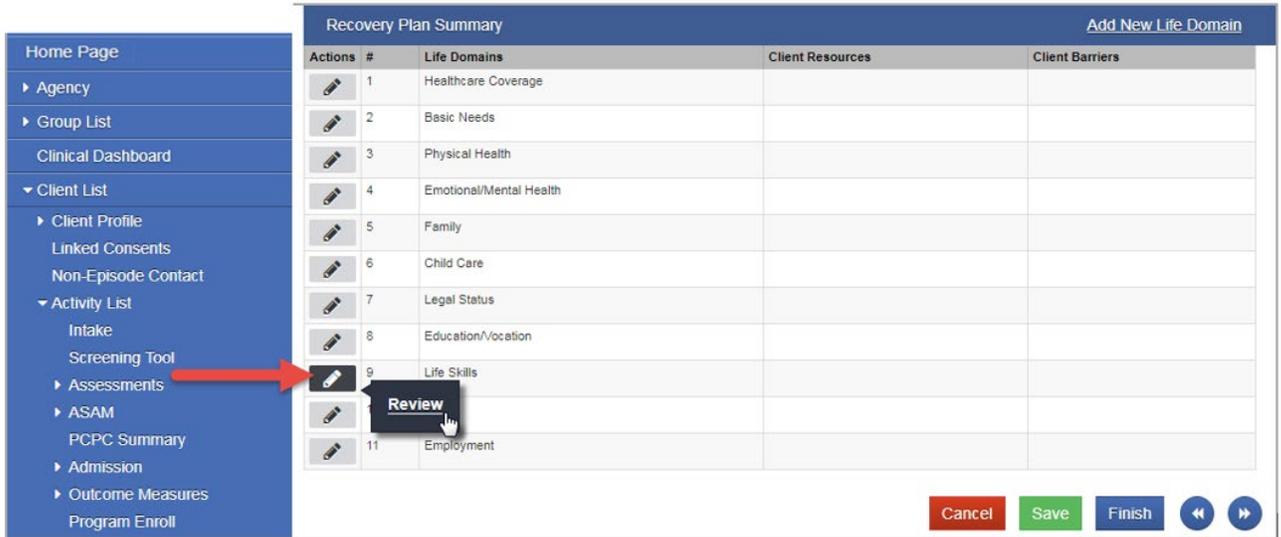


Figure 4-13: Recovery Plan Summary screen, Life Domains

10. Complete the Life Domain/Strengths and Challenges Profile.

NOTE • Users should not change the Life Domain displayed on this screen.

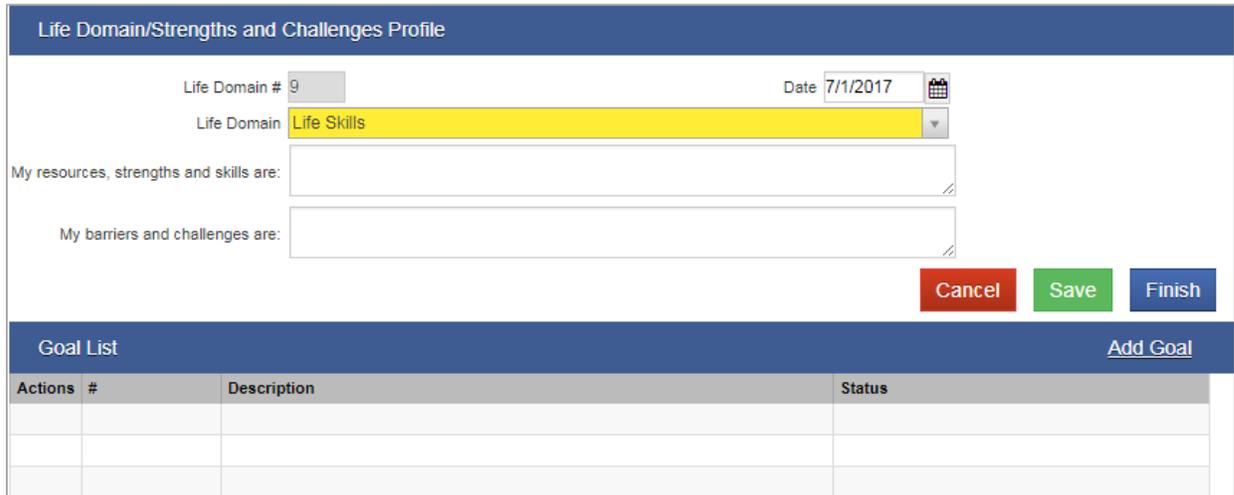


Figure 4-3: Life Domain/Strengths and Challenges Profile screen

11. Click **Save**.

Add Goal

A Goal may have one or several Objectives.

12. On the Life Domain/Strengths and Challenges Profile, click **Add Goal**.

The screenshot shows a web form titled "Life Domain/Strengths and Challenges Profile". It contains several input fields: "Life Domain #" with the value "9", "Date" with "7/1/2017", and a dropdown menu for "Life Domain" set to "Life Skills". There are two text areas: "My resources, strengths and skills are:" containing the text "My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.", and "My barriers and challenges are:" containing "My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.". At the bottom right of the form are three buttons: "Cancel", "Save", and "Finish". Below the form is a "Goal List" section with a table header: "Actions", "#", "Description", and "Status". A red arrow points to the "Add Goal" link in the top right corner of the table area.

Figure 4-14: Life Domain/Strengths and Challenges Profile

13. Complete the fields on the Goal Profile.

Table 4-3: Goal Profile fields

Field	Description
Goal Status	Select from In Progress, Completed, Deferred, and Withdrawn
My goal in this area is:	
I will know I have achieved this goal when:	
Projected Achievement Date	

Goal Profile

Life Domain #: 9
 Life Domain: Life Skills
 Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.
 Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.

Goal Status:

My goal in this area is:

I will know I have achieved this goal when:

Projected Achievement Date:

Cancel **Save** **Finish**

Objective List [Add Objective](#)

Actions	#	Description	Status

Goal Profile

Life Domain #: 9
 Life Domain: Life Skills
 Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.
 Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.

Goal Status:

My goal in this area is:

I will know I have achieved this goal when:

Projected Achievement Date:

Cancel **Save** **Finish**

Objective List [Add Objective](#)

Actions	#	Description	Status

14. Click **Save**.

Add Objective

Each Objective can be associated with one or multiple Action Steps. You may add multiple goals for each life domain, multiple objectives for each goal, and multiple action steps for each objective, as appropriate for your client.

15. Click Add Objective.

Goal Profile

Life Domain #: 9
Life Domain: Life Skills
Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.
Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.

Goal Status: In progress
My goal in this area is: My goal is to learn how to better handle life situations to reduce my overall anxiety levels.
I will know I have achieved this goal when:
Projected Achievement Date

Cancel Save Finish

Objective List [Add Objective](#)

Actions	#	Description	Status

16. Complete the fields on the Objectives screen.

Objectives

Life Domain #: 9
Date Assessed: 7/1/2017
Life Domain: Life Skills
Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.
Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.
Goal: My goal is to learn how to better handle life situations to reduce my overall anxiety levels.

Objective# 1 Create Date
I will achieve my goal by (objective):
Objective Status
Expected Achieve Date Resolution Date

Cancel Save Finish

Action Steps [Add Action Step](#)

Actions	#	Description	Status

17. Click **Save**.

Add Action Step

18. On the Objectives screen, click **Add Action Step**.

The screenshot shows the 'Objectives' screen. At the top, there is a blue header with the text 'Objectives'. Below this, the screen is divided into several sections. The first section contains the following information: Life Domain #: 9, Date Assessed: 7/1/2017, Life Domain: Life Skills, Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography., Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work., and Goal: My goal is to learn how to better handle life situations to reduce my overall anxiety levels. Below this, there is a form for 'Objective # 1' with a 'Create Date' of 7/6/2017. The 'I will achieve my goal by (objective):' field contains the text 'Reduce life stressors.' The 'Objective Status' is set to 'In progress'. There are also fields for 'Expected Achieve Date' and 'Resolution Date', both with calendar icons. At the bottom right of this section are three buttons: 'Cancel' (red), 'Save' (green), and 'Finish' (blue). Below this section is a blue header for 'Action Steps' with a red arrow pointing to the 'Add Action Step' link. At the bottom of the screen is a table with the following structure:

Actions	#	Description	Status

19. Complete the fields on the Action Steps screen.

The screenshot shows the 'Action Steps' screen. At the top, there is a blue header with the text 'Action Steps'. Below this, the screen is divided into several sections. The first section contains the following information: Life Domain #: 9, Life Domain: Life Skills, Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography., Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work., and Goal: My goal is to learn how to better handle life situations to reduce my overall anxiety levels. Below this, there is a form for 'Objective # 1' with the objective 'Reduce life stressors.' and 'Objective Create Date: 7/6/2017'. The 'Objective Status' is set to 'In progress'. Below this, there is a form for 'Action Step # 1' with the text 'To achieve my goal, I will participate in the following activities:' and the text 'Identify what causes stress in my life.' The 'Create Date' field is empty. The 'Action Step Status' is set to 'In progress'. At the bottom right of this section are three buttons: 'Cancel' (red), 'Save' (green), and 'Finish' (blue).

20. Click **Finish**.

21. Add additional Actions Steps as needed.

Objectives

Life Domain #: 9
 Date Assessed: 7/1/2017
 Life Domain: Life Skills
 Strengths/Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.
 Barriers and Challenges: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.
 Goal: My goal is to learn how to better handle life situations to reduce my overall anxiety levels.

Objective# Create Date

I will achieve my goal by (objective):

Objective Status

Expected Achieve Date Resolution Date

Action Steps
[Add Action Step](#)

Actions	#	Description	Status
	1	Identify what causes stress in my life.	In progress
	2	Meet with a life coach and enroll in life skills class.	In progress

22. Click **Finish**.

Plan Outline

The Recovery Plan Outline allows the staff to review, add or delete to all the Life Domains from one screen. The Generate Report link at the top right will open a popup window of a pdf file of the Recovery Plan in a report format.

The screenshot shows a web interface for a Recovery Plan. At the top right, there is a 'Generate Report' button with a document icon and a 'Snapshot' button with an eye icon. A red arrow points to the 'Generate Report' button. Below this is a dark blue header bar with the text 'Recovery Plan'. Underneath is a light grey bar with the text 'Plan Outline' and a blue 'Finish' button. A red arrow points to the 'Finish' button. The main content area contains six life domain entries, each in a white box with a blue border. Each entry has a title, a description, and a list of links: 'Review', 'Delete', and 'Add Goal'. A red arrow points to the 'Review' link of the second life domain. The life domains are: 1. Healthcare Coverage, 2. Basic Needs, 3. Physical Health, 4. Emotional/Mental Health, 5. Family, and 6. Child Care. Each entry also includes 'Resources, Strengths and Skills:' and 'Barriers:' labels.

Recovery Plan ([Review](#) | [Add Life Domain](#))

Recovery Plan: Recovery Plan
Start Date: 9/20/2017 End Date: 11/19/2017

Life Domain 1 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Healthcare Coverage
Resources, Strengths and Skills:
Barriers:

Life Domain 2 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Basic Needs
Resources, Strengths and Skills:
Barriers:

Life Domain 3 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Physical Health
Resources, Strengths and Skills:
Barriers:

Life Domain 4 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Emotional/Mental Health
Resources, Strengths and Skills:
Barriers:

Life Domain 5 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Family
Resources, Strengths and Skills:
Barriers:

Life Domain 6 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Child Care
Resources, Strengths and Skills:
Barriers:

- Home Page
- State Waitlist
- Agency
- Group List
- Clinical Dashboard
- Client List
- Client Profile
 - Linked Consents
 - Non-Episode Contact
 - Activity List
 - Intake
 - Screening Tool
 - Assessments
 - ASAM
 - PCPC Summary
 - Admission
 - Outcome Measures
 - Program Enroll
 - Diagnosis List
 - Encounters
 - Notes
 - Drug Testing
 - Tx Team
 - Treatment Plan
 - Discharge
 - Recovery Plan
 - Profile
 - Overview
 - Life Domains/Goals
 - Plan Outline
 - Consent
 - Referrals
 - Episode List
 - System Administration
 - Reports
 - Support Ticket

Recovery Plan
Finish

Recovery Plan ([Review](#) | [Add Life Domain](#))

Recovery Plan: Recovery Plan
Start Date: 7/1/2017 End Date: 9/1/2017

Life Domain 1 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Healthcare Coverage
Resources, Strengths and Skills:
Barriers:

Life Domain 2 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Basic Needs
Resources, Strengths and Skills:
Barriers:

Life Domain 3 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Physical Health
Resources, Strengths and Skills: I have health insurance.
Barriers: Fear of doctors offices. I'm not sure what to do to help improve my overall physical health.

Goal 3.1 ([Review](#) | [Delete](#) | [Add Objective](#))

Goal: To incorporate healthy eating and exercise into my daily life. Goal Status: In progress

Objective 3.1.1 ([Review](#) | [Delete](#) | [Add Action Step](#))

Objective: Preparing and eating healthier meals. Objective Status: In progress

Action Step 3.1.1.1 ([Review](#) | [Delete](#))

Action Step: Keep a daily food journal. Action Step Status: In progress

Action Step 3.1.1.2 ([Review](#) | [Delete](#))

Action Step: Enroll in healthy cooking class. Action Step Status: Deferred

Objective 3.1.2 ([Review](#) | [Delete](#) | [Add Action Step](#))

Objective: Participating in at least 30 minutes of activity 5 days a week. Objective Status: In progress

Life Domain 4 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Emotional/Mental Health
Resources, Strengths and Skills: My sister is supportive, my medication has been helping.
Barriers: Triggers that cause panic attacks/anxiety.

Life Domain 5 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Family
Resources, Strengths and Skills: My closest family member is my sister.
Barriers: I have trouble talking with my parents sometimes.

Life Domain 6 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Child Care
Resources, Strengths and Skills: N/A
Barriers: N/A

Life Domain 7 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Legal Status
Resources, Strengths and Skills: N/A
Barriers: N/A

Life Domain 8 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Education/Location
Resources, Strengths and Skills:
Barriers:

Life Domain 9 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Life Skills
Resources, Strengths and Skills: My family and friends are supportive. Some of my strengths include my love for learning and desire to better myself. I'm also somewhat skilled in art and photography.
Barriers: My job is very stressful and causes anxiety which also makes me depressed. I feel like I don't have much time to accomplish anything outside of work.

Goal 9.1 ([Review](#) | [Delete](#) | [Add Objective](#))

Goal: My goal is to learn how to better handle life situations to reduce my overall anxiety levels. Goal Status: In progress

Objective 9.1.1 ([Review](#) | [Delete](#) | [Add Action Step](#))

Objective: Reduce life stressors. Objective Status: In progress

Action Step 9.1.1.1 ([Review](#) | [Delete](#))

Action Step: Identify what causes stress in my life. Action Step Status: In progress

Action Step 9.1.1.2 ([Review](#) | [Delete](#))

Action Step: Meet with a life coach and enroll in life skills class. Action Step Status: In progress

Life Domain 10 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Social
Resources, Strengths and Skills: I'm not sure.
Barriers: It's hard making new friends with similar interests.

Goal 10.1 ([Review](#) | [Delete](#) | [Add Objective](#))

Goal: Meet at least one new person and participate in an extracurricular activity together. Goal Status: In progress

Objective 10.1.1 ([Review](#) | [Delete](#) | [Add Action Step](#))

Objective: Attending a group class or activity. Objective Status: In progress

Action Step 10.1.1.1 ([Review](#) | [Delete](#))

Action Step: Identify several group activities or classes to enroll in. Action Step Status: In progress

Action Step 10.1.1.2 ([Review](#) | [Delete](#))

Action Step: Enroll and attend at least one class session. Action Step Status: In progress

Life Domain 11 ([Review](#) | [Delete](#) | [Add Goal](#))

Life Domain: Employment
Resources, Strengths and Skills:
Barriers: Stressful work environment; long commute with lots of traffic.

Figure 4-4: Plan Outline

Sign Off

Once the Recovery Plan is complete, you can Sign off on it. Once signed off, the Recovery Plan becomes read-only.

23. On the Recovery Plan Profile, in the Administrative Actions box, click **Sign Off**.

The screenshot shows the 'Recovery Plan Profile' form. It includes the following fields and values:

Created By:	Full, Clinical	Updated By:	Full, Clinical
Created Date:	6/15/2018	Last Updated Date:	6/15/2018
Plan Name:	Recovery Plan	Plan Start Date:	6/15/2018
Plan Period (Days):	60	Plan End Date:	8/14/2018
Plan Status:	Active - Not Signed Off	Next Review Date:	8/14/2018
Client Participated in Recovery Plan Development:		Yes	

Administrative Actions:

- Create New Version
- [Sign Off](#)

Buttons: Cancel, Save, Finish, and a right arrow button.

24. Click **Yes** only if appropriate treatment team members have approved the recovery plan. Once you click Yes, this plan becomes the active recovery plan.

Click **Yes** only if appropriate treatment team members have approved the recovery plan. Once you click **Yes**, this plan becomes the active recovery plan.

Buttons: Yes, No

Note: The "Sign Off" link is no longer a clickable link on the Recovery Plan Profile screen.

Create New Recovery Plan Version

A user can use the Create New Version when updates need to be made to an Active –Signed off Recovery Plan. A new version will pull forward all the information from the previous plan into the new plan in an edit mode.

Recovery Plan Profile	
Created By: Full, Clinical	Updated By: Full, Clinical
Created Date: 6/15/2018	Last Updated Date: 6/15/2018
Plan Name: Recovery Plan	Plan Start Date: 6/15/2018
Plan Period (Days): 60	Plan End Date: 8/14/2018
Plan Status: Active - Signed Off	Next Review Date: 8/14/2018
Client Participated in Recovery Plan Development: Yes	
Administrative Actions	
Create New Version Sign Off	
Finish 	

25. Click **Create New Version** in the Administrative Actions box.

26. Answer **Yes** to the question "Are you sure you want to start a new recovery plan? Doing so will cause the current one to become inactive which cannot be undone."

Are you sure you want to start a new recovery plan? Doing so will cause the current one to become inactive which cannot be undone.	
Yes	No

27. Click the right arrow to move from the Recovery Plan Profile screen to the Recovery Plan Summary screen. You can now make any changes or updates to the client's recovery plan.

Diagnosis List



Where: *Client List* > *Activity List* > *Diagnosis List*

Note: if Outcome Measures have already been created for the client, this Diagnosis screen will display the diagnoses previously entered for the client in the Outcome Measures section. For more information, see Diagnosis in Part 3, Activity List.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Diagnosis List**.
4. Click **Add New Diagnosis**, or hover over the Actions column and click **Review** to view a previously entered Diagnosis.

The screenshot shows the Pennsylvania-WITS UAT interface. The top navigation bar includes the WITS logo, version 18.22.0, and the user's name 'Jones, Sarah A., CCS' with a 'Logout' link. Below the navigation bar, the user is logged in as 'Asteraceae, Zinnia | A23608019956780 | 1'. The left sidebar menu has 'Client List' expanded, with 'Review' highlighted. The main content area is titled 'Diagnosis List' and features an 'Add New Diagnosis' button. A table with the following columns is displayed: Actions, Principal Behavioral (Primary), Principal Medical, Source, Created Date, Created By, Effective Date & Time, Expiration Date & Time, and Diagnosing Clinician. The first row contains the following data: a pencil icon in the Actions column, 'Alcohol use, unspecified with alcohol-order' in the Principal Behavioral column, 'Alcohol use complicating pregnancy, first trimester' in the Principal Medical column, 'Outcome Measures - Client Status' in the Source column, '7/10/2017' in the Created Date column, 'Jones, Ashley A.' in the Created By column, '6/4/2017 12:00 AM' in the Effective Date & Time column, an empty cell in the Expiration Date & Time column, and 'Jones, Sarah A., CCS' in the Diagnosing Clinician column. A 'Review' tooltip is visible over the pencil icon in the Actions column.

Actions	Principal Behavioral (Primary)	Principal Medical	Source	Created Date	Created By	Effective Date & Time	Expiration Date & Time	Diagnosing Clinician
	Alcohol use, unspecified with alcohol-order	Alcohol use complicating pregnancy, first trimester	Outcome Measures - Client Status	7/10/2017	Jones, Ashley A.	6/4/2017 12:00 AM		Jones, Sarah A., CCS

Figure 4-5: Diagnosis List, Review previously entered Diagnosis

Drug Testing



Where: [Client List](#) > [Activity List](#) > [Drug Testing](#)

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Drug Testing**.
4. Click Add Test Result.

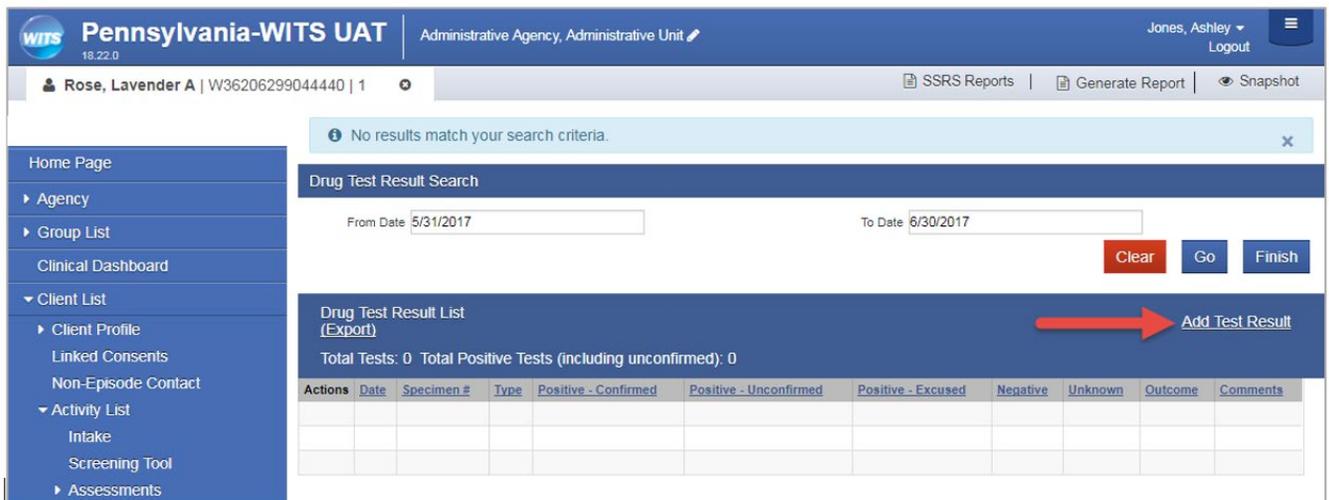


Figure 4-6: Drug Testing screen

5. Complete the Drug Test Results Profile fields.

Table 4-4: Drug Test Results Profile fields

Field	Description
Specimen #	Type the Specimen Identification, or Tracking Number.
Date	Type the date of the drug test.
Client Outcome	Select the outcome of the drug test from the drop-down list.
Specimen Type	If the client produced a specimen, this field will become required. Select an option from the drop-down list.
Staff	Defaults to the staff member currently signed in.
Facility	Defaults to the current facility location.
Location	(Optional) Select the specimen collection location from the drop-down list.
Comments	Type any comments as needed.

Drug Test Result Profile

Specimen #

Date

Client Outcome

Specimen Type

Staff: Jones, Ashley

Facility: Administrative Unit

Location:

Blood Alcohol Content:

Marijuana Content:

Comments:

Add Drug Test Results

Drug Type:

Test Result:

Alcohol
Amphetamines
Barbiturates
Benzodiazepine
Cocaine
Creat
Hallucinogens
Heroin
Inhalants
Marijuana
Methadone
Other Opiates
PCP
Propoxyphene
Sedatives

Drug Test Results Test Result:

Actions	Drug	Test Result

Figure 4-7: Drug Test Result Profile screen

- In the **Add Drug Test Results** section, in the **Drug Type** field, select one or more types. Then in the **Test Result** field, select an option from the drop-down list and click **Add**. These options will be displayed in the **Drug Test Results** section of the screen.

Add Drug Test Results

Drug Type:

Test Result: Negative 

Alcohol
Amphetamines
Barbiturates
Benzodiazepine
Cocaine
Creat
Hallucinogens
Heroin
Inhalants
Marijuana
Methadone
Other Opiates
PCP
Propoxyphene
Sedatives

Drug Test Results Test Result:

Actions	Drug	Test Result

Figure 4-8: Add Drug Test Results

Drug Test Result Profile

Specimen # <input type="text" value="J-8327619"/>	Staff <input type="text" value="Jones, Ashley"/>
Date <input type="text" value="6/12/2017"/>	Facility <input type="text" value="Administrative Unit"/>
Client Outcome <input type="text" value="Specimen Collected"/>	Location <input type="text" value="Other Service Agency"/>
Specimen Type <input type="text" value="Urine Sample"/>	Blood Alcohol Content <input type="text"/>
	Marijuana Content <input type="text"/>

Comments

Add Drug Test Results

Drug Type
Test Result

- Barbiturates
- Benzodiazepine
- Cocaine
- Creat
- Hallucinogens
- Inhalants
- Methadone
- PCP
- Propoxyphene
- Sedatives

Drug Test Results Test Result [Edit Test Result](#)

	Actions	Drug	Test Result
<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Amphetamines	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Heroin	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Other Opiates	Negative

Figure 4-9: Drug Test Profile with Drug Test Results added

- To update a Drug Test Result(s), click the **check box** beside the drug name(s). In the **Test Result** field, select an option from the drop-down list.

Drug Test Results Test Result [Edit Test Result](#)

	Actions	Drug	Test Result
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	Positive - Confirmed
<input type="checkbox"/>	<input type="checkbox"/>	Marijuana	Positive - Confirmed
<input type="checkbox"/>	<input type="checkbox"/>	Amphetamines	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Other Opiates	Positive - Unconfirmed
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sedatives	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Heroin	Negative
<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	Unknown

- Positive - Confirmed
- Negative
- Unknown
- Positive - Unconfirmed
- Positive - Excused

Drug Test Result Profile

Specimen # Staff

Date Facility

Client Outcome Location

Specimen Type Blood Alcohol Content

Marijuana Content

Comments

Add Drug Test Results

Drug Type Test Result

Barbiturates
Benzodiazepine
Creat
Hallucinogens
Inhalants
Methadone
PCP
Propoxyphene

Drug Test Results Test Result [Edit Test Result](#)

Actions	Drug	Test Result
	<input type="checkbox"/> Alcohol	Positive - Confirmed
	<input type="checkbox"/> Marijuana	Positive - Confirmed
	<input type="checkbox"/> Amphetamines	Negative
	<input type="checkbox"/> Other Opiates	Positive - Unconfirmed
	<input checked="" type="checkbox"/> Sedatives	Negative
	<input type="checkbox"/> Heroin	Negative
	<input type="checkbox"/> Cocaine	Unknown

The Drug Result List screen displays all previously entered test results. You can see the type, result, and outcome from the list screen. For more detailed information, click on the pencil icon to review the test result profile.

Drug Test Result Search

From Date To Date

Drug Test Result List (Export) [Add Test Result](#)

Total Tests: 2 Total Positive Tests (including unconfirmed): 1

Actions	Date	Specimen #	Type	Positive - Confirmed	Positive - Unconfirmed	Positive - Excused	Negative	Unknown	Outcome	Comments
	6/10/2017	N/A							Excused Absence	
	6/11/2017	PI-3.14159265359	Urine Sample	Alcohol, Marijuana	Other Opiates	Sedatives	Amphetamines, Heroin	Cocaine, Hallucinogens	Specimen Collected	

Part 5: Notes

Notes



Where: [Client List](#) > [Activity List](#) > [Notes](#)

The Notes screen displays a combined list of the client’s Miscellaneous Notes and Encounter Notes, and includes links to add new notes for both types. Miscellaneous Notes can be added before a client is enrolled in a program, however, Encounter Notes require a program enrollment.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Notes**.
4. From this screen, both **Miscellaneous Notes** and **Encounter Notes** can be added. To add an Encounter Note, continue to step 5. Procedures to add Miscellaneous Notes are available following the Encounter Note procedures.

The screenshot shows the 'Notes Search' section with 'Start Date' set to 10/31/2016 and 'End Date' set to 10/31/2017. Below the search filters are 'Clear' and 'Go' buttons. The 'Notes List' section features a table with columns: Actions, Note Type, Date, Duration, Staff, and Service/Summary. The table contains four rows of notes. To the right of the table are three buttons: 'Print Notes', 'Add New Encounter Note', and 'Add New Misc. Note'. A red arrow points from the 'Add New Misc. Note' button to the 'Add New Encounter Note' button.

Actions	Note Type	Date	Duration	Staff	Service/Summary
	Progress Notes	10/31/2017	60 Min	Jones, Ashley	Outpatient (Activity 861A)
	TB Screening	10/27/2017		Jones, Ashley	Client does have have TB
	Gambling Screening	10/27/2017		Jones, Ashley	Client does not have gambling ...
	Case Management Note	6/10/2017		Jones, Sarah A., CCS	Case/Care Management (Activity...

Figure 5-1: Notes screen, add new note

Encounter Notes (PA Form 1006)

Note: The client must be admitted and enrolled in a program before adding an encounter record. If the client is not yet enrolled in a program, an informational message will be displayed indicating to complete the program enrollment before creating an encounter record.

Create an Encounter Note

- On the Notes screen, click the **Add New Encounter Note** link.

The screenshot shows the 'Notes Search' section with fields for Start Date (10/31/2016), End Date (10/31/2017), and Allow Disclosure of Note. Below this is the 'Notes List' section with a table of notes and two links: 'Print Notes' and 'Add New Encounter Note'. A red arrow points to the 'Add New Encounter Note' link.

Actions	Note Type	Date	Duration	Staff	Service/Summary
	Progress Notes	10/31/2017	60 Min	Jones, Ashley	Outpatient (Activity 861A)
	TB Screening	10/27/2017		Jones, Ashley	Client does have TB
	Gambling Screening	10/27/2017		Jones, Ashley	Client does not have gambling ...
	Case Management Note	6/10/2017		Jones, Sarah A., CCS	Case/Care Management (Activity...

Figure 5-2: Notes screen, Add New Encounter Note link

NOTE • Encounters can also be added by navigating to the Encounters screen: Client List > Activity List > Encounters. On the Encounters screen, click the Add Encounter link. This will open the same screen as shown in *Figure 5-3* below.

The screenshot shows the 'Encounter Search' section with fields for Start Date (7/3/2016), End Date (7/3/2017), Rendering Staff, Encounter Status, Allow Disclosure of Note, Service, and Program. Below this is the 'Encounter List' section with a table of encounters and a link: 'Add Encounter'. A red arrow points to the 'Add Encounter' link.

Actions	Svc Date	Service	ENC ID	Rendering Staff	Program Name	Status

6. Complete the Encounter fields as shown in the table below.

Table 5-1: Encounter Note fields

Field	Description
Note Type	Description of field.
ENC ID	When the Encounter is saved, this read-only field displays the Encounter ID.
Created Date	When the Encounter is saved, this read-only field displays the date the Encounter was created.
Service	Select the appropriate service from the drop-down list.
Program Name	This field is pre-populated with the Facility Name and name and date of the client's current Program Enrollment.
Billable	No is selected by default.
Service Location	Select an option from the drop-down list.
Start Date	Enter the date when the client received this service.
End Date	
Start Time	
End Time	
Duration	
# of Service Units/Sessions	

The screenshot shows the 'Encounter' form with the following fields filled out:

- Note Type: Case Management Note
- ENC ID: (empty)
- Created Date: (empty)
- Program Name: DDAP Training 01/Case Management : 5/3/2018 -
- Service: Service 1 (Effective Date: 1-1-2017)
- Billable: No
- Start Date: 5/1/2018
- End Date: (empty)
- Service Location: Office
- Start Time: (empty)
- End Time: (empty)
- Duration: (empty)
- # of Service Units/Sessions: 1

Below the main form, there is a section for 'Diagnoses for this Service' with three dropdown menus for Primary, Secondary, and Tertiary diagnoses, all set to 'Select an option'. There are also dropdown menus for 'Rendering Staff' (Full, Clinical) and 'Supervising Staff' (empty). At the bottom, there is an 'Administrative Actions' section with a 'Finalize Encounter' link and a row of buttons: Cancel, Save, Finish, and a right-arrow button.

Figure 5-3: Encounter Note filled out

7. Then click **Save**, and then the **right-arrow** button.

The **Encounter Notes** section of the Encounter allows the staff to enter notes related to the time spent with the client. If the client has an Active Treatment Plan, the staff can add Goals, Objectives, and Interventions to the encounter. The Goals, Objectives, and Interventions that are available to select, will be taken from the client’s most recent active signed-off Treatment plan that is effective on the Encounter Start Date. Entering this information is optional.

Prerequisite: Active Signed-off Treatment Plan

1. Enter any notes in the **Unsigned Notes** field.
2. When finished, indicate whether the notes can be disclosed to another agency by selecting **Yes** or **No** in the **Allow Disclosure** field.
3. Click **Finish**.

Encounter Notes

Goal Progress

Add Goals [Add Goals](#)

Actions	Goal #	Goal	Description

Add Objectives [Add Objectives](#)

Actions	Obj #	Objective	Description

Add Interventions [Add Interventions](#)

Actions	#	Intervention	Status

Signed Notes

Allow Disclosure Cancel Save Finish ⏪ ⏩

Unsigned Notes

Add Note Sign Note

Administrative Actions

Figure 5-4: Encounter Note, Add Goals, Objectives, and Interventions

Miscellaneous Notes

1. On the Notes screen, click the **Add New Misc. Note** link.

Actions	Note Type	Date	Duration	Staff	Service/Summary
	Progress Notes	10/31/2017	60 Min	Jones, Ashley	Outpatient (Activity 861A)
	TB Screening	10/27/2017		Jones, Ashley	Client does have have TB
	Gambling Screening	10/27/2017		Jones, Ashley	Client does not have gambling ...
	Case Management Note	6/10/2017		Jones, Sarah A., CCS	Case/Care Management (Activity...

Figure 5-4: Notes screen, Add New Misc. Note link

2. Complete the following information:

Field	Description
Note Type	Select from the available types
Service Date	Enter the date the service took place
Summary	Enter a brief note summary
Unsigned Notes	Enter any notes about the client in this field. If the field pre-populates with questions, answer the questions, but do not edit the question text.

3. After you have entered all required information, click Sign Note. You will notice the text from the Unsigned Notes field will move to the Signed Notes field.
4. Click Finish when you have completed the note.

Please note that a separate note record should be created for each note that needs to be created.

Note Type: Case Management Note

Miscellaneous Notes

Author Name: Jones, Ashley
Author Title: Administrator
Created Date:

Note Type: **Case Management Note** Service Date: 6/29/2017 Duration: [] []
Program: [] Start Time: [] Alert No: [] [Mark Alert](#)
Frequency: [] End Time: [] Was Report Sent to State: []

Summary: []

Signed Notes: []

Unsigned Notes

Please specify the service provided from the following choices:
Medical, Psychiatric and Mental Health Services; Educational; Vocational; Social Support and Community-Based Services; Related Assessments; Treatment Planning (Designated case manager for children only); Post-Discharge Follow-up Activities

Fully describe how you assisted the recipient and/or the recipient's family in the access and coordination of the identified case management service(s):

Release these notes? No [] **Cancel** **Save** **Finish**
Add Note **Sign Note**

Figure 5-5: Miscellaneous Notes, Case Management Note Type

Note Text:

Please specify the service provided from the following choices:

Medical, Psychiatric and Mental Health Services; Educational; Vocational; Social Support and Community-Based Services; Related Assessments; Treatment Planning (Designated case manager for children only); Post-Discharge Follow-up Activities

Fully describe how you assisted the recipient and/or the recipient's family in the access and coordination of the identified case management service(s):

Note Type: Grievance and Appeal

The screenshot shows a web form titled "Miscellaneous Notes" with a dark blue header. Below the header, the form is divided into several sections:

- Author Information:** Author Name: Jones, Ashley; Author Title: Administrator; Created Date: (empty).
- Note Details:** Note Type: Grievance and Appeal (highlighted in yellow); Service Date: 6/29/2017 (with a calendar icon); Duration: (empty); Program: (empty); Start Time: (empty); End Time: (empty); Alert: No (with a "Mark Alert" link); Frequency: (empty); Was Report Sent to State: (empty).
- Summary:** A yellow highlighted text area.
- Signed Notes:** A large grey text area.
- Unsigned Notes:** A text area with labels: SCA: (with a red underline), Issue: (with a red underline), UCN: (with a red underline), and Level: (with a red underline).
- Buttons:** "Release these notes?" (No dropdown), "Cancel" (red), "Save" (green), "Finish" (blue), "Add Note" (blue), and "Sign Note" (blue).

Figure 5-6: Miscellaneous Notes, Grievance and Appeal Note Type

Note Text:

SCA:

Issue:

UCN:

Level:

Briefly describe the individual's grievance with the SCA: (Include date the grievance was filed with SCA).

Briefly describe the outcome of the grievance and the basis for the decision: (Include date of review).

Grievance Resolved: Yes () No ()

Note Type: Gambling Screening

The screenshot shows a web form titled "Miscellaneous Notes" for a "Gambling Screening" note type. The form is populated with the following information:

- Author Name:** Jones, Ashley
- Author Title:** Administrator
- Created Date:** (empty)
- Note Type:** Gambling Screening (highlighted in yellow)
- Service Date:** 6/29/2017
- Duration:** (empty)
- Program:** (empty)
- Start Time:** (empty)
- Alert:** No (with a "Mark Alert" link)
- Frequency:** (empty)
- End Time:** (empty)
- Was Report Sent to State:** (empty)
- Summary:** (empty, highlighted in yellow)
- Signed Notes:** (empty text area)
- Unsigned Notes:** A text area containing two questions:
 1. Have you lied to cover up the extent of your gambling?
 2. Have you bet increasing amounts of money to achieve the level of desired excitement?

At the bottom right of the form, there are several buttons and a dropdown menu:

- Release these notes?:** No (dropdown)
- Cancel** (red button)
- Save** (green button)
- Finish** (blue button)
- Add Note** (blue button)
- Sign Note** (blue button)

Figure 5-7: Miscellaneous Notes, Gambling Screening Note Type

Note Text:

1. Have you lied to cover up the extent of your gambling?
2. Have you bet increasing amounts of money to achieve the level of desired excitement?

Note Type: TB Screening

Miscellaneous Notes

Author Name: Jones, Ashley
Author Title: Administrator
Created Date:

Note Type: **TB Screening** Service Date: **6/29/2017** Duration: [] [] []
Program: [] Start Time: [] Alert: **No** [Mark Alert](#)
Frequency: [] End Time: [] Was Report Sent to State: []
Summary: []

Signed Notes

Unsigned Notes

1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB-incidence areas (Asia, Africa, South America, Central America)?
2. Are you a recent immigrant (within the past 5 years) from a high TB-risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
3. Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? *If residents of any of these facilities

Release these notes? **No** [Cancel](#) [Save](#) [Finish](#)
[Add Note](#) [Sign Note](#)

Figure 5-8: Miscellaneous Notes, TB Screening Note Type

Note Text:

1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB-incidence areas (Asia, Africa, South America, Central America)?
2. Are you a recent immigrant (within the past 5 years) from a high TB-risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
3. Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? *If residents of any of these facilities were tested within the past three months, they don't need to have their risk for TB reassessed.
4. Have you had any close contact with someone diagnosed with TB?
5. Have you been homeless within the past year?
6. Have you ever been an injection drug user?
7. Do you or anyone in your household, currently have the following symptoms, such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?