



SUBSTANCE USE DISORDER MIS ASSESSMENTS TRAINING



Live Well San Diego

**County of San Diego
Behavioral Health Services**



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This handout contains screen shots of confidential and proprietary information for view only. It shall not be copied or shared for anything other than its intended purpose as a training resource for the County of San Diego, Substance Use Disorder (SUD) Management Information System (MIS).



CONFIDENTIALITY

Title 42 CFR Part 2 imposes strict privacy and confidentiality protection of all Substance Use Disorder (SUD) client information.

HIPAA regulations mandate that all client information be treated confidentially.

Access to SanWITS is based on your position and your functional roles. You will have the access you need to complete your job duties. This can include access to clients in your agency and other facilities. Remember – with more access comes greater responsibility regarding confidentiality!

You are not to share passwords with other staff. The Summary of Policy you signed before receiving your access to SanWITS included your agreement to this directive. You are still responsible if someone with whom you have shared your password violates confidentiality!

The County SUD MIS Unit investigates any suspicions regarding sharing of passwords. Consequences are up to and may include termination.

Do not open any client record unless instructed to do so, or if it is required to complete your job duties. “Surfing” clients is a blatant breach of confidentiality.

Remember, you are personally and legally responsible for maintaining privacy and confidentiality of SUD client records. Take it seriously.

Do not leave your computer unlocked with client data on the screen for others to access or view while you are away from your desk. Lock your SanWITS session before leaving your computer.



When printing, make sure you are printing to a confidential printer, and pick up your printout promptly. Leaving printed Protected Health Information (PHI) out is also a confidentiality violation.

Safe and Secure – Keep in mind how you would want your own PHI handled!





SANWITS SOFTWARE BASICS

- San Diego Web Infrastructure for Treatment Services (**SanWITS**) is accessed through <https://sandiego.witsweb.org>. **Save this address to your favorites or create a shortcut for your desktop.**
- **NAVIGATE** by using function links, icons, ellipses, buttons, signs, or arrow keys.
- **BACK < BUTTON** pulls up the previous screen, usually a search screen. The back arrow in the internet browser does not pull up the previous screen.
- **CLIENT LIST** is used to search a client or activate/hide the **Fly-Out** menu.
- **FUNCTION LINKS** are underlined links allowing certain actions to be completed. Most function links are preceded by a plus sign (+) and are usually near the upper corner of the page.
- **SYSTEM REQUIRED FIELDS** are indicated with a solid  or striped  orange bar on the side of the field. The solid orange fields must be completed to save the screen and move forward. The system allows saving of the record with the striped fields left blank, but the activity will display as incomplete (In Progress).
- **SYSTEM GENERATED FIELDS** are in gray. Nothing can be changed or added in these fields.
- **GO** executes a change in agency or facility.
- **SEARCH** loads data and/or launches new screens.
- **CANCEL** returns to the previous screen without saving the data entered.
- **SAVE** stores the information entered and, in certain screens, adds multiple records of data.
- **FINISH** returns the user to the first screen of the module or activity.

Reminder:

Staff access is set up according to credentials (roles). The menu screens you have at your program may be different from the screenshots shown in this packet.



LOGIN INFORMATION

Access to San Diego Web Infrastructure for Treatment Services (SanWITS) is restricted to San Diego County (County) authorized users only. County authorized users are staff members who attend the SanWITS software training.

Logging in to SanWITS

The restrictions and penalty for abuse and noncompliance warning is the first screen users will see on their SanWITS window. To proceed with login, click **Continue**.

WARNING

Access to this system is restricted to authorized users only. Violators subject to imprisonment and/or fine. Continuing beyond this point certifies your understanding and compliance with all applicable restrictions and regulations.



At the Log In screen, enter the following: User ID, Password, and PIN. Click **Login**.

WITS SanWITS
Web Infrastructure for Treatment Services

Log In

User ID
Username

Password
Password

PIN
PIN

[Forgot Password or Pin?](#)

Login

First time SanWITS users will be directed to set up their security question with a corresponding answer, password, and PIN.



Note: A user account receives an automatic email notification if there is no SanWITS login activity within 60 days. A user account is locked if there is no login activity within 90 days.



PASSWORD AND PIN SECURITY

Resetting Credentials

First time users are directed to set up their credentials, which includes selecting:

1. A security question with a corresponding answer
2. A password, and
3. A PIN

To confirm credentials, click **Save**.

The password and PIN requirements differ based on the settings established for the environment.



IMPORTANT: A security question and answer combination allows the user to use the **Forgot Password** link at the Log In screen to self-reset password and PIN.

SanWITS
Web Infrastructure for Treatment Services

Reset Credentials

Display Name

Email

Security Question

Answer

Password

Confirm Password

PIN

Confirm PIN

Show Password/Pin

Changing Credentials (Security Question, Password, and PIN)

Users can change their credentials at any time. To change the security question and answer, password, or PIN, on the right side of the screen of the active login session, click the drop down arrow (▼) and click **Change Credentials**.

EO OS Counselor Interop
San Diego County, Main Facility

▼



HOME PAGE

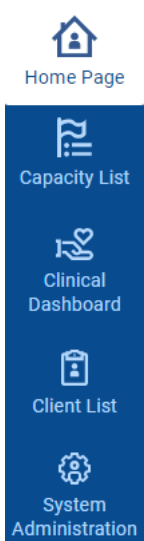
Users assigned to one facility will begin their session at the Home Page.

Changing Facility

Users who have access to multiple facilities must first select a facility before viewing the full Home Page. Click the drop down arrow (▼) at the New Facility field, select the facility, and click **Go**.



Note: Always click **Go** when changing facilities. The facility will change only after **Go** is clicked.



The Home Page navigation pane is located on the left side of the screen.

Most actions are completed through the navigation pane.

The navigation pane options vary depending on the staff's roles.

Action screens are located to the right of the navigation pane.

The screenshot displays the main content area of the application. At the top left, there is a date widget showing 'December 15' and a greeting 'Hello,'. To the right of the date is a notification box that says 'There are currently 4 people that have been referred in.' Below this are three main sections: 'Announcements' with the message 'You have no announcements.', 'Alert List' with 'You have no alerts.', and 'Scheduler'. The Scheduler section includes a search bar for the calendar, an 'Edit/Add Schedule' button, and date pickers for 'Start Date' (set to 12/15/2021) and 'End Date', along with a 'Refresh' button. At the bottom of the Scheduler section, it says 'You have no appointments.'

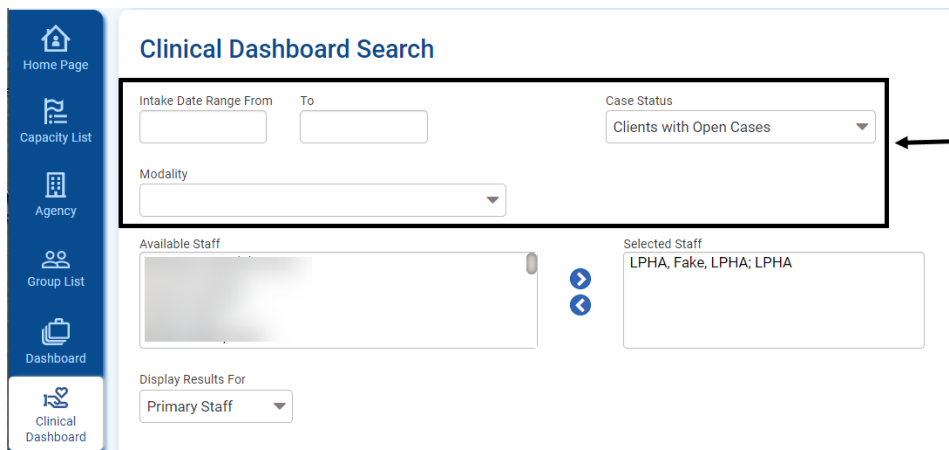


CLINICAL DASHBOARD

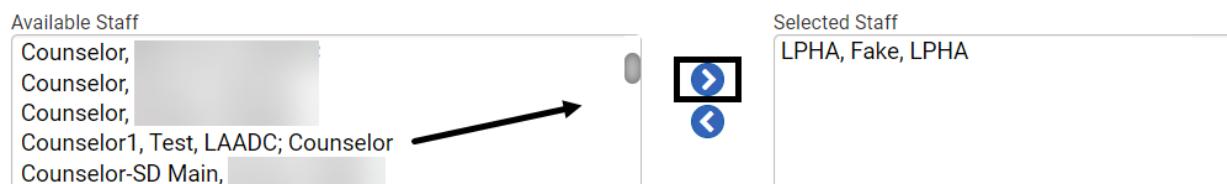
The Clinical Dashboard displays clients who are assigned to a primary staff or to a treatment team. The counselors can view their assigned clients and can also launch a client's electronic chart directly from the clinical dashboard. To open the Clinical Dashboard from the navigation pane, click **Clinical Dashboard**.



To search and pull up a specific set of clients, complete the Clinical Dashboard Search parameters. The Case Status field defaults to Clients with Open Cases.

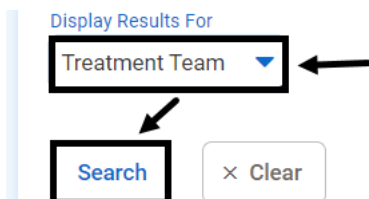


The Selected Staff defaults to the staff who is logged in. Clinicians can access their own caseloads only. Clinical supervisors may access the clinical dashboards of all clinicians within the facility. Select the staff and click the right arrow key.





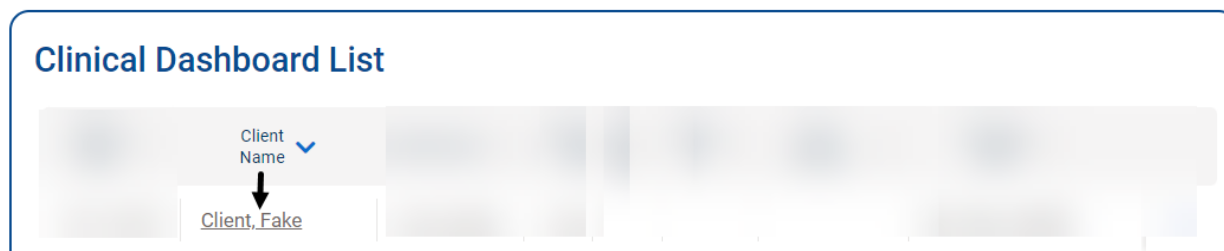
The Display Results For field defaults to Primary Staff. For best results, change it to **Treatment Team**, and click **Search**.



The Clinical Dashboard List can be sorted by any of the column titles, such as Intake Date, Client Name, ASAM Date, DDN Date, Admission Date, Treatment Plan Finalization Date, and so forth.

Intake date	Client Name	ASAM Date	DDN Date	Admission Date	Treatment Plan Finalization Date	Modality	Last Encounter Date	Discharge date	Case Closed	Primary Staff
4/7/2022	Client, Fake			4/7/2022		,ODS OS,				Counselor, Fake, CAADE
3/10/2022	Optum, Test	3/15/2022	3/21/2022	3/10/2022	3/21/2022	,ODS OS,				Counselor, Fake, CAADE
12/10/2021	Super, Treatment	12/10/2021	12/10/2021	12/10/2021		,ODS OS,				LPHA, Fake, LPHA LPHA

In the Client Name column, click the **client's name** to pull up the client record.



Make sure that all treatment records are completed in a timely manner.

The client is removed from the clinician's dashboard as soon as the episode is closed or when the clinician is removed from the client's treatment team.

NOTES



CLIENT SEARCH

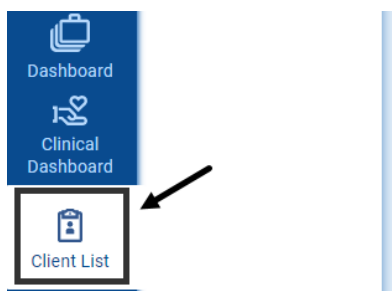
If a facility client is not listed in the staff's clinical dashboard, a counselor or an LPHA can perform a client search. A client should have only one client profile per agency. Conduct a careful and thorough search to determine whether or not the client has an existing profile in the agency.

Searching Clients

Typographical errors during client profile data entry may affect search results. Therefore, it is a good practice to search several ways to open the client's existing profile. Search the client's profile by using the basic identifiable information, such as:

- First Name
- Last Name
- Date of Birth (DOB)
- Social Security Number (SSN)
- Unique Client Number (UCN)

For best results, add the wildcard or asterisk (*) to the first few characters of the client's name, SSN, or UCN. For example, enter **Jo*** for John and **Do*** for Doe. Search by using the client's birth name, current name, and other alternate names (former names and aliases) the client may have used. To search a client from the navigation pane, click **Client List**.



On the Client Search screen, enter part of the client's identifiable information and an asterisk (*). Click **Search**.



To conduct an advanced search, click **Advanced Search**.

Complete the additional search parameters and click **Search**.

Client Search

Facility <input type="text"/>	First Name <input type="text"/>	Last Name <input type="text"/>	Unique Client Number <input type="text"/>
SSN <input type="text"/>	DOB <input type="text"/>	SanWITS UAT Client Id <input type="text"/>	Provider Client ID <input type="text"/>
Agency San Diego County	Primary Care Staff <input type="radio"/> Yes <input type="radio"/> No	Treatment Staff <input type="text"/>	Intake Staff <input type="text"/>
Case Status All Clients	Number Type <input type="text"/>	Intake ID <input type="text"/>	Enrollment ID <input type="text"/>
Other Number <input type="text"/>	Include Only Active Consents <input checked="" type="radio"/> Yes <input type="radio"/> No	Encounter ID <input type="text"/>	

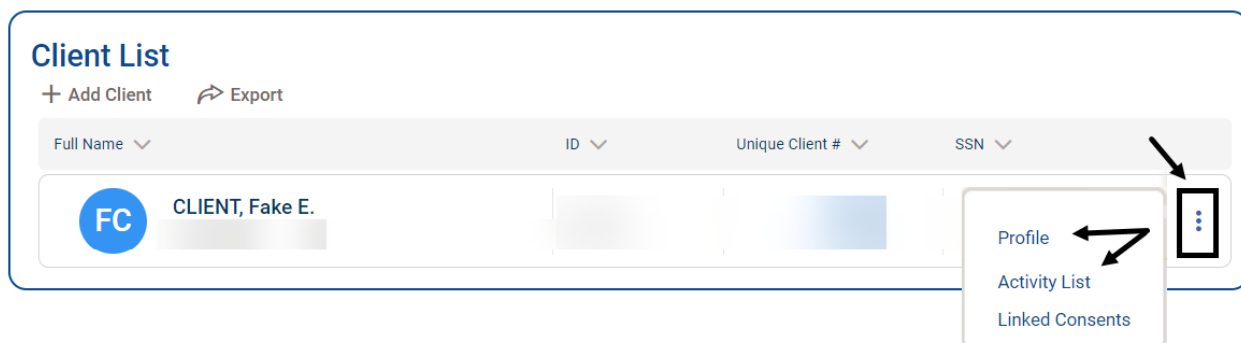
If no match is identified, a message alert “No results match your search criteria” will display above the Client Search field.

No results match your search criteria.

Before requesting an authorized staff to add a client in the system, search several ways. It is a good practice to reset the search criteria by clicking the **Clear** button.



If a match is identified, the Client List will populate with the matching results. To open a client record, hover over the **ellipsis** and click **Profile** or **Activity List**.



Additional Important Considerations in Searching Client Records:

1. Always double check the spelling of the client's first, middle, and last names.
2. Search by current and birth names. The current name may be different from the birth name, but the birth name should never change.
3. Search all other alternate names the client uses or may have used.
4. Use the wildcard or asterisk (*).
5. If the client has a two-word name or a hyphenated name, search for one of the names at a time and add the *.
6. If search results show a client has a middle name in SanWITS but the client's physical photo ID has no middle name, confirm all other identifying information.
7. Search several times with different combinations of identifiable information.

To exit out of a client profile, click **X**.





FLY-OUT MENU

Additional information in the Client Profile and the Activity List can be accessed through the Client List Fly-Out Menu.

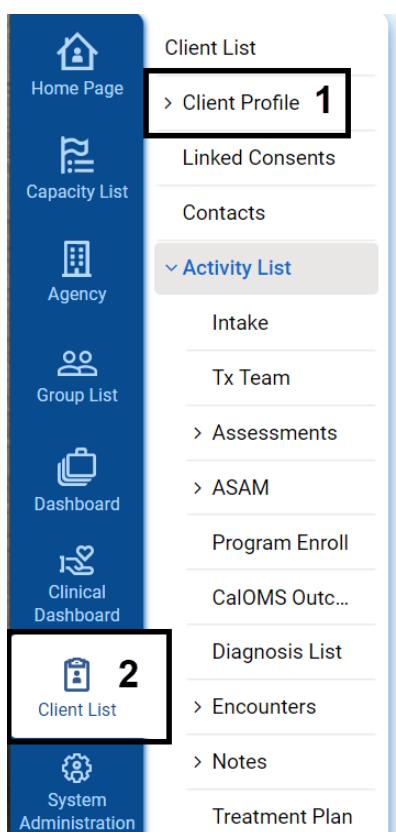
The screenshot shows the 'Client Profile Workspace' interface. On the left is a vertical navigation menu with icons and labels: Home Page, Capacity List, Agency, Group List, Dashboard, Clinical Dashboard, Client List, and System Administration. A fly-out menu is open from the 'Client List' icon, listing: Client List, Client Profile (expanded), History, Payor Group Enrollment, Authorization, Allergies, Linked Consents, Contacts, Activity List, and Episode List. The main content area is titled 'Client Profile Workspace' and contains a 'Profile' section with a form. The form fields are: Current First Name: Fake, Middle Name: (blank), Current Last Name: Client, Birth First Name: Fake; Birth Last Name: Client, Mother's First Name: (blank), Sex: (blank), Gender Identity: (blank); DOB: (blank), No Readmit Until: (blank), Provider Client ID: (blank), SSN: (blank); Driver's License #: (blank), Driver's License State: (blank), Medicaid #: (blank), Date of Death: (blank); Place of Birth County: (blank), Place of Birth State: (blank), Consent on File for Future Contact: (blank), Has Paper File: (blank); State Client No: (blank), State Client ID (UCN): (blank); Record Created By: (blank), Created Date Time: (blank), Last Updated By: (blank), Last Updated Date Time: (blank).

A client record must be opened first to access the Fly-Out menu. To access the Fly-Out menu from the Profile screen, click **Client List**.

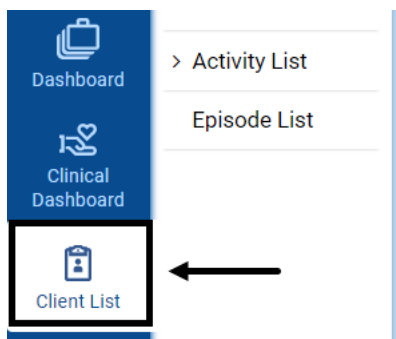
This image is a close-up of the fly-out menu from the previous screenshot. The 'Profile' section is expanded, showing a list of options: Additional Information, Alternate Names, Contact Information, Collateral Contacts, and Other Numbers. At the bottom of the menu, the 'Client List' option is highlighted with a black box, and a black arrow points to it from the right.



To view the additional options under Client Profile while the Activity List is on expanded view or if any record in the Activity List is open, first click **Client Profile** and then click **Client List**.



To hide or unhide the Fly-Out menu or to toggle between Activity List and Client Profile, click **Client List**.





CLIENT PROFILE

The Client Profile contains client identifiable information that was directly obtained from the client or representative. The majority of the data entered on the client profile is required by the State of California Outcomes Measurement System (CalOMS) or the County of San Diego. Below is the full content of the Client Profile:

Client Profile Workspace

Profile, Additional Information, Alternate Names, Contact Information, Collateral Contacts, Other Numbers

Client Profile Fly-Out Menu

History (shows audit trails as read only), Payor Group Enrollment, Authorization (for residential clients only), Allergies (currently not in use)

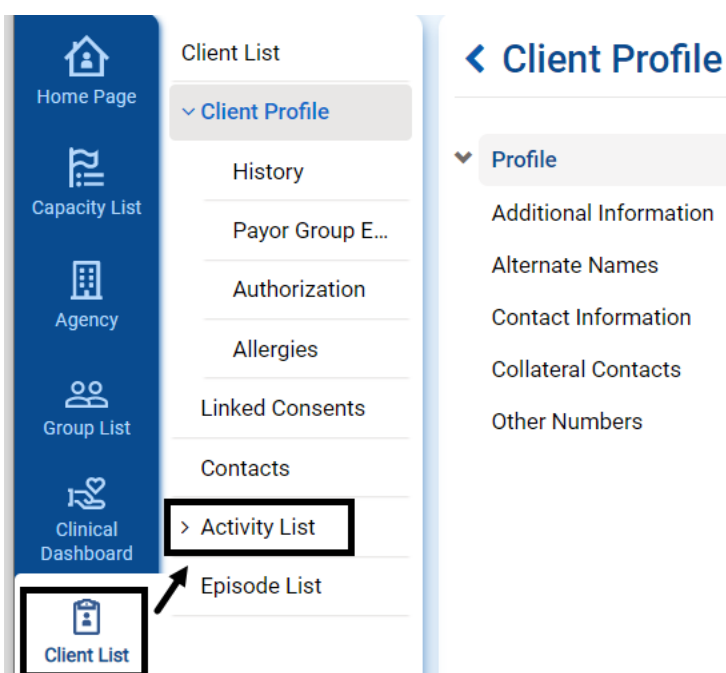
NOTES



ACTIVITY LIST

The Activity List is a multi-level tile which allows activities or records to be completed for the client. The Activity List also serves as a storage system for the same records and displays a list of completed activities on one screen.

To launch the Activity List, the Client Profile must first be opened from the Clinical Dashboard. Refer to the Clinical Dashboard section in this training manual for the path to access the Clinical Dashboard. Once the Client Profile is open, click **Client List**. Then click **Activity List**.



To the right of the Activity List is Client Activity List, which displays a list of actions completed for the client. The actions can be sorted by Activity, Activity Date, Created Date, and Status. It also includes a link to view the record.

Activity	Activity Date	Created Date	Status	
Client Information (Profile)	3/10/2022	3/14/2022	Completed	⋮
Intake Transaction	3/10/2022	3/14/2022	Completed	⋮
Client Program Enrollment (ODS OS)	3/10/2022	3/14/2022	Completed	⋮
CalOMS Outcome Measures Summary	3/10/2022	3/14/2022	Not Applicable	⋮
Additional Assessments Summary	3/10/2022	3/14/2022	Not Applicable	⋮
Adult Initial Level of Care	3/10/2022	3/15/2022	Finalized	⋮



The Status column provides a quick view of the progress of an activity.

Completed indicates all the required fields were accurately filled in and signed.

Pending Signature indicates the activity is completed but has not been signed.

Pending finalization means an activity is awaiting an LPHA signature and finalization.

Finalized means the activity has been signed and finalized by a clinician.



Not Applicable indicates it is not required in SanWITS or it has multiple activities.

Rejected indicates an activity is being returned by an LPHA to a staff for corrections.

In Progress indicates an activity is missing information or pending completion.

Status ▾
Completed
Pending Signature
Pending Finalization
Finalized
Not Applicable
Rejected
In Progress (Details)

To view an activity, hover over the ellipsis and click **Review**.

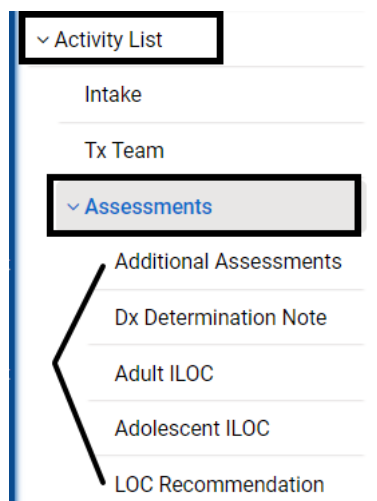
Adult Initial Level of Care	3/10/2022	3/15/2022	Finalized	 Review
Diagnosis Summary	3/10/2022	3/15/2022	Completed	

NOTES



ASSESSMENTS

Clinical staff should enter assessments that are available in SanWITS. These assessments are under the **Activity List** within the **Assessments** pane.



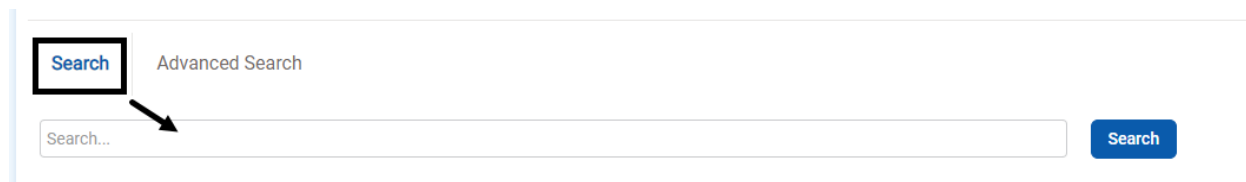
The Dx Determination Note, Adult ILOC, Adolescent ILOC, and LOC Recommendation are individually listed within the Assessments pane.

The Discharge Summary, Parent/Guardian Initial Level of Care Assessment, and Risk Assessment and Safety Plan are accessed through the **Additional Assessments** pane.

Searching Assessments

If there are several existing assessments created for the client and the list is long, it can be narrowed down.

To search for assessments that were previously entered, select the assessment. At the specific assessment Search screen, enter the search parameters in the Search field. The system automatically starts the search as soon as a character is entered. For best results, enter more characters.





To perform an advanced search, click **Advanced Search**.

Click **Add Search Criteria**.

Select the primary filter from the dropdown menu. The selection menu depends on the type of assessment being searched.

Complete the remaining search specifications.

When a primary filter is selected, a secondary filter populates with a default value. To change the default value, click the dropdown menu and select one from the list.

To add an additional search filter, repeat the same steps.

To remove the search criteria, click **X**.

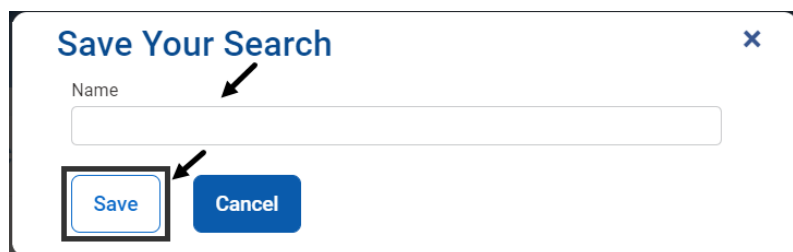
To complete the advanced search, click **Search** or **Advanced Search** again.



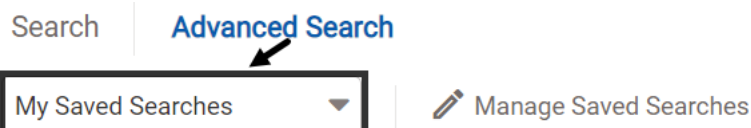
Search templates can be saved for future use at the individual staff level. To save the template, click **Save Search**.



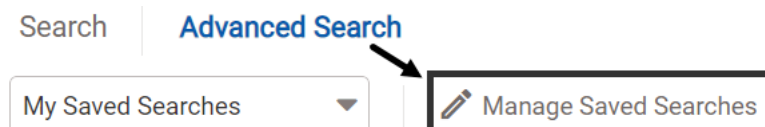
Enter the name of the search template and click **Save**.



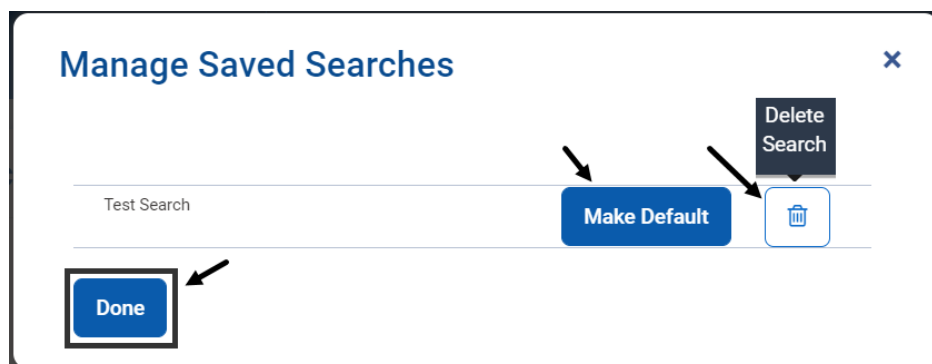
To use a saved search template, click **My Saved Searches** and select the saved template.



To remove a saved search template or to make it a default search, click **Manage Saved Searches**.



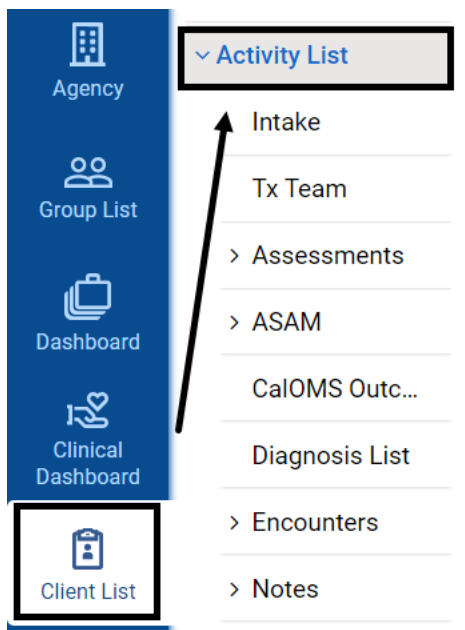
Click **Make Default** to make a saved template the default search or click **Delete Search** to remove it. Click **Done**.





Viewing Assessments

To view an existing clinical assessment after launching the Client Profile from the navigation pane, click **Client List**. Then click **Activity List**.



- 1) To view an existing Adult ILOC or Adolescent ILOC assessment, hover over the ellipsis and click **Review**.

Activity	Activity Date	Created Date	Status	
Client Information (Profile)	3/10/2022	3/14/2022	Completed	⋮
Intake Transaction	3/10/2022	3/14/2022	Completed	⋮
Client Program Enrollment (ODS OS)	3/10/2022	3/14/2022	Completed	⋮
CalOMS Outcome Measures Summary	3/10/2022	3/14/2022	Not Applicable	⋮
Adult Initial Level of Care	3/10/2022	3/15/2022	Finalized	⋮
Diagnosis Determination Summary	3/10/2022	3/15/2022	Completed	⋮

The 'Adult Initial Level of Care' row is highlighted with a yellow border. A black box highlights the ellipsis icon in the rightmost column of this row. An arrow points from the ellipsis icon to a 'Review' button that has appeared.



- 2) To view an existing Parent/Guardian Initial Level of Care Assessment, Risk Assessment and Safety Plan, or Discharge Summary, locate the **Additional Assessments Summary** in the Client Activity List. Hover over the ellipsis and click **Review**.

Client Activity List

Activity	Activity Date	Created Date	Status	
Client Information (Profile)	3/10/2022	3/14/2022	Completed	⋮
CalOMS Outcome Measures Summary	3/10/2022	3/14/2022	Not Applicable	⋮
Additional Assessments Summary	3/10/2022	3/14/2022	Not Applicable	⋮ Review
Diagnosis Determination Summary	3/10/2022	3/14/2022	Not Applicable	⋮

On the Assessment Search screen, hover over the ellipsis and click **View**.

Showing 1-6 of 6

Select Columns [icon] Select View [icon] Export Results [icon]

Type	Assessment Date	Interviewed By	Status	
Risk Assessment and Safety Plan	03/10/2022	Counselor, Fake, CAADE	Finalized	⋮ View
Parent/Guardian Initial Level of Care Assessment	03/11/2022	Counselor, Fake, CAADE	Finalized	⋮
Discharge Summary	04/04/2022	LPHA, Fake, LPHA	In Progress	⋮

Below is a sample of the top section of a finalized assessment. A finalized assessment is a read only document.

< Adult Initial Level of Care

Edit [icon] [icon] [icon] [icon] [icon]

- Adult Initial Level of Care
 - Profile
 - Personal Information
 - Questionnaire
 - Alcohol and/or Other Drug Use

Adult Initial Level of Care

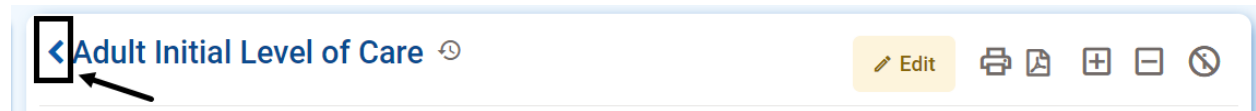
Status: Finalized

Assessment Date: Interviewer: Created By: Created Timestamp:



A counselor may edit a pending (In Progress) assessment as long as it is not signed. A signed assessment is locked to the counselor for editing. If the LPHA rejects the signed assessment, then the assessment becomes available to the counselor for editing. However, if the LPHA signs and finalizes the assessment, the record becomes read only.

To return to the previous screen, click the **Back** button.



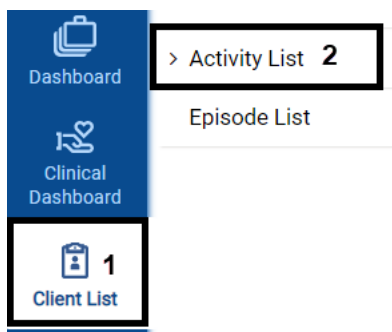
NOTES



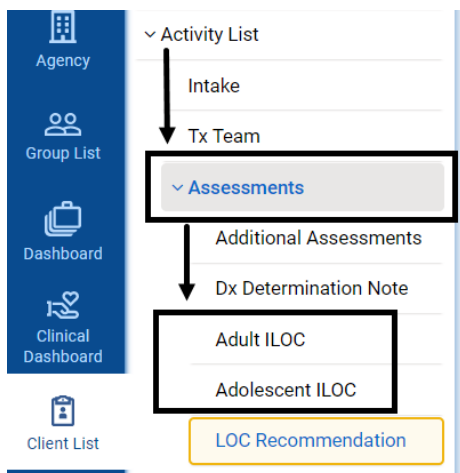
Adding Assessments

The standards for completing an assessment in SanWITS are the same as those shown in the assessment instructions posted on the Optum website.

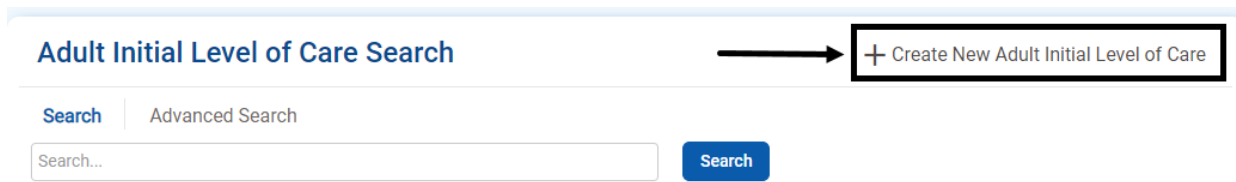
To add an Adult ILOC or Adolescent ILOC from the navigation pane, click **Client List** and **Activity List**.



Click **Assessments** → **Adult ILOC** or **Adolescent ILOC**



The Assessments screen launches, displaying a section to search assessments and a button to create a new assessment. To continue adding a new assessment, click **Create New Adult Initial Level of Care** if Adult ILOC was selected.





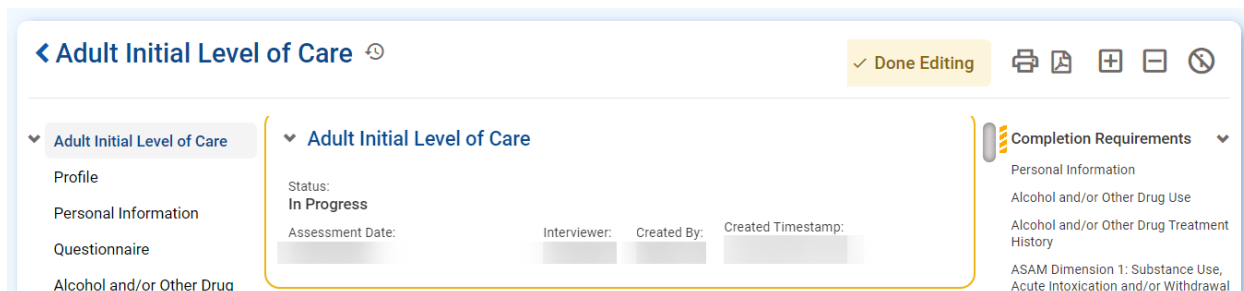
Click **Create New Adolescent Initial Level of Care** if Adolescent ILOC was selected.



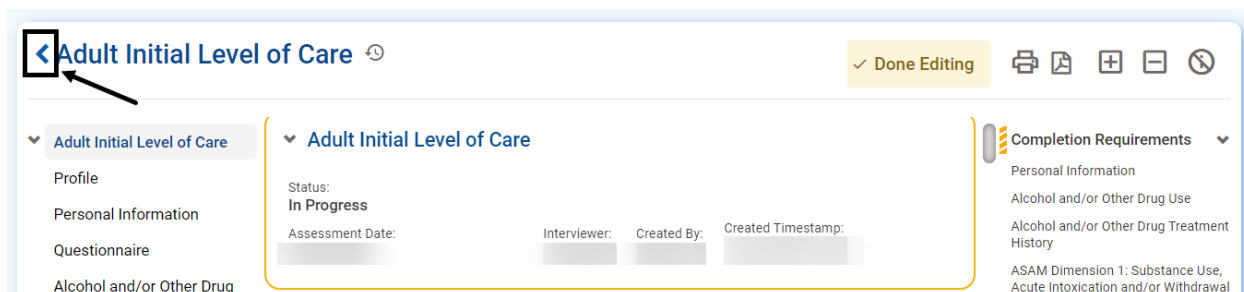
On the next screen, select the Interviewer or staff who interviewed the client and the Assessment Date. Click **Save**.



The assessment form launches and is ready for completion.



To return to the Assessment Search screen, click the **Back** button.





There are several action buttons in the top right of the assessment.



The system automatically saves responses to questions. If there are interruptions and it is necessary to pause, it is best practice to click **Done Editing** to lock the assessment from editing.



Click **Edit** to enable editing of the assessment.



Printing Assessments

The standard print button opens the print window. However, it is best to click **Generate Report** to convert the assessment to an Acrobat Adobe document before printing it.



To expand all panels, click the **Expand All (+)** button. To collapse all panels, click the **Collapse All (-)** button.

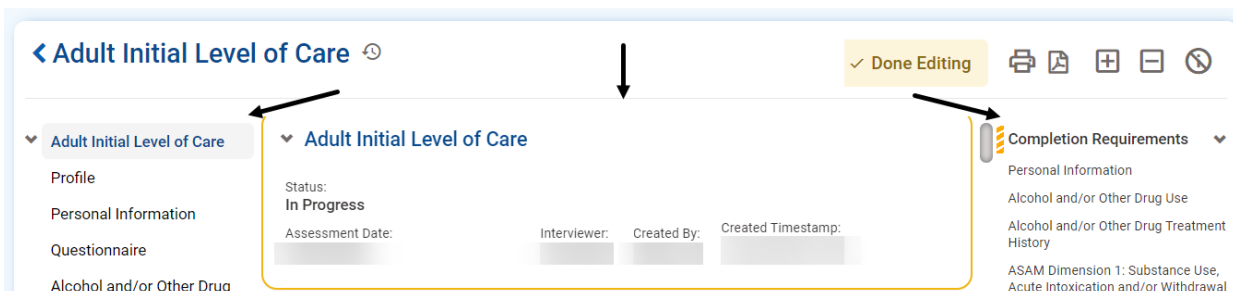


The **Details** button hides or unhides question help texts.

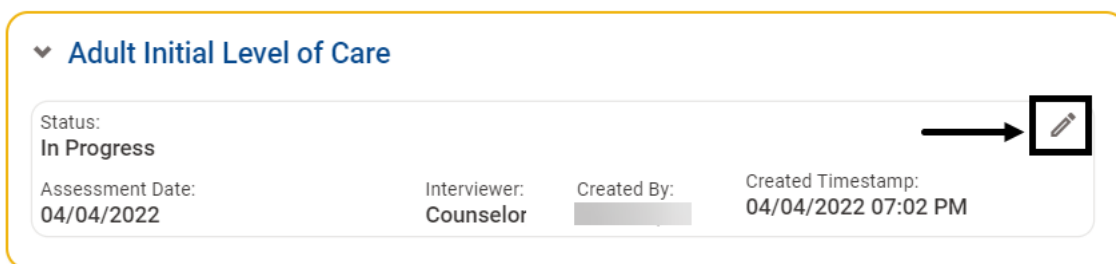




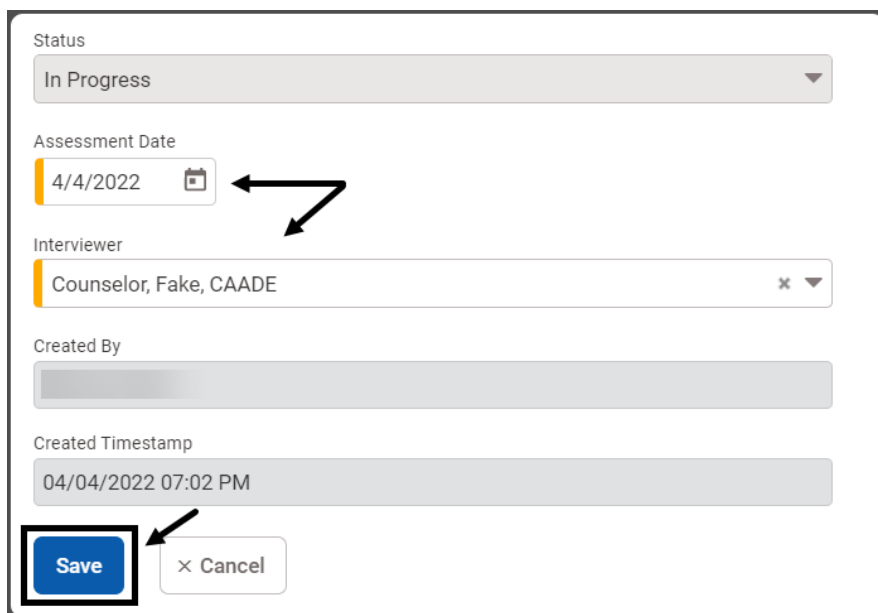
The left side of the assessment contains the panel headers, the right side shows the completion requirements, and the middle part is the actual form.



To change the Assessment Date and/or Interviewer, hover over in the white space and click **Edit**.



The initial screen re-opens. If necessary, update the Assessment Date and/or Interviewer, and click **Save**.





The status bar located at the bottom of each section shows the # Total Required Questions, # Required Questions Completed, and % Complete. It is a good practice to confirm that the questions answered equal the total required questions before moving on to the next section.

# Total Required Questions	# Required Questions Completed	% Complete
20	0	0

Fields that are marked with an orange bar, either solid or striped, are required and must be completed. The questions may be answered by entering a free flowing text, selecting from a dropdown menu, entering a date, or choosing from the radio button selections.

Below are sample questions:

▼ **Personal Information** Next Question

1) Place of Interview:

Enter free flowing text ←

Primary Drug

1) Primary Drug:

Select →

10) Date Last Used:

←

▼ **Alcohol and/or Other Drug Treatment History** Next Question

1) Have you ever received treatment for alcohol and/or other drugs in the past?

Yes ←

No



When the answer to a question is 'None' or 'No', follow up questions may prepopulate with 'Not Applicable' as read only and cannot be changed.

Tertiary Drug (Select "None" if this does not apply)

11) Tertiary Drug:
None ←

12) # of Days used in past 30 days:
Not Applicable

13) Route of Admission:
Not Applicable

14) Age of First Use:
Not Applicable

15) Date Last Used:
Not Applicable

If the system does not prepopulate 'Not Applicable' to a follow up question, enter N/A (not applicable) or any additional information provided by the client.

Intoxication and/or Withdrawal Potential

1) Do you have a history of serious withdrawal, seizures, or life-threatening symptoms during withdrawal?
 Yes
 No →

2) Please describe:
[Empty text box]

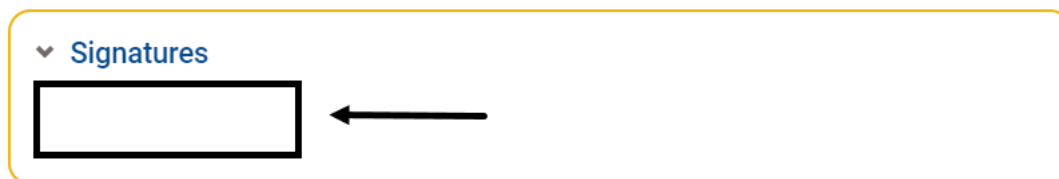
3) Are you currently experiencing intoxication/withdrawal symptoms, such as tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting, etc.?
 Yes
 No →

4) Please describe:
[Empty text box]

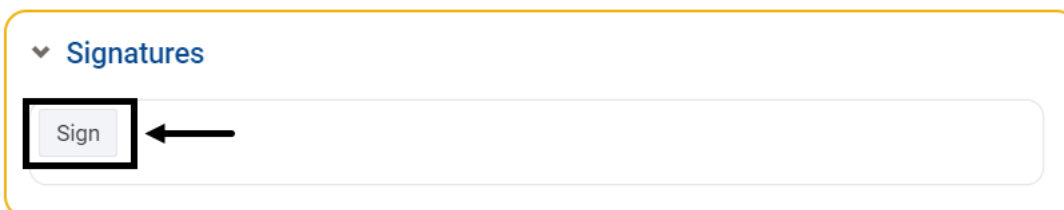


Signatures

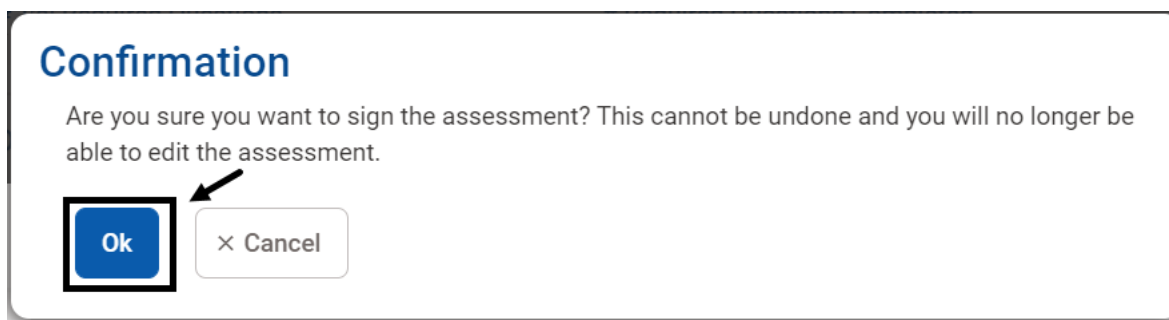
The assessment form must be completely filled in before the signature line becomes active. If there is missing information, the system hides the signature button. This is by design. It is a validation tool to ensure the required fields are completed.



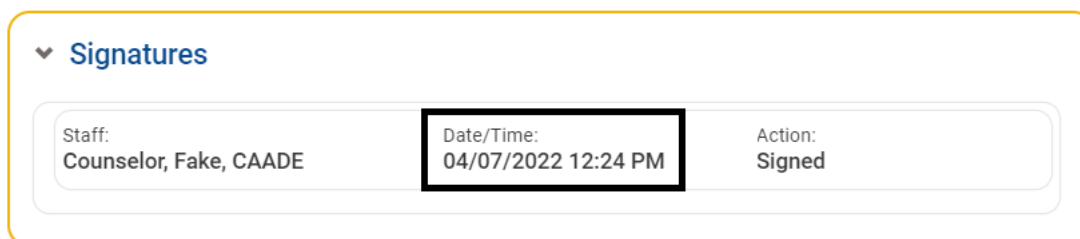
When the assessment form is one hundred percent (100%) complete, the Completion Requirements section clears, and the signature line is activated. Click **Sign**.



On the Confirmation screen, click **OK** to confirm.



The system generates the date and the time that the staff signed the assessment.





If a counselor signed the assessment, it is forwarded to the LPHA Dashboard for the LPHA to sign and finalize. If the LPHA prepared the assessment, the Sign and Finalize button becomes active after it is signed by the LPHA.

Click **Sign and Finalize**.

▼ Signatures

Sign and Finalize Reject

Staff: Counselor, Fake, CAADE Date/Time: 04/07/2022 12:24 PM Action: Signed

After clicking Sign and Finalize, the system closes the assessment form and displays the Confirmation screen. To confirm finalization of the assessment, click **OK**.

Confirmation

Are you sure you want to sign and finalize the assessment? This cannot be undone and you will no longer be able to edit the assessment.

Ok × Cancel

A finalized assessment may not be edited. If there are errors that need to be corrected, create a new assessment to update the information.

▼ Signatures

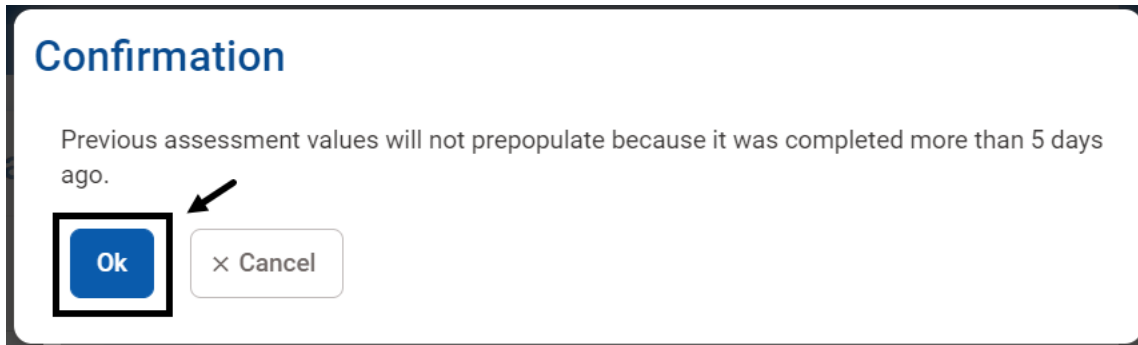
Staff: Counselor, Fake, CAADE	Date/Time: 04/07/2022 12:24 PM	Action: Signed
Staff: LPHA, Fake, LPHA	Date/Time: 04/07/2022 01:25 PM	Action: Finalized

The system generates a finalized read only ASAM from a finalized assessment.

Information from the most recently finalized assessment will prepopulate to a new one of the same kind if the date of the new form is more current and within five (5) calendar days from the assessment date of the previous one.



If the new assessment is not completed within 5 days from the previous assessment, the confirmation message will indicate that the previous assessment will not prepopulate. Click **Ok** to continue.



NOTES

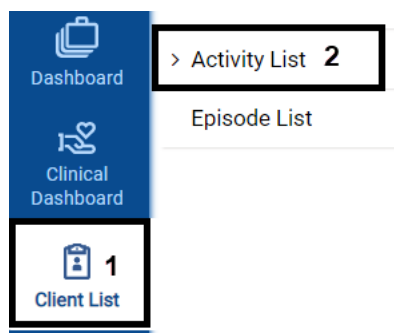


Note: Use the **LOC Recommendation** pane within the Assessment in the Activity List to complete a Follow Up Assessment,. A finalized LOC Recommendation will generate a finalized ASAM for the Follow Up Assessment.

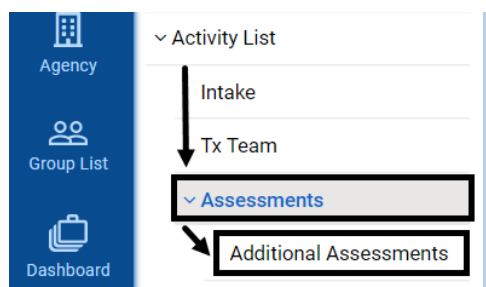


Adding Additional Assessments

Risk Assessment and Safety Plan, Parent/Guardian Initial Level of Care Assessment, and Discharge Summary forms can be accessed under Additional Assessments. To add any of these additional assessments while the client record is open, on the navigation pane click **Client List** and **Activity List**.



Click **Assessments** and then **Additional Assessments**.



The Assessments screen launches, displaying a section to search assessments and a button to create a new assessment. To continue, click **Create New Assessment**.





On the next screen, select the Assessment, Assessment Date, and Interviewer. Click **Save**.

Add Assessment

Assessment

Assessment Date

Interviewer

Save × Cancel

The assessment form launches and is ready for completion.

Questionnaire Profile

✓ Done Editing

Discharge Summary

Profile

Treatment Summary

Health and Medical

Employment and Income

Discharge Summary

Status: In Progress

Assessment Date: 04/04/2022 Interviewer: LPHA, Fake, LPHA Created By: [redacted] Created Timestamp: 04/04/2022 07:04 PM

For basic navigation on how to complete the assessment including signing and finalizing the assessment, refer to the previous section on **Adding Assessments**.

Additional assessments have the same navigation features as the Adult ILOC and Adolescent ILOC, with a few differences stated below.

The Completion Requirements section is not available. It is best to check the status bar at the bottom of each section to ensure that the number of Required Questions Completed matches the number of Total Required Questions, which is equivalent to 100% Complete.

Total Required Questions 6 → # Required Questions Completed 0 → % Complete 0



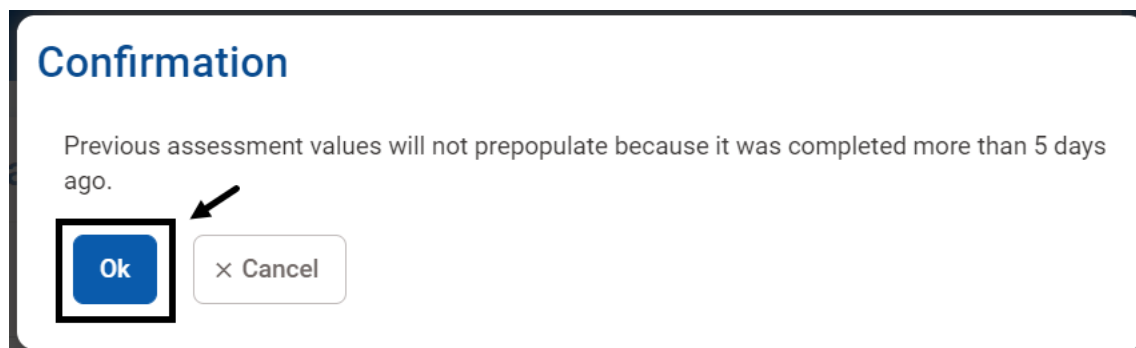
A *Discharge Summary*, if signed by a counselor, does not need to be finalized by an LPHA. Furthermore, a signed Discharge Summary cannot be edited. If there are errors that need to be corrected, add another one.

Another difference is if a *Parent/Guardian Initial Level of Care* form is completed by an LPHA, the Sign button is hidden so the LPHA can Sign and Finalize right away. A finalized Parent/Guardian Initial Level of Care assessment cannot be edited. If there are errors that need to be corrected, add another one.

If a *Risk Assessment and Safety Plan* is completed by an LPHA, the Sign button is also hidden so the LPHA can Sign and Finalize right away. A finalized Risk Assessment and Safety Plan cannot be edited. If there are errors that need to be corrected, add another one.

Information from the most recently finalized additional assessment will prepopulate to a new one of the same kind if the new form is more current and within five (5) calendar days from the assessment date of the previous one.

If the additional assessment is not completed within 5 days from the previous assessment of the same type, the confirmation message will indicate that the previous assessment will not prepopulate. Click **Ok** to continue.



If there are issues with any of the assessments, contact SUD MIS at SUD_MIS_Support.HHSA@sdcounty.ca.gov.

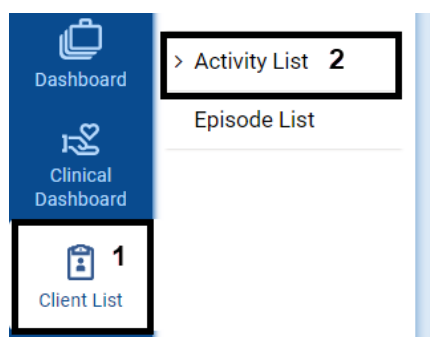
NOTES



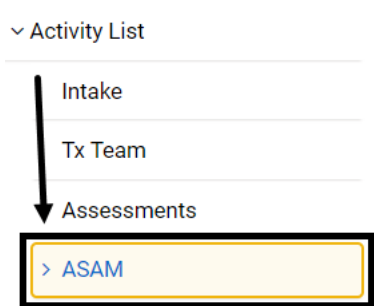
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

SanWITS has a screen for capturing the American Society of Addiction Medicine (ASAM) assessment criteria for clients.

The system generates a read-only ASAM from a finalized Adult ILOC, Adolescent ILOC, and LOC Recommendation. To access the ASAM from the navigation pane, click **Client List** and **Activity List**.



Click **ASAM**.



The ASAM List screen launches showing all existing ASAM records. The ASAM List also provides an overview of ASAM Assessment Date, Type of Assessment, Staff Name, Recommended Level of Care, Status, and Updated Date. The Adult/Adolescent ILOC is populated to Initial LOC Assessment, and the LOC Recommendation is populated to Follow Up Assessment.

ASAM List							
+ Add ASAM							
Assessment Date	Type of Assessment	Program	Staff Name	Recommended Level of Care	Status	Updated Date	
4/7/2022	Follow Up Assessment		LPHA, Fake	1 Outpatient	Completed	4/7/2022	⋮
3/10/2022	Initial LOC Assessment		LPHA, Fake	1 Outpatient	Completed	3/15/2022	⋮



To view an existing ASAM in the system, hover over the ellipsis and click **Review**.

A horizontal card representing an ASAM record. The card contains the following text from left to right: '3/10/2022', 'Initial LOC Assessment', 'LPHA, Fake', '1 Outpatient', 'Completed', and '3/15/2022'. On the right side of the card, there is a vertical ellipsis menu icon. A white callout box with a black border points to this icon, containing the word 'Review' in blue text.

The ASAM launches.

The ASAM assessment form is displayed with a light blue border. The title 'ASAM' is at the top left. Below it, 'Type of Assessment' is a dropdown menu showing 'Initial LOC Assessment'. Under 'Dimension', there is a text field with '1 - Acute Intoxication and/or Withdrawal Potential'. To the right, 'Level of Risk' is a dropdown showing '1', and 'Level of Care' is a text field. Below these is a large 'Comments' text area. All these input fields are grayed out.

Everything is grayed out including the assessment date and finalized date/time information. To return to the previous screen, click **Cancel**.

The bottom section of the ASAM form. At the top, 'Assessment Date' is a text field with '3/10/2022' and 'Program' is a text field. Below this is a paragraph of text: 'A face-to face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this ASAM LOC Recommendation form occurred and was finalized by LPHA on the date listed.' This is followed by a disclaimer: '*Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians'. At the bottom, there are three buttons: 'Save', 'Save and Finish', and 'Cancel'. The 'Cancel' button is highlighted with a black box and an arrow points to it from the right. Below the buttons is an 'Administrative Actions' section with four text fields: 'Signed By' (Counselor, Fake, CAADE), 'Signed On' (3/15/2022 11:33 AM), 'Finalized By' (LPHA, Fake, LPHA), and 'Finalized On' (3/15/2022 7:35 AM). All these fields are grayed out.

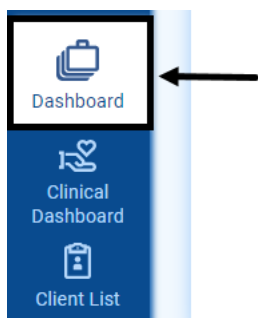


DASHBOARD (LPHA)

The Dashboard screen in SanWITS is designed to hold several tiles that can be viewed based on a user's role.

The Licensed Practitioners of the Healing Arts (LPHAs) who serve as clinical supervisors may use the Dashboard LPHA Workload Tile to review and sign pending client activities.

To open the Dashboard from the navigation pane, click **Dashboard**.



The LPHA Workload screen launches.

Search...

Clinical

LPHA Workload

Filter Export search results

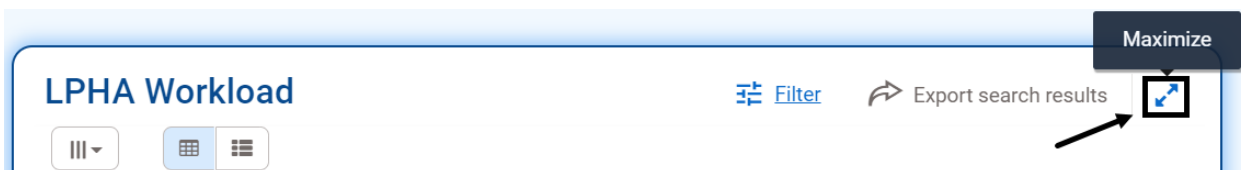
Client Name	Type	Activity Status	LPHA Status	Activity Date	LPHA Due Date	Admission Date	Type Of Treatment	Finalized Date
	Diagnosis Determination Note	Pending Signature	Not Signed	03/21/2022	04/19/2022	03/21/2022	Outpatient	>
	Adult Initial Level of Care	Pending Finalization	Pending Finalization	03/14/2022	03/16/2022	03/10/2022	Outpatient	>
	Risk Assessment and Safety Plan	In Progress	Not Signed	03/20/2022	03/07/2022	03/01/2022	Outpatient	>

To search for a specific activity, enter the identifying information in the Search field, and click **Search**.





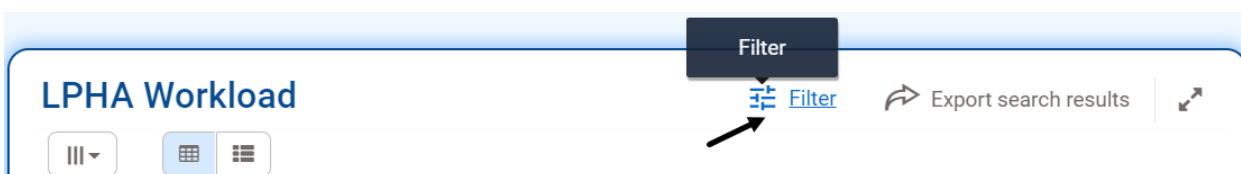
To view the LPHA Workload in full screen, click **Maximize** (facing out arrows).



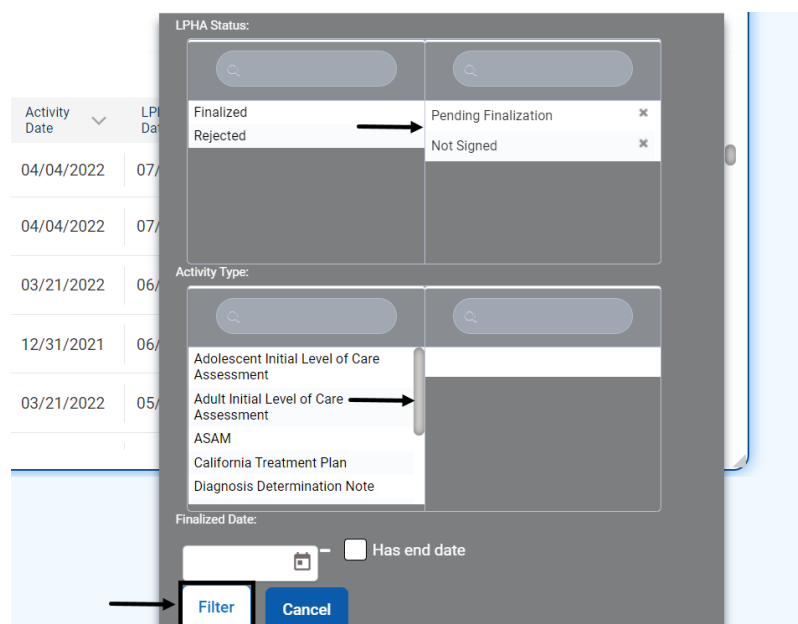
To convert the list to an Excel spreadsheet, click **Export search results**.



To change filters, click **Filter**.

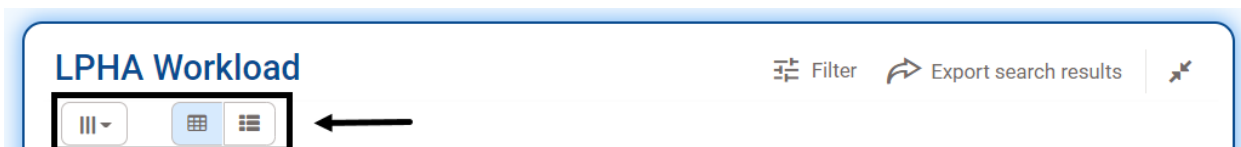


Select the desired filters and click **Filter**.





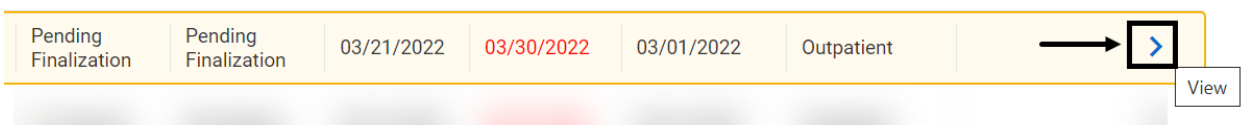
Columns can be selected or deselected for viewing. Information may also be displayed as a table or a panel.



The displayed items can be sorted by selecting a subject title, such as Client Name, Type, Activity Status, LPHA Status, Activity Date, LPHA Due Date, or Admission Date. The LPHA Due Date turns red if the activity is not finalized within a certain number of days from the Activity Date. Follow the County and agency policies regarding client record timelines. The Timeliness of Records section in this training manual is not a comprehensive list of records, but it covers the initial forms that must be completed when a client is admitted to a facility.

Client Name	Type	Activity Status	LPHA Status	Activity Date	LPHA Due Date	Admission Date	Type Of Treatment	Finalized Date
	Diagnosis Determination Note	Pending Signature	Not Signed	03/21/2022	04/19/2022	03/21/2022	Outpatient	>
	Adult Initial Level of Care	Pending Finalization	Pending Finalization	03/14/2022	03/16/2022	03/10/2022	Outpatient	>
	Risk Assessment and Safety Plan	In Progress	Not Signed	03/20/2022	03/07/2022	03/01/2022	Outpatient	>

To open a listed record, click **View**.



Once the assessment is launched, click **Edit** to review the assessment for accuracy.



To return to the Dashboard, click the **Back** button.

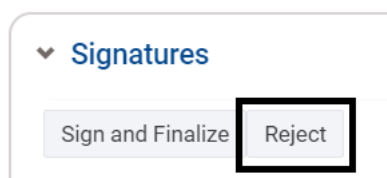




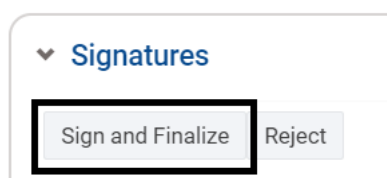
Answer the questions that an LPHA must complete.

To add a new diagnosis, refer to the **Adding Diagnosis** on the DDN section in this training manual.

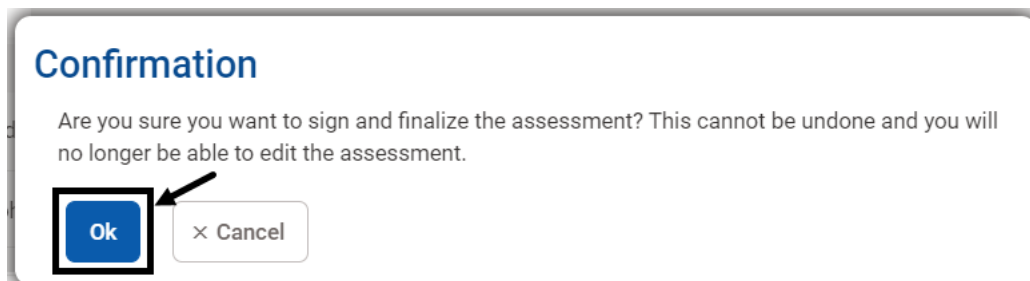
If the LPHA finds errors that the counselor should correct, return the assessment to the counselor by clicking **Reject** in the Signatures section.



If everything is accurate, Click **Sign and Finalize**.



After clicking Sign and Finalize, the system closes the assessment form and displays the Confirmation screen. To confirm finalization of the assessment, click **OK**.



A finalized assessment may not be edited. If there are errors that need to be corrected, a new assessment should be created.

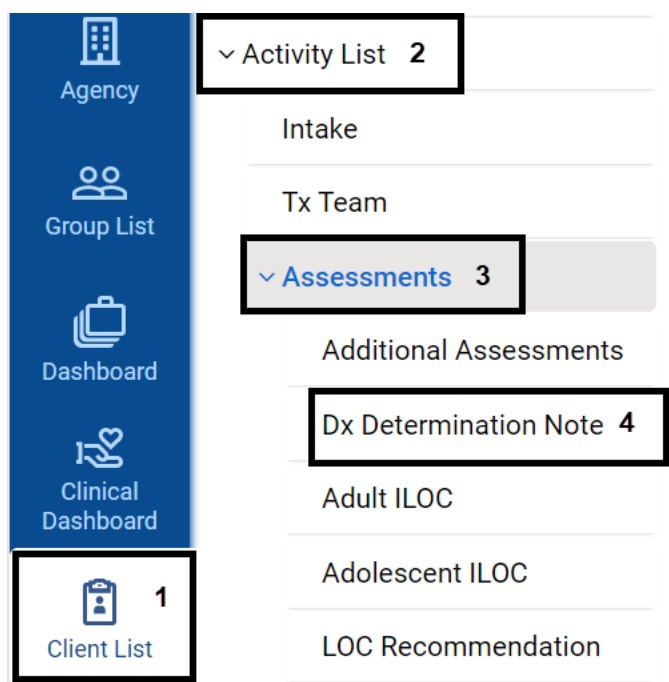
After rejecting or finalizing a form, the system automatically returns to the LPHA Workload screen. The LPHA should review the remaining activities requiring his review or action.



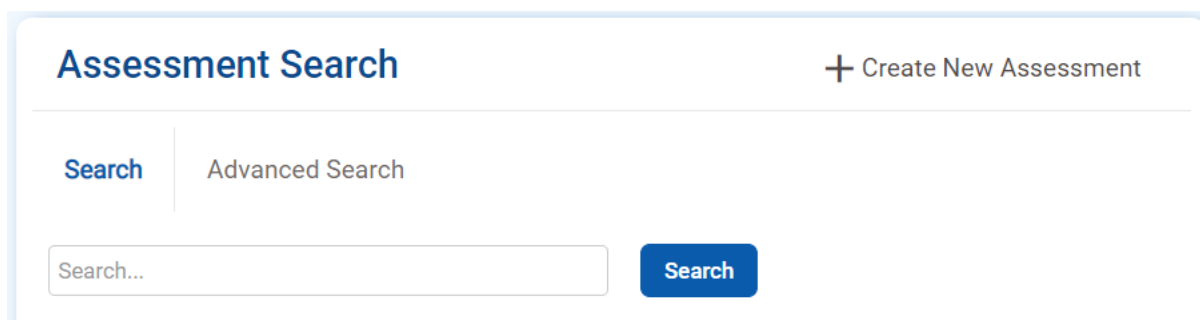
DIAGNOSIS DETERMINATION NOTE (DDN)

Medical Doctors (MDs) and Licensed Practitioners of the Healing Arts (LPHAs) should enter a Diagnosis Determination Note (DDN) in SanWITS. The standards for completing the DDN in SanWITS are the same as those shown in the DDN instructions posted on the Optum website.

To enter a DDN from the navigation pane, click **Client List**, then **Activity List** to expand it. Click **Assessments** and then **Dx Determination Note**.



The Assessments screen launches, displaying a section to search assessments and a button to create a new assessment.





To search for a specific DDN, enter the identifying criteria and click **Search**.

To add a new DDN, click **Create New Assessment**.

Complete the Add Assessment screen. Diagnosis Determination Note prepopulates as the Assessment type. It is read only. Select the Assessment Date and the Diagnosing Clinician. Click **Save**.

After the assessment is saved, the DDN form launches. It is ready for completion.

For basic navigation on how to complete the assessment including signing and finalizing the assessment, refer to the **Adding Assessments** section.

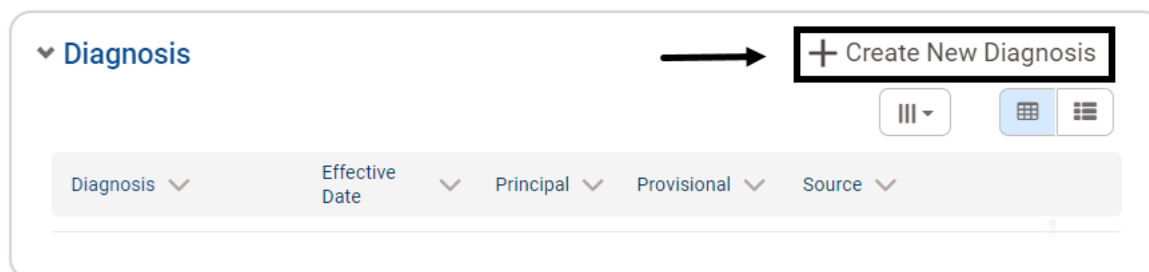
The DDN has the same navigation features as the Adult ILOC and Adolescent ILOC, with a few differences.



Adding Diagnosis

All new diagnosis should be created by an LPHA through the DDN.

To add a new diagnosis, click **Create New Diagnosis**.



The Add Diagnosis screen launches.

Select the Diagnosis. Confirm the Effective Date is the same as the DDN Effective Date. Mark the diagnosis as Principal Diagnosis. Click **Save**.

Only one principal diagnosis is allowed in SanWITS.



If there is an existing principal diagnosis in SanWITS and the new diagnosis was marked principal, a confirmation message appears on the screen. To confirm the new diagnosis as the principal diagnosis, click **OK**.

Confirmation

Currently F10.129 - Alcohol intoxication, With mild use disorder is the Principal. Do you wish to make F11.10 - F11.10 - Opioid use disorder, Mild the Principal Diagnosis?

Ok × Cancel

The diagnosis section displays the new diagnosis as the principal diagnosis.

▼ **Diagnosis** + Create New Diagnosis

☰ 📅 📄

Diagnosis ▼	Effective Date ▼	Principal ▼	Provisional ▼	
F11.10 - Opioid use disorder, Mild	04/04/2022	Yes	No	⋮
F10.129 - Alcohol intoxication, With mild use disorder	03/10/2022	No	No	⋮
F12.10 - Cannabis use disorder, Mild	03/10/2022	No	No	⋮

To make changes to or view the historical trail of a principal diagnosis, hover over the ellipsis and select Edit, Make Provisional, Delete, or History. The same steps apply to a provisional diagnosis. However, an option to select 'Make Principal' is available.

▼ **Diagnosis** + Create New Diagnosis

☰ 📅 📄

Diagnosis ▼	Effective Date ▼	Principal ▼	Provisional ▼	
F11.10 - Opioid use disorder, Mild	04/04/2022	Yes		⋮
F10.129 - Alcohol intoxication, With mild use disorder	03/10/2022	No		⋮
F12.10 - Cannabis use disorder, Mild	03/10/2022	No		⋮

Edit

Make Provisional

Delete

History



If Edit was selected, the Diagnosis screen opens. Make changes to the editable fields and click **Save**.

If either Make Provisional or Make Principal was selected and the change was successful, the system briefly displays a confirmation message.



If Delete was selected, a confirmation message appears on the screen. To confirm deletion, click **OK**.



If there is no record attached to the diagnosis, the diagnosis is deleted from the list of diagnoses. If there is an assessment or billing linked to the diagnosis, an error message pops up on the screen, and the diagnosis is not deleted. To remove the error message from the screen, click **X**.

F10.10 - Alcohol use disorder, Mild cannot be deleted because it is associated with an assessment that has been finalized. **X**

The History screen displays the audit trail of a diagnosis. It is read only.

History ✕

Showing 1-1 of 1 Previous **1** Next

Operation Timestamp	User Name	Entity Name	Operation Name	Context
04/08/2022 03:41:34 PM		Diagnosis	Create Client Diagnosis	disorder, Mild, EffectiveDate = 4/4/2022 12:00:00 AM, IsPrincipal = True, IsProvisional =

DDN Signature

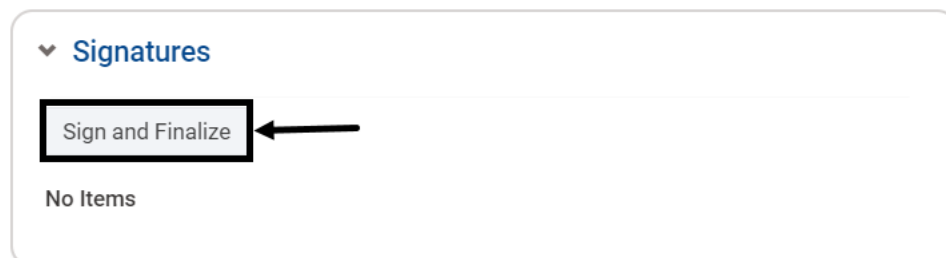
The Signatures section is inactive until the DDN form is one hundred percent (100%) complete. If there is missing information, the section displays 'No Items'. This is by design, and it serves as another validation to ensure the required fields are completed.

▼ Signatures

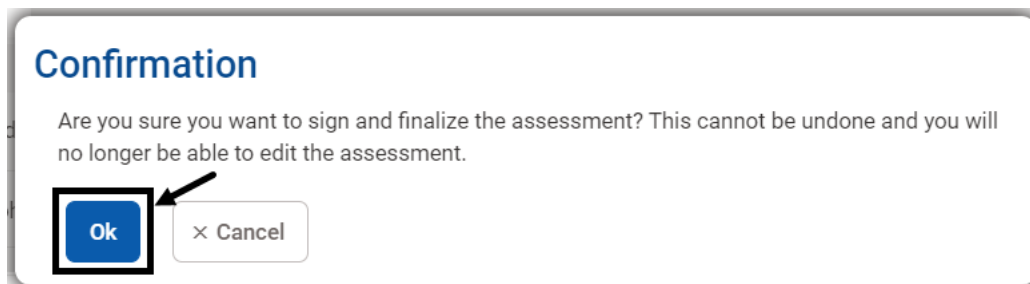
No Items ←



After the assessment form is 100% complete, the Signatures section is activated. The MD/LPHA may then click **Sign and Finalize**.



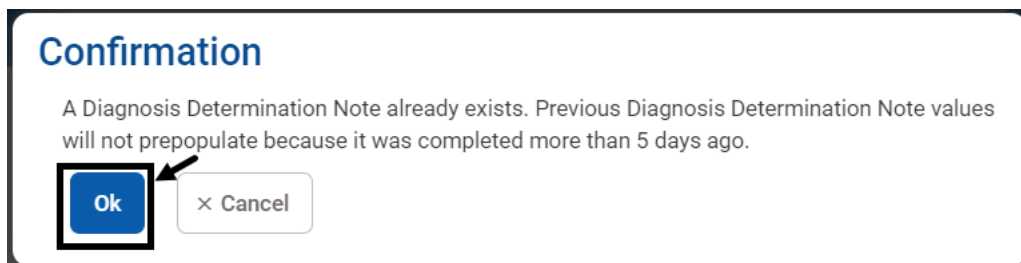
After clicking Sign and Finalize, the system closes the DDN form and displays the Confirmation screen. To confirm finalization of the DDN, click **OK**.



A DDN may not be edited after it is signed and finalized. If there are errors that need to be corrected, add another one.

Information from the most recently finalized DDN will prepopulate to the new DDN if the new DDN is more current and within 5 calendar days from the assessment date of the previous one.

If the new DDN is not within 5 days from the previous DDN, the confirmation message will indicate the previous DDN will not prepopulate. Click **Ok** to continue.



If there are issues with the system or the DDN, contact SUD MIS at SUD_MIS_Support.HHSA@sdcounty.ca.gov.



TIMELINESS OF RECORDS

Document	Level Of Care (LOC)	Timeframe for Completion
Initial LOC Assessment	Withdrawal Management	Within 24 hours of admission
	Residential	Day of admission (no more than 24 hours after admission)
	Outpatient (OS/IOS)	Within 7 days of admission
ASAM LOC Assessment	Withdrawal Management	Within 7 days of admission, and prior to a planned discharge
	Residential	After ASI/YAI, in conjunction with (not after) Initial Treatment Plan; within 10 days of admission and whenever an updated treatment plan is completed
	Outpatient (OS/IOS)	After ASI/YAI, in conjunction with (not after) Initial Treatment Plan; within 30 days of admission and whenever an updated treatment plan is completed
Risk Assessment and Safety Plan	Withdrawal Management	Within 24 hours of admission
	Residential	Completed, reviewed, and signed by LPHA within 24 hours of admission
	Outpatient (OS/IOS)	Completed, reviewed, and signed by LPHA within 7 days of admission
Diagnosis Determination Note (DDN)	Withdrawal Management	Within 72 hours of admission
	Residential	Within 10 days of admission
	Outpatient (OS/IOS)	Within 30 days of admission
	Recovery Services	Within 30 days of admission

NOTES



BHS SUD INSTRUCTIONS FOR COMPLETING ASSESSMENTS

The following instructions may also be downloaded from the DMC-ODS, SUDURM page on the Optum website at <https://www.optumsandiego.com>.

ADULT INITIAL LEVEL OF CARE ASSESSMENT INSTRUCTIONS

REQUIRED FORM: This form is required within the client file.

WHEN: Form to be completed by LPHA/SUD counselor with the client during the assessment/admission process for adult clients in a SUD program.

Timelines:

- **Outpatient programs** – To be completed within 7 calendar days from day of admit
- **Residential programs** – To be completed with 24 hours from day of admit

PURPOSE: To determine possible admission of a client into a SUD treatment program and appropriate level of care. Increased collaboration between LPHA/SUD counselor and client by use of Motivational Interviewing techniques will result in a more comprehensive and useful assessment.

REQUIRED ELEMENTS:

- **Client Name:** Enter "Client Name." On the form-fill, hit tab to get to "Client ID #", *once you hit tab again to get to the next field, the client name and ID will populate on the rest of the pages.*
- **Client ID#:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Staff Completing the Form:** Name of staff completing the assessment
- **Place of Interview:** Location of assessment (jail, program, etc.)
- **Date of Assessment:** Date of assessment
- **Referral source:** Referral source name (e.g., Probation, CWS, Parole, etc.) and contact information (e.g., contact person, phone number, etc.).

PERSONAL INFORMATION

- **Name:** Client's first name, middle initial and last name. (Obtain copy of legal ID, if available)
- **Age:** Client's age.
- **Social Security Number:** Client's social security number (obtain a copy of card, if available). If client does not have a social security number, follow your agency guidelines.
- **Birth Date:** Client's month/day/year of birth.
- **Phone Number:** Client's phone number.
- **Ok to leave a message:** Check the appropriate box.
- **Preferred language:** Client's preferred language.
- **Address:** Client's current, physical address. If client is homeless, document "homeless" and address issue on ASAM Dimension 6: Recovery Environment.
- **What are the main reasons you are seeking help here today?** Write in client's own words, ask client to prioritize based upon importance/risk.
- **Gender Identity:** Check the appropriate box. If "OTHER", write in client's own words specifics.
- **Sexual Orientation:** Check the appropriate box. If "OTHER", write in client's own words specifics.
- **Veteran Status:** Check Yes or No.
- **Pregnant /Due date:** Client's pregnancy status.
 - If pregnant, complete due date. Inform client they may be asked to provide



- documentation such as proof of pregnancy.
- If unknown, inquire if client might need a pregnancy test.
- **Number of Children Under 18:** Complete client's number of children under the age of 18. Programs requiring additional information may refer to "Supplemental A: Minor Children Information Form."
- **Medi-Cal:** Check Yes or No.
 - If yes, complete Medi-Cal card number. Inform client they may be required to provide proof of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility.
- **Other Health Coverage/Private Health Insurance (non Medi-Cal Plan):** Check Yes or No.
 - If yes, complete Insurance Company's name. Inform client they may be required to provide proof of insurance. Follow agency guidelines for health insurance eligibility.
- **Medically Assisted Treatment:** Check Yes or No.
 - If yes, list medication(s) and name of program client receives the medication. (Note: Post COSD-ODS, services may become billable).
- **Have you ever been arrested/charged/convicted/registered for arson?** Check Yes or No.
- **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?** Check Yes or No.
- **Emergency Contact Information:** Name, relationship, and contact number of designated emergency contact.

ALCOHOL AND/OR OTHER DRUG USE

- **Alcohol and/or other drug use:** Fill in ALL prompts within the boxes, document with N/A or "client denies" within boxes as appropriate. DO NOT LEAVE ANY BOXES BLANK.
- **Have you used needles in the Past 12 Months:** Check Yes, No, or decline to state.
 - If yes, specify date.
- **Date last used any drugs including alcohol:** Enter date.
- **If date of last use is longer than 7 days from today, how were you able to remain abstinent?** Enter in client's own words.
- **Number of days in a Row using:** Complete the number of consecutive days the client has been using alcohol and/or other drugs, up to the last date used.
- **How long do you think you have had a problem with alcohol and/or other drugs?** Enter in client's own words.

ALCOHOL AND/OR OTHER DRUG TREATMENT HISTORY

- **Have you received treatment for alcohol and/or other drugs in the past?** Check Yes or No.
 - If yes, specify in the boxes below; Type of Treatment, Name of Treatment Facility, Dates of Treatment, and if treatment was completed. DO NOT LEAVE ANY FIELDS BLANK.

ASAM DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- **History of serious withdrawal, seizures, or life-threatening symptoms during last withdrawal:** Check Yes or No.
 - If yes, describe in detail using client's own words.
- **Are you currently experiencing intoxication/withdrawal symptoms, tremors, excessive sweating, rapid heart rate, blackouts, anxiety, vomiting:** Check Yes or No.
 - If yes, immediately follow agency policy and procedure for further medical evaluation of



client.

- Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, and Withdrawal Potential): Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

(LPHA/Counselor to review the Health Questionnaire and TB Questionnaire in your determination below)

- Do you currently have any medical concerns? Check Yes or No.
 - If yes, describe in detail.
- Are you currently taking prescription medications for any medical conditions?: Check Yes or No.
 - If yes, describe in detail.
- If recently enrolled in Medi-Cal, have you received a health screening to identify health needs within 90 days of enrollment into Medi-Cal?: Check Yes, No, or N/A
- Severity Rating – Dimension 2 (Biomedical Conditions and Complications): Follow the prompts and check the current, assessed level of risk. (Include review of Health Questionnaire and TB Questionnaire in your determination).
- For residential programs: if risk rating in this dimension is greater than "zero" (0), submit completed Health Screening Questionnaire along with Initial Assessment/Intake Form to assist with obtaining initial authorization.

ASAM DIMENSION 3: EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS/COMPLICATIONS

(Review Risk Assessment and Co-Occurring Screening from for historical information relevant to this dimension include as a part of your assessment of severity below)

- Do you have a history of being unable to control your anger or impulsivity? Check Yes or No.
 - If yes, please describe how this has impacted your life: Enter in client's own words.
- Do you have current thoughts of hurting yourself or others? Check Yes or No.
 - If yes continue questions per your agency policy and procedures to include additional screens, and assessment if client has a plan or means to harm self or others. Document client responses and respond according to your agency policy and procedure.
- Are you currently being treated or sought help in the past for a mental health condition (Depression, Anxiety, PTSD, Bipolar, other mental health condition): Check Yes or No.
 - If yes, describe in detail. (Include as much information as possible; who, what for, where, when, was treatment helpful or not, was treatment completed or not.
 - If yes to above, are you currently prescribed medications: Check Yes or No.
 - If yes, describe in detail.
- Do you feel like you are unable to care for yourself (hygiene, food, clothing, shelter, etc.)? Check Yes or No.
 - If yes, describe in detail.
- Do you currently have a LPHA and/or Psychiatrist? Check Yes or No.
 - If yes, provide contact information to include; name, agency, address, and contact number/email.
- Over the past 2 weeks, how often have you been bothered by any of the following problems: Check ALL the following six questions with either: Not at all, Several Days, More Than Half the Days, Nearly Every Day. DO NOT LEAVE ANY QUESTIONS BLANK.
- Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or



Complications): Follow the prompts and check the current, assessed level of risk. (Review Co-Occurring Conditions Screening Form for historical information relevant to this dimension)

ASAM DIMENSION 4: READINESS TO CHANGE

- How long do you think you have had a problem with alcohol and/or other drugs? Document client self-report in as much detail as possible, in client's own words.
- Have you tried to stop drinking/using before? If so, what interfered with your success with that goal? Document client self-report in as much detail as possible in client's own words.
- Do you intend to reduce or quit drinking/using in the next 2 weeks? Check appropriate box.
- What substance(s) are you willing to stop using? Document client self-report in as much detail as possible.
- What would be helpful for you now in order to change your drinking/using? Document client self-report in as much detail as possible using client's own words.
- Do you imagine alcohol or other drug use will be an active problem for you 12 months from now? Check the appropriate box.
- How important is it for you to receive treatment for Alcohol Problems: Check the appropriate box.
- How important is it for you to receive treatment for Drug Problems: Check the appropriate box.
- Severity Rating – Dimension 4 (Readiness to Change): Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

- What's the longest period of time that you have gone without using alcohol and/or other drugs? Document client self-report.
 - What was happening in your life at that time? Use client's own words.
- If you previously stopped using alcohol and/or other drugs, what are the reasons you started using again? Document client self-report in as much detail as possible using client's own words.
- Are you aware of your triggers to use alcohol and/or other drugs? Check Yes or No.
 - If yes, list triggers.
- What are some coping tools you have used in the past to avoid using? Document client self-report in as much detail as possible.
- Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential): Follow the prompts and check the current, assessed level of risk.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

- Are you homeless or at risk? Check Yes or No.
 - If yes, obtain additional information; how long, do you have a caseworker, would you be interested in a referral and linkage with housing services, has this/will this be a barrier to your receiving/continuing with services?
 - What is your living situation? Enter living situation.
- How does your living situation impact your substance use? Use client's own words.
- Are you currently employed? Check Yes or No.
- Vocational/Educational Achievements (Highest grade level completed, training or technical education, etc.): List and attempt to make the list all inclusive.



- Do you have friends and/or family that are supportive of your seeking treatment for problems related to substance use? Check Yes or No.
 - If yes, describe: what do the friends/family of the client do that he/she feels is supportive? Are they currently involved in the client's life?
- Do you have friends and/or family that might interfere with your recovery efforts related to substance use? Check Yes or No.
 - If yes, describe how might they interfere in your treatment; has this happened in the past?
- PO Contact Name and Phone Number: Enter information or N/A
- Pending Court Date(s): Check Yes or No.
 - If yes, enter reason and date(s).
- Are there any transportation, childcare, housing or employment issues that could interfere with your treatment for problems related to substance use? Check Yes or No.
 - If yes, describe: is the client able to problem solve these issues so they are not a barrier to treatment.

- Severity Rating – Dimension 6 (Recovery Environment): Follow the prompts and check the current, assessed level of risk.

- READ LEVEL OF CARE DETERMINATION INSTRUCTIONS ON THE FORM.
- *Optional Risk Rating Summary: (provided to the left of the Level of Care Determination Instructions) Optional to enter risk ratings for each of the 6 dimensions here.*
- Recommended Level of Care: Enter ASAM LOC that offers the most appropriate treatment setting given the client's current severity and functioning: Read "Level of Care Determination Instructions" above. Based on the ASAM risk ratings, enter client's recommended level of care.
- Actual Level of Care: Enter next appropriate level of care if a level of care other than the recommended level of care above is provided.
- Additional Level of Care: Use this section if client is in two levels of care at the same time (e.g. when a client is receiving OTP services concurrently with outpatient or residential services): Enter additional level of care if applicable.
- Reason for Discrepancy: Check reasons for discrepancy between level of care recommendation and level of care provided. Document an explanation of the reason(s) on the line provided. Put N/A if not applicable.
- Designated Treatment Provider Name/Location: Complete this if services are NOT going to be provided by the program completing this assessment and they are referring the client to another program.
- Counselor/LPHA Name: Print name, signature, credentials, and date, if applicable.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY AN LPHA

PROVISIONAL DIAGNOSIS

All programs must provide a provisional diagnosis.

****PLEASE NOTE THAT REGISTERED NURSES (RNs) MAY NOT DIAGNOSE****

- Enter Provisional DSM-5 Diagnostic Label(s) & ICD-10 Code(s): Ensure to utilize correct DSM-5 diagnostic label and ICD-10 code; a diagnosis of Substance Use will be the primary and listed first. There can be additional DSM-5 Diagnostic Labels and ICD-10 codes listed as well, but will need to follow the SUD label if appropriate.
- A Face to Face interaction occurred between both SUD Counselor and LPHA to validate medical necessity: Enter the date of the face to face interaction, if applicable.



Note: If an LPHA does not conduct the assessment, a face-to-face interaction must take place, at a minimum, between the SUD counselor who has completed the assessment for the client and the medical director, licensed physician, or LPHA. The medical director, licensed physician, or LPHA must document the date when the face-to-face interaction took place and then sign and date the Assessment form.

- **LPHA* Name:** Print name, signature, credentials, and date.

**Licensed Practitioner of the Healing Arts (LPHA) includes: MD, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LPC), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family LPHA (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.*



Risk Assessment and Safety Management Plan Instructions

REQUIRED FORM:

This form is a required document in the client file.

WHEN:

This form must be completed upon admission and updated as clinically necessary, but at least annually.

COMPLETED BY:

Counselor or LPHA with the client upon admit; if completed by Counselor, then must be reviewed and signed by LPHA.

- **Outpatient programs** – To be reviewed and signed by LPHA within **7 calendar days** from day of admit.
- **Residential programs** – To be reviewed and signed by LPHA within **24 hours** from day of admit.

REQUIRED ELEMENTS:

- **Client Name:** Complete the client's full name.
- **Client ID#:** Complete the client's SanWITS Unique Client Number (UCN).
- **Date:** Complete with date assessment was completed.
- **Assessment of Risk Factors:** Ask the client the questions in **bold and underlined**. Document client's responses by checking the boxes marked yes or no. If the client responds "yes" to the 2nd question, then ask questions 3, 4, 5, and 6. If the client responds "no" to the 2nd question, then go directly to question 6.
 - **Note:** Questions 1-5 are regarding the past month and question 6 is about the client's lifetime and the past 3 months.
- **Check the Appropriate Level of Risk:** Select the appropriate level of risk (e.g. no identified risk, low, moderate, or high) at the bottom based on the highest risk level color code of the client's responses.
 - **Note:** Each program is required to develop and implement their own practice guidelines for each level of risk (e.g. Low Risk = a behavioral health referral, Moderate Risk = same day behavioral health evaluation and consider suicide precautions, High Risk = immediate suicide risk precautions). See Safety Management Plan Guidelines for further details.
- **Current Violence/Homicidal Ideation:** Select the appropriate boxes for no, yes, or refuse/cannot assess, following the prompts indicated on the form.
 - **Tarasoff Warning indicated?** Select appropriate answer: No, Yes.
 - **If yes, include potential victim(s) name and contact information (Tarasoff Warning Details):** If yes to Tarasoff Warning indicted, complete victim(s) information.
 - **Tarasoff Reported To:** If the Tarasoff Warning indicated is marked yes, complete this field with the law enforcement agency representative to whom the Tarasoff report was given.
 - **Date:** Complete the date Tarasoff Warning was reported.
- **Current Domestic Violence:** Select the appropriate boxes for no, yes, or refuse/cannot assess, following the prompts indicated on the form.
 - **If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:** Explain the domestic violence situation.
 - **If yes, is a Child Welfare/Adult Protective Services Notification Indicated?** Select appropriate box for No or Yes.



- **Reported To:** If there is current domestic violence, complete this field with the CWS/APS representative to whom the report was given.
- **Date:** Complete the date the domestic violence incident was reported.
- **Protective Factors:** Discuss protective factors with client (examples are listed on the form) and ask the client to identify their own protective factors. Document responses in the space provided.
- **Safety Management Plan:** If client is identified at any level of risk, then a Safety Management Plan is required. Staff must document the plan and **ACTIONS** to be taken.
 - **Note:** If found that there is an **Immediate Risk** and staff is not licensed/licensed eligible, then a consultation with a supervisor must be completed **before the client leaves your program.**
 - **Safety Management Plan Guidelines**

Each program must develop internal guidelines for the risk assessment with regards to the Safety Management Plan as what will be the plan of action when someone is identified at the various levels of risk (e.g. low, moderate, high). If the risk assessment is completed by staff that is not licensed/licensed eligible and risk is identified, then a consultation with the supervisor must be included as part of the internal guidelines. The Safety Management Plan may include the following information:

 - Documentation about consultation
 - Considerations of higher level of services or additional services such as case management, more frequent sessions, and/or coordination for care with current mental health treatment providers
 - Coordination with emergency contacts (e.g. client's spouse or parents)
 - Linkage to additional resources such as providing client with referrals to 211 or Access & Crisis Line (1-888-724-7240; TDD/TTY Dial 711)
 - Referrals made to higher level of care such as a crisis house or psychiatric hospital
 - Contacting Psychiatric Emergency Response Team (PERT) or the police
 - If applicable, changes made to the client's treatment plan
 - Frequency of re-assessment for risk
 - The documentation should also include how the use of Protective Factors and coping skills will be employed by the client

****Please note: If more room is needed to document Safety Management Plan, please document on a Progress Note and reference the Progress Note in this section****

- **Name and Signature of Counselor and Date:** If applicable, Counselor to print or type name, sign and date by hand
- **Name and Signature of *LPHA and Date:** LPHA that completed or reviewed the form to print or type name, sign and date by hand

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Diagnosis Determination Note Instructions

REQUIRED FORM: This form is required in client file.

WHEN:

- **For Outpatient:** Completed within thirty (30) days from date of admission.
- **For Residential:** Completed within ten (10) days from date of admission.

COMPLETED BY: This form is to be completed by the Medical Director (MD) or a LPHA.

REQUIRED ELEMENTS:

- **Client Name:** Document client's full name.
- **Client ID:** Complete the client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Substance Use Disorder Criteria:** Identify the name of each substance and check off the DSM – 5 criteria that have occurred in the past 12 months related to each substance.
- **Total number of Criteria:** add checks from each column.
- **Basis for Diagnosis Narrative:** Document the basis or justification for diagnosis using applicable DSM – 5 criteria. The narrative should be individualized to capture the client's substance use history and medical necessity to justify treatment services. It should include all applicable DSM – 5 specifiers, including if a client has only maintained sobriety in a Controlled Environment. Document all relevant symptoms, impairments, and timeframes, etc.
 - **Sobriety for More than 365 Days:** Documentation must clearly state the medical necessity as outlined in Title 22 CCR 51303:
 - "health care services... which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through diagnosis of treatment of disease, illness or injury are covered by the Medi-Cal program, subject to utilization controls... Such utilization controls shall **take into account these diseases, illnesses or injuries which require preventative health services or treatment to prevent serious deterioration of health.**"
 - Document client specific potential risk factors for relapse (e.g., unstable living environment, physical and mental health issues, past behaviors, etc.)
- **DSM – 5 Diagnosis(es)/ICD -10 codes:** Based on criteria documented in the narrative the MD or LPHA must document the diagnosis and matching ICD – 10 code(s).
- **Printed Name and Credentials:** MD or LPHA who completed the form print their name and credentials
- **Signature and date:** MD or LPHA who completed the form signs and dates it

NOTE: Must be reviewed by QAR for an initial, stay, extension, and discharge.



Discharge Summary Instructions

REQUIRED FORM:

This form is a required document in client file

WHEN:

Completed within 30 days of the date of the provider's last face-to-face or telephone treatment contact with the client

COMPLETED BY:

An SUD Counselor or LPHA from the program

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **ID #:** Complete the client's unique client number (UCN) as designated for the client in SanWITS.
- **Admission Date:** Complete client's date of admission to program.
- **Discharge Date: (Date of Last Contact):** This is the date of the client's last treatment contact (face-to-face or telephone) and his/her SanWITS discharge date.
- **Treatment Summary:** Summarize client's presenting problems, treatment provided, and outcome. Please complete in narrative form. The summary should include: 1) a summary of services the client received during treatment, 2) current living situation (i.e. homeless, sober living, with parents), 3) current alcohol or other drug use, 4) legal status/history of criminal justice system involvement, 5) diagnostic changes during treatment, 6) vocational/educational achievements, and 7) progress towards Treatment Plan goals.
- **Health & Medical**
Medications at Discharge: If YES, list name(s), dosage(s), and supply given/prescribed (# of days) Did client provide documentation of a physical exam completed within the past 12 months? Notified client's primary care physician of discharge?
- **Employment & Income**
Read prompt, If YES, provide explanation
- **Care Coordination**
List other service providers working with the client at discharge, if applicable.
Did the client meet medical necessity for another level of care at the end of treatment phase?
If YES, was client provided a warm hand-off to another level of care?
If YES, please explain in Discharge Recommendations/Referrals section below
Discharge Recommendations/Referrals (include ASAM Level of Care if referred to another SUD provider)



- **Discharge**
Prognosis: Mark the appropriate box for client's prognosis (good, fair, poor) and explain.
Reasons for Discharge: Mark the appropriate box for client's reason for discharge. This must match the client's SanWITS reason for discharge.
If discharge was involuntary: Mark the appropriate yes/no, or not applicable box if client was advised of the Grievance and Appeal Process and applicable Notice of Adverse Benefit Determination given?
 - If yes, which NOABD was issued?: List name and type of NOABD that was issued
 - Date NOABD was issued (if applicable): List the date the NOABD was issued to client
- **Client Comments:** Use this space to document any client comments at discharge. If completing for a client with whom the program lost contact, note that here.
- **Counselor or LPHA Printed Name:** Counselor or LPHA completing discharge summary to legibly print or type name.
- **Counselor or LPHA Signature/Date:** Counselor or LPHA completing the discharge summary must sign with credentials and write date of signature.



GLOSSARY

ASAM	American Society of Addiction Medicine
BHS	Behavioral Health Services
CalOMS	California Outcomes Measurement System
DHCS	Department of Health Care Services
DDN	Diagnosis Determination Note
DMC	Drug Medi-Cal
HHSA	Health and Human Services Agency
LPHA	Licensed Practitioner of the Healing Arts
MD	Medical Doctor
ODS	Organized Delivery System
OTP	Opioid Treatment Program
SanWITS	San Diego Web Infrastructure for Treatment Services
SUD	Substance Use Disorder
Tx	Treatment
UCN	Unique Client Number



CONTACT INFORMATION

SanWITS System and End User Support

[SUD MIS Support.HHSA@sdcounty.ca.gov](mailto:SUD_MIS_Support.HHSA@sdcounty.ca.gov)

Phone: 619-584-5040 (for password resets)

Fax: 1-855-975-4724

Clinical Processes and Documentation

QIMatters.HHSA@sdcounty.ca.gov

BHS SUD Instructions, Manuals, and Forms

www.optumsandiego.com

SanWITS Training Registration

<https://www.regpack.com/reg/dmc-ods>

1-800-834-3792 x3

Please consult with your facility manager and your resource packets prior to contacting the Support Desk and Quality Management Teams.

