OWITS Reference Manual

Volume 5

Client Activity and Contact

Revision 1-5

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Description

Because the primary purpose of the OWITS application is to track and record treatment and services provided to behavioral health clients, a long and complex list of record-keeping modules is available for various aspects of treatment. The majority of those modules are described in this volume.

Purpose

To provide a detailed explanation of most of the Activity List modules available in OWITS for use by non-ATR providers.

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Definitions / Abbreviations

- Access Level / Access Rights: General terms referring to OWITS security settings which allow users to access some functions or data but not others. OWITS defines Access Level and Access Rights through the "Job Function Roles" and "Role Attributes" settings.
- Agency: The collective locations and offices of a company, corporation, or organization that provides addiction recovery or mental health treatment and services. See also *Facility*.
- AMH: The Addictions and Mental Health division of the Oregon Health Authority.
- ASAM: American Society of Addiction Medicine – An organization responsible for developing the "Patient Placement Criteria" that serves as a reference for addiction recovery counselors and clinicians to use when identifying the most appropriate services for each client. In OWITS, "ASAM" generally refers to the results of the ASAM assessment, a multi-dimensional method of organizing biopsychosocial information to assist with the selection of the most appropriate level of service for a client's individual needs and preferences.
- Box: A general term for a square or rectangle that appears on a web page and is generally used for data entry. See also *Field*, *Option Transfer Box*, and *Text Box*.
- Browser: Computer software used to locate, retrieve, and display content on the World Wide Web.
- Button: An image or icon on a computer screen that executes a command when clicked, such as "the OK button" or "the Cancel button."
- CDC: Centers for Disease Control and Prevention – An organization that exists for the purpose of collaborating to create the expertise, information, and tools that people and communities need to protect their health through health promotion, preparedness for new health threats, and the prevention of disease, injury, and disability.
- Character: A single unit of information, including letters, numerical digits, punctuation marks, spaces, and symbols.
- Click: To press a button on a computer mouse. "Click" refers to pressing the left mouse button once. "Double-click" refers to pressing the left mouse button twice in rapid succession. "Right-click" refers to pressing the right mouse button once.
- Client: An individual who is receiving, has received, or will receive treatment or services.
- CPMS: Client Process Monitoring System – The data collection and consolidation tools used by AMH to record treatment data and report to SAMHSA.
- Data / Dataset: Pieces of information or groups of pieces of information.
- Default: A preset setting or value; an option that is automatically selected in every situation.
- Dialogue Box: A type of window that appears in specific circumstances that allows users to perform a command, asks users a question, or providers users with information.
- Drop-Down Menu: A list of options in a data entry field that allows users to select only one item.
- DUII: Driving Under the Influence of Intoxicants – In Oregon, a Class A misdemeanor or a Class C felony charged against individuals who operate a motor vehicle on public roadways while under the influence of an intoxicating substance, including alcohol, controlled substances, and inhalants. In OWITS, the term DUII is most often related to substance abuse treatment in which courts require clients to demonstrate at least 90 days abstinence from alcohol and other

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drugs and the client's successful discharge from treatment before reinstating his or her driver's license or other legal privileges.

- EHR: Electronic Health Record – computer software designed to track data regarding the demographics and treatment of patients.
- Environment: A subdivision of the overall OWITS system containing all available aspects of the program but resulting in a different final result.
- Facility: The individual locations or offices of a company, corporation, or organization that provides addiction recovery or mental health treatment and services. Multiple facilities may exist within a single agency. See also *Agency*.
- FEi: Focused eHealth Innovations – The vendor that provides and supports the WITS software to Oregon. See also *OWITS*.
- Field: A general term for an individual point of data entry on a web page or in a database application, usually a smaller piece of data from a larger collection or a record.
- FICA: Federal Insurance Contributions Act – A United States law requiring a deduction from paychecks and income that goes toward the Social Security and Medicare programs. Both employers and employees are responsible for sharing FICA payments.
- File: A self-contained block of information or resource for storing information—such as a document, spreadsheet, or image—stored in or used by a computer or related device.
- Heading / Subheading: The title of an OWITS module or of divisions and screens within OWITS modules. See also *Module*.
- HIV: Human Immunodeficiency Virus – The virus responsible for progressive immune system failure in humans that often leads to AIDS (Acquired Immunodeficiency Syndrome).
- IP Address: A numerical label assigned to each device (computer, printer, etc.) participating in a computer network.
- Key: A button on a computer keyboard, such as "the Enter key" or "the CTRL key."
- Link: Short for "hyperlink," a connection to another web site or document.
- Locator: This consists of three lines of text in the upper center portion of the OWITS window and is used to identify the current active (or "context") agency, facility, user, and client records.
- Module: A smaller component of a larger system.
- Navigate / Navigation: Movement through a series of data entry screens.
- Navigation Pane / Navigation View: The OWITS menu system, located on the left side of each OWITS page.
- Option Transfer Box: A pair of boxes on a web page that allow options to be selected and moved from one box to another. Also known as a "Mover Box."
- OWITS: Oregon Web-Infrastructure for Treatment Services – an electronic behavioral health record program as modified for Oregon.
- Pop-up: A new browser window that opens to display additional information without disrupting the page currently open.
- POSIT: Problem Oriented Screening Instrument for Teenagers – A screening tool designed to identify problems and the potential need for service in ten functional areas for adolescents.

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- SAMHSA: Substance Abuse and Mental health Services Administration – an agency of the U.S. Department of Health and Human Services which serves to focus attention, programs, and funding on improving the lives of people with or at risk for mental health and substance abuse disorders.
- Screen: A specific informational view that can be displayed in OWITS at one time.
- Table: A grid of information with rows of information divided into categorical columns.
- Text Box: A bordered square or rectangle in a web page into which users can type text.
- Tier: A layer or ranking within a hierarchy.
- Treatment Domain: A designation in OWITS client records that separates some client information based on the type of treatment or service administered.
- URL: Uniform Resource Locator – a string of characters that constitute a reference to an Internet resource, such as a file or web page.
- User: A person who interacts with the OWITS system.
- User ID: A unique name assigned to each user to control access to confidential records or to OWITS in general and to track record change history.
- Value: A specific data point for a given data type, such as one option in a drop-down menu.
- Wi-Fi: Technology allowing electronic devices (such as computers) to exchange information over a computer network using radio waves.
- Wildcard: A character such as an asterisk (*) or a question mark (?) that can be used in place of letters or other characters to indicate an unknown value. See also *Character*.
- WITS: Web-Infrastructure for Treatment Services – an electronic behavioral health record program.

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1.0 Purpose of the Activity List

1.1 The Activity List is comprised of records of clients' progress through the treatment programs and services rendered by the provider agencies and facilities.

1.1.1 Parts of the Activity List are similar to parts of the CPMS forms previously used by AMH for collecting treatment and service data.

1.1.1.1 See Appendix C – Example of CPMS Mental Health Enrollment Form and Appendix D – Example of CPMS Alcohol & Drug Enrollment Form for examples of CPMS forms.

1.1.2 The Intake screen conveys the same data that the CPMS referral boxes and form types conveyed but in a more comprehensive manner.

1.1.3 The Admission and Program Enroll screens convey treatment data similar to that found in the lower half of the CPMS forms.

1.1.4 See Appendix A – Activity List Module Hierarchy for an illustration of the hierarchy associated with the Intake, Admission, Program Enroll, Program Disenrollment, and Discharge records.

1.2 Without an Activity List, the client's record would consist of little more than a name and a number, turning the OWITS EHR into a complicated address book.

1.3 The Activity List contains:

1.3.1 Referrals, treatment domains, and infectious disease and prenatal statistics.

1.3.2 Records for collecting vital signs such as height, weight, and blood pressure, laboratory orders and results, and immunization history.

1.3.3 Evaluations of client program eligibility and payment ability.

1.3.4 Drug test orders and results.

1.3.5 The ability to add the client to waiting lists for programs or refer the client to other agencies or facilities.

1.3.6 The ability to assign staff members to treatment teams and to create and evaluate treatment and recovery plans.

1.3.7 Screening and assessment tools.

1.3.8 Treatment admission records.

1.3.9 Program enrollment records.

1.3.10 Diagnoses of specific problems, conditions, diseases, etc.

1.3.11 Records of specific treatment or service encounters with the client.

1.3.12 Release of information consent records (not forms) and a referral tool.

1.3.13 General treatment and service notes.

1.3.14 Service completion records and discharges.

1.3.15 Payment records.

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1.4 The Activity List is an ongoing record that should be updated frequently as the client receives services and treatment.

1.5 Some portions of the Activity List contain fields required for federal and state reporting.

1.5.1 Provider agencies and facilities may choose to complete only the required sections.

1.5.1.1 Required sections other than the Client Profile are Intake, Admission, Encounters, and Program Enrollment.

1.5.1.1.1 The Discharge record is also required if the agency or facility needs to close a client's treatment episode.

1.5.1.1.2 The Discharge record is not required if the agency or facility will only use program enrollment and disenrollment data to report treatment episodes to AMH.

1.5.1.1.3 See OWITS Reference Manual, Volume 9: Client Discharge for details regarding the differences between disenrollment and discharge data.

1.5.1.2 An Intake refers to an overall series of treatments or services within a treatment domain (see 7.0).

1.5.1.2.1 A new Intake record should be created the first time a client is admitted for treatment or services and again each time the client returns for new treatment or services.

1.5.1.2.2 Individual agencies and facilities must determine the difference between continuing treatment or services and beginning new treatment or services.

1.5.1.2.3 An Intake record determines the type (domain) of treatment or services the client will receive (see 7.4.20).

1.5.1.2.4 In OWITS and throughout this manual, the terms Intake, Case, and Episode are often used interchangeably.

1.5.1.3 An Admission refers to the specific details regarding the problem for which the client is seeking treatment (see 17.0).

1.5.1.3.1 A new Admission should be created when the client begins receiving treatment or services for the first time or when the client's problem significantly changes.

1.5.1.3.2 Individual agencies and facilities must determine what criteria constitute a change in problem significant enough to warrant the creation of a new Admission record as opposed to a change in program enrollment.

1.5.1.3.3 Only one admission record can be created per episode, which means that starting a new admission requires discharging the client (see 26.0), closing the case (see 7.4.21 and OWITS Reference Manual, Volume 9: Client Discharge), and starting a new episode (see 7.3).

1.5.1.4 A Program Enrollment refers to the client's participation in treatment or service programs, curriculums, agendas, etc. (see 18.0).

1.5.1.4.1 Program Enrollments should be changed when a client completes a program, when a client is no longer eligible for a program (due to age,

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time-sensitive funding, or other factors), or when a client stops participating in the program for any other reason.

1.5.1.4.2 To remove a client from a program, providers complete a "disenrollment" record (see 26.5).

1.5.1.5 An Encounter refers to billable services provided to clients (see 20.0).

1.5.1.5.1 An Encounter record should be completed for each billable service provided, regardless of whether the client is billed and regardless of whether the agency uses OWITS for billing purposes.

1.5.1.5.2 Encounter records should be completed as soon as possible after the service is completed.

1.5.1.6 A Discharge refers to a client's conclusion of a phase of treatment or service (see 26.0).

1.5.1.6.1 A Discharge record should be completed when a client has completed all programs related to a treatment or service, no longer has or needs regular or scheduled appointments at the facility, and is not expected to return for an extended period of time.

1.5.1.6.2 A Discharge record could also be created if the client voluntarily terminates treatment or services for any reason.

1.5.1.6.3 A Discharge record does not remove the client from the facility or agency records.

1.5.2 Provider agencies and facilities may choose to complete any or all of the non-required sections that prove beneficial in fulfilling client, staff, and business needs.

1.5.2.1 Appendix B – Activity List Modules: Required, Optional, or Recommended indicates whether each of the modules in the Activity List is required, recommended, or optional.

1.5.2.2 Required modules must be completed for OWITS records to function properly and/or to report federally-required or state-required data elements.

1.5.2.3 Recommended modules contain information that many treatment and service providers may find useful or that makes OWITS operate more smoothly, but that information can be left out of OWITS without any significant negative impact.

1.5.2.4 Modules that are not required ("optional") may be used or ignored at the discretion of the agency or facility.

1.6 In the sections below, independent text and field labels quoted from OWITS will be *italicized*.

2.0 Order of Operations

2.1 Certain data elements within the Activity List cannot be completed until the Client Profile has been completed (see OWITS Reference Manual, Volume 4: Client Profile) *and* data has been added to other portions of the Activity List.

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2.1.1 The Client Profile cannot be completed until the agency, facility, staff, and program records are also completed (see OWITS Reference Manual, Volume 3: Agencies Facilities, Programs, and Staff Records).

2.2 The instructions in this manual describe entering data in the order suggested by the headings and subheadings in the Navigation View.

2.2.1 Individual agencies and facilities must determine the actual order of data entry and record completion.

2.2.2 Appendix B – Activity List Modules: Required, Optional, or Recommended indicates whether each of the modules in the Activity List is required, recommended, or optional.

2.3 To avoid error messages and potentially frustrating loops of data entry, the following order of operations is provided for a relatively streamlined process of recording the required aspects of client activity and contact.

2.3.1 Client List > Non-Episode Contact

2.3.1.1 Non-Episode Contact records can be added at any time following the completion of a client profile.

2.3.2 Client List > Activity List > Intake

2.3.2.1 An Intake record is required before any other activity can be recorded for the client in the Activity List.

2.3.2.2 The Intake screen can also be accessed via Client List > Episode List (see 5.0).

2.3.3 The following can be completed any time after the Intake is completed.

2.3.3.1 Client List > Activity List > Vital Signs

2.3.3.2 Client List > Activity List > Lab/Radiology

2.3.3.3 Client List > Activity List > Client Eligibility

2.3.3.4 Client List > Activity List > Fee Determination

2.3.3.5 Client List > Activity List > Drug Testing

2.3.3.6 Client List > Activity List > Wait List

2.3.3.7 Client List > Activity List > TX Team

2.3.3.8 Client List > Activity List > Screening

2.3.3.9 Client List > Activity List > Assessments

2.3.3.9.1 The ASAM assessment record within the Assessments module is only available to ATR facilities.

2.3.3.9.2 ASAM records are available to non-ATR providers in other modules, including Admission (17.3.17) and Discharge (26.6.2).

2.3.3.10 Client List > Activity List > Problem List

2.3.3.11 Client List > Activity List > Immunization

2.3.3.12 Client List > Activity List > Notes > Misc. Notes

2.3.3.13 Client List > Activity List > Consent

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2.3.3.14 Client List > Activity List > Referrals

2.3.3.15 Client List > Activity List > Payments

2.3.3.16 Client List > Activity List > Treatment > Medications

2.3.3.17 Client List > Activity List > Recovery Plan

2.3.3.17.1 Completing an Admission record prior to creating a recovery plan will avoid one potential error.

2.3.3.18 Client List > Activity List > Recovery Plan Review

2.3.3.18.1 A Recovery Plan must be completed before a Recovery Plan Review can be completed.

2.3.4 Client List > Activity List > Admission

2.3.5 Client List > Activity List > Program Enroll

2.3.5.1 An Admission must be completed before a Program Enrollment can be completed.

2.3.5.2 A client may be enrolled simultaneously in as many programs as are available in the facility.

2.3.6 Client List > Activity List > Treatment > TX Plan

2.3.7 Client List > Activity List > Treatment > TX Plan Review

2.3.7.1 A Treatment Plan must be completed before a Treatment Review can be completed.

2.3.8 Client List > Activity List > Encounters

2.3.9 Client List > Activity List > Discharge

2.3.9.1 An Admission must be completed before a Discharge can be completed.

2.3.9.2 The client must be "disenrolled" from all programs before a Discharge can be completed.

2.3.9.3 The client cannot be enrolled in any more programs in the current episode after a Discharge has been completed.

3.0 Initial Steps

3.1 The instructions for each of the modules described in this manual assume that the user has already completed the following series of initial steps required to access a client's record in OWITS.

3.2 Log in to the appropriate OWITS environment.

3.2.1 Use Training for practice, demonstration, or test purposes.

3.2.2 Use Production to record actual client records.

3.3 Locate the client's profile.

3.3.1 In the Navigation View, click the "Client List" link.

3.3.2 The Client Search page will display.

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3.3.3 Perform a search to locate the client's profile.

3.3.3.1 Search terms should be as broad as possible to increase the possibility of locating an existing record.

3.3.3.2 Use wildcards (such as asterisks or question marks) if multiple name spellings are possible.

3.3.3.2.1 For details regarding the specific actions of wildcard characters, see OWITS Reference Manual, Volume 1: OWITS Basics.

3.3.3.3 Set the Facility field to the null (blank) value.

3.3.3.3.1 Searches will be limited to the selected agency.

3.3.3.3.2 Client Profiles are saved at the Agency record and will not be visible to specific facilities until an Intake is complete.

3.3.3.4 Ensure that modifiers (such as Case Status and Active Consents) are set to include the maximum range of clients.

3.3.4 If a profile does not already exist, create a new profile before proceeding with the Intake (see OWITS Reference Manual, Volume 4: Client Profile).

3.3.4.1 A Client Profile record must be created for the client before any other records can be added.

3.3.5 In the Actions column of the Client List table, click the "Profile" or "Activity List" link for the desired client.

3.3.5.1 Using the "Profile" link is recommended for the Non-Episode Contact (4.0), Episode List (5.0), and Intake (7.0) modules.

3.3.5.2 Using the "Activity List" link for all other modules can save time.

4.0 Non-Episode Contact

4.1 Use of the Non-Episode contact module is recommended.

4.2 This module records instances of communication between the client and the agency that occur outside a treatment or service episode (see 5.2.1).

4.2.1 "Outside" an episode may include initial inquiries about services available, brief follow-up phone calls after a period of treatment or service has ended, requests for information, appointment scheduling, etc.

4.2.2 "Outside" an episode may include communication during a treatment episode that does not relate to any aspect of the current episode, such as might occur when a Substance Abuse client is identified as having a co-occurring Mental Health problem.

4.2.3 In-episode contact is recorded in the Miscellaneous Notes module (see 22.6.2.1.4).

4.3 In the Navigation View, navigate to Client List > Non-Episode Contact.

4.3.1 The Non-Episode Contact List will display.

4.3.2 This table shows records of previous non-episode contact between the client and the current agency.

4.4 Create new records of non-episode contact as needed.

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4.4.1 Click the "Add New Non-Episode Contact Record" link in the Non-Episode Contact List heading.

4.4.2 The Non-Episode Contact Note screen will display, which consists of the following fields:

4.4.2.1 *Contact Date*

4.4.2.1.1 Enter the date on which this non-episode contact occurred.

4.4.2.1.2 This date may be in the future for instances of planned or scheduled contact.

4.4.2.2 *Time (hh:mm)*

4.4.2.2.1 Enter the time at which this non-episode contact occurred.

4.4.2.2.2 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

4.4.2.2.3 Example: 08:30 AM

4.4.2.2.4 Example: 03:25 PM

4.4.2.2.5 Example: 1630

4.4.2.3 *Contacted By*

4.4.2.3.1 This field will automatically populate with the name of the current user.

4.4.2.3.2 Select the name of the staff member who initiated this non-episode contact with the client or who was contacted by the client.

4.4.2.3.3 Available selections will consist of all active agency staff members.

4.4.2.4 *Referral*

4.4.2.4.1 Indicate whether the client was referred to the agency for this instance of non-episode contact.

4.4.2.4.2 Select "Formal" to indicate a referral as an official recommendation from a professional, such as a law enforcement officer, physician, or therapist.

4.4.2.4.3 Select "Informal" to indicate a referral as a casual recommendation from a professional or any recommendation from a non-professional, such as a friend or neighbor.

4.4.2.5 *Referring Agency*

4.4.2.5.1 If the client was referred from another agency, enter the name of that agency in this field.

4.4.2.5.2 The referring agency does not necessarily need to be an OWITS agency.

4.4.2.6 *Referred By – First Name*

4.4.2.6.1 If referred by an individual, and if that individual is known or can be identified, enter his or her first name.

4.4.2.7 *Referred By – Last Name*

4.4.2.7.1 If referred by an individual, and if that individual is known or can be identified, enter his or her last name.

4.4.2.8 *Referred By – Phone*

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4.4.2.8.1 If referred by an individual, and if that individual's phone number is known or can be acquired, enter it in this field.

4.4.2.8.2 OWITS will automatically format any ten digit number as a standard long-distance phone number.

4.4.2.9 *Contact Reason*

4.4.2.9.1 Select the option that best describes the purpose for this non-episode contact.

4.4.2.10 *If Other, Specify*

4.4.2.10.1 Selecting "Other" in the Contact Reason field above (4.4.2.9) will make this field available.

4.4.2.10.2 If a fitting contact reason is not available, enter a brief description of the purpose for the non-episode contact in this field.

4.4.2.10.3 This field is limited to 128 characters, including spaces.

4.4.2.11 *Location*

4.4.2.11.1 Select the option that best describes the location at which the non-episode contact occurred.

4.4.2.11.2 Select "Office" for contact that occurs within the treatment location (agency or facility offices or clinics), including phone calls or email messages.

4.4.2.12 *Contact Type*

4.4.2.12.1 Select the option that best describes the method used to establish contact.

4.4.2.13 *Duration (hrs)*

4.4.2.13.1 Enter the amount of time, measured in hours, that it took to begin and conclude the non-episode contact.

4.4.2.13.2 This field will accept decimal values up to two decimal places, such as entering 0.25 to indicate a duration of fifteen minutes.

4.4.2.13.3 OWITS will round decimals beyond two decimal places to the nearest hundredth.

4.4.2.14 *Severity Rating*

4.4.2.14.1 Select the option that best describes the perceived severity or urgency of any problems identified by this non-episode contact.

4.4.2.14.2 Example: An administrative assistant who called the client to verify that he or she is still planning to attend the next day's group therapy session and identified no problems might select "Not at all" in this field.

4.4.2.14.3 Example: A clinician who received an email from the client indicating that he or she would be attending a party where alcohol would be served and was concerned that the client might become intoxicated might select "Moderate" or "High" in this field.

4.4.2.14.4 Example: A clinician who observed suicidal behavior in a client during a follow-up consultation might select "Critical" in this field.

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4.4.2.15 *Created Date*

4.4.2.15.1 This read-only field will automatically populate with the date and time at which the "Add New Non-Episode Contact Record" link (4.4.1) was clicked.

4.4.2.15.2 This field refers specifically to the OWITS record of non-episode contact, not the contact instance itself.

4.4.2.16 *Signed Notes*

4.4.2.16.1 This field contains notes that have been added to this contact record and signed by the user who added them.

4.4.2.16.2 Signed notes are "electronically signed" with the user's name and the date and time the notes were signed.

4.4.2.16.3 Signed notes cannot be edited or deleted.

4.4.2.17 *Unsigned Notes*

4.4.2.17.1 Enter any desired information that will be applied to this contact record.

4.4.2.17.2 This may include a narrative description, list, or other text that details the information exchanged in relation to this contact record.

4.4.2.17.3 When the notes have been entered as desired and reviewed for accuracy, click the Sign Note button.

4.4.2.17.3.1 It is possible to save the Non-Episode Contact record without signing the notes.

4.4.2.17.3.2 Some users may enter the notes and save the record for supervisors, clinicians, or other users to open and sign at a later time.

4.4.2.18 *Outcome*

4.4.2.18.1 Select the option that best describes the outcome or results of this contact as determined by the user creating the non-episode contact record.

4.4.2.18.2 Example: "Proceed to Screening" indicates that the client should be screened or assessed for treatment or service needs.

4.4.2.18.3 This field may be left blank if none of the options are applicable to this instance of non-episode contact.

4.4.2.19 *Reason for Ineligibility*

4.4.2.19.1 If applicable, enter an explanation of why the client is not eligible for treatment or services.

4.4.2.20 *Follow-Up Steps*

4.4.2.20.1 Select the options that best describe any additional actions that are recommended for meeting this client's treatment or service needs.

4.4.2.20.2 Select "Other" if no applicable option is available.

4.4.2.20.3 Select "None" if no additional steps are recommended or necessary.

4.4.3 When all of the required fields (and others as appropriate) have been filled, click Save.

4.4.4 Click Finish to return to the Non-Episode Contact List screen.

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4.5 Review existing records of non-episode contact as needed.

4.5.1 In the Actions column of the Non-Episode Contact List table, click the "Review" link for the desired contact record.

4.5.2 Fields (detailed in 4.4.2.1 through 4.4.2.20) may be modified or updated as needed.

4.5.3 Additional notes can be added as needed.

4.5.4 Unsigned notes can be signed as needed.

4.5.5 Click Finish to return to the Non-Episode Contact List screen.

4.6 Existing records of non-episode contact can be moved.

4.6.1 Some users will see a "Move Non-episode Contact" link in the Actions column of the Non-Episode Contact List table.

4.6.1.1 This function transfers the record of non-episode contact to another client.

4.6.1.2 Non-episode contact records may only be transferred to any other client within the current agency.

4.6.2 Obtain the OWITS Client ID number for the client to whose profile the non-episode contact record will be moved.

4.6.2.1 It may be necessary to navigate to the Client Search screen (see 3.3.1) and perform a search to locate the client.

4.6.2.2 Copy the Client ID number from the Client List table.

4.6.2.3 To avoid losing track of the current client, ensure that the name of the client displayed in the Locator at the top of the screen does not change during this process.

4.6.2.4 For additional information about the OWITS Client ID number, see OWITS Reference Manual, Volume 4: Client Profile.

4.6.3 On the Non-Episode Contact List screen, click the "Move Non-episode Contact" link in the Actions column.

4.6.4 On the following screen, in the Client # field, enter the OWITS Client ID number for the client to whose profile the non-episode contact record will be moved.

4.6.5 Click Go.

4.6.5.1 The name, date of birth, and gender of the client to whose profile the non-episode contact record will be moved will appear in the read-only fields on this screen.

4.6.6 Confirm that the correct client has been selected.

4.6.6.1 If the correct client has been selected, click Finish.

4.6.6.2 If the client has been selected is not the correct client, click Cancel to return to the Non-Episode Contact List screen, locate a different OWITS Client ID number, and try again.

4.6.7 When the record has been moved, OWITS will return to the Non-Episode Contact List screen.

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4.6.7.1 The screen that displays after an instance of Non-Episode Contact has been moved will be for the client whose record received it.

4.6.7.2 To return to the record from which the instance was removed, return to the Client List screen and select the desired client using the "Profile" or "Activity List" link in the Actions column.

4.7 Existing records of non-episode contact can be deleted.

4.7.1 Some users will see a "Delete" link in the Actions column of the Non-Episode Contact List table.

4.7.1.1 This action will completely remove a selected instance of non-episode contact from the client's record.

4.7.2 On the Non-Episode Contact List screen, click the "Delete" link in the Actions column.

4.7.2.1 OWITS will confirm the delete command.

4.7.2.2 The selected instance of non-episode contact will be deleted.

4.7.2.3 This action cannot be undone.

4.8 Use the Navigation View links to exit the Non-Episode Contact module.

5.0 Episode List

5.1 Use of the Episode List module is required for record navigation.

5.2 The episode list details all of the selected client's periods of treatment within the current agency.

5.2.1 An episode (or "case" or "intake") refers to the period of time between the Intake Date (7.4.9) and the Case Closed date (7.4.21).

5.2.2 A client in any agency can have one open case per treatment domain (7.4.20) per facility at a time.

5.3 To view the Episode List, select a client (see 3.3.5) and use the Navigation View to navigate to Client List > Episode List.

5.4 The Episode List table for the selected client will display.

5.4.1 If the client does not have an Intake record (7.0) created in any facility in the current agency, this table will be blank.

5.4.2 The Episode List table consists of the following columns:

5.4.2.1 *Case #*

5.4.2.1.1 Cases are recorded sequentially in the order in which the Intake records were completed and saved.

5.4.2.1.2 The most recent case will appear with the highest number.

5.4.2.1.3 This column reflects the value displayed in the Case # field on the Intake screen (7.4.6).

5.4.2.2 *Status*

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5.4.2.2.1 "Open Active" indicates an episode that has not been closed and in which it is likely that treatment and services are currently being rendered.

5.4.2.2.2 "Closed" indicates an episode that has been completed and to which no new data can be added.

5.4.2.2.3 This column reflects the value displayed in the Case Status field on the Intake screen (7.4.7).

5.4.2.3 *Facility*

5.4.2.3.1 The value in this column indicates the facility in which the Intake and other records associated with this episode are saved.

5.4.2.4 *Intake By*

5.4.2.4.1 The name in this column is the agency staff member who entered or recorded the Intake.

5.4.2.4.2 This column reflects the value displayed in the Intake Staff field on the Intake screen (7.4.2).

5.4.2.5 *Intake Date*

5.4.2.5.1 The date in this column is the date of the Intake record (7.4.9).

5.4.2.6 *Closed Date*

5.4.2.6.1 The date in this column is the date the episode was closed, indicating that the client was discharged and is no longer receiving treatment or services from the associated facility.

5.4.2.6.2 This column reflects the date displayed in the Date Closed field on the Intake screen (7.4.21).

5.4.2.6.3 For details regarding discharging clients and closing cases, see OWITS Reference Manual, Volume 9: Client Discharge.

5.4.2.7 *Latest PE*

5.4.2.7.1 This column displays some of the programs into which the client was enrolled during the episode.

5.4.2.7.2 All current program enrollments in the indicated facility (5.4.2.3) will be displayed.

5.4.2.7.3 If the client has been enrolled into and disenrolled from a program more than once, the program record with the most recent disenrollment date may be displayed.

5.4.2.8 *Domains*

5.4.2.8.1 This column displays the treatment domain (7.4.20) associated with the facility.

5.4.2.8.2 Domains are limited to "ATR," "Mental Health," and "Substance Abuse."

5.4.2.9 *Actions*

5.4.2.9.1 This column contains the "Review" link.

5.4.2.9.2 To select an episode to view, click the "Review" link.

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5.4.2.9.3 The selected episode's case number will display in the Locator at the top of the screen.

5.4.2.9.4 The Client Activity List (6.0) will display.

5.4.2.9.5 Episodes can only be viewed if the current ("context") facility matches the facility in the Facility column (5.4.2.3) for the selected episode.

5.4.2.9.6 To view episodes recorded in a facility other than the context facility, change facilities by navigating to My Settings > Change Facility and following the prompts.

5.5 The Episode List is the screen from which new Intake records are created (7.0).

5.6 Using the Episode List to access client records (instead of going directly to the Activity List) can reduce potential frustration in accessing the correct data.

6.0 Using the Activity List

6.1 Use of the Activity List module is required for record navigation.

6.2 The Activity List displays records created for the client within each episode (case) within each facility.

6.2.1 The current agency, facility, client, and case can be found in the Locator at the top of the screen.

6.2.2 When viewing the Activity List, it may be necessary to change facilities using the My Settings > Change Facility screen (see OWITS Reference Manual, Volume 1: OWITS Basics).

6.2.3 When viewing the Activity List, it may be necessary to change clients using the Client List screen (see 3.3).

6.2.4 When viewing the Activity List, it may be necessary to change episodes (cases) using the Episode List screen (see 5.4.2.9.2).

6.3 The Activity List is a table with five columns.

6.3.1 *Activity* – displays the name of the record that was created.

6.3.1.1 Items in this column generally refer to modules found under the Activity List heading in the Navigation View.

6.3.1.2 Example: "Intake Transaction" refers to the Intake record (7.0).

6.3.1.3 Example: "Treatment Plan (Initial Plan)" refers to a treatment plan (23.0) that was named "Initial Plan."

6.3.1.4 Example: "Client Program Enrollment (90-Day Alcohol)" refers to the client's enrollment in a Program named "90-Day Alcohol."

6.3.2 *Activity Date* – displays the date on which the activity occurred.

6.3.2.1 Example: The date for "Intake Transaction" comes from the "Intake Date" field on the Intake screen (7.4.9).

6.3.2.2 Example: The date for "Treatment Plan (Initial Plan)" comes from the "Plan Start Date" field on the TX Plan screen (23.4.1.12).

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6.3.2.3 Example: The date for "Client Program Enrollment (90-Day Alcohol)" comes from the "Start Date" field on the Program Enroll screen (18.4.2.5).

6.3.3 *Created Date* – displays the date on which the record was created and saved.

6.3.4 *Status* – displays a general description of the degree to which the activity record has been completed.

6.3.4.1 Example: "Completed" indicates that all of the federally-required, state-required, and system-required fields have been filled with valid data.

6.3.4.2 Example: "In Progress" indicates that all of the system-required fields have been filled with valid data but that some of the federally-required or state-required fields are still blank or that a conclusive step (such as a signature) has not yet been performed.

6.3.4.2.1 Not all modules that require conclusive steps (such as signatures) will display the "In Progress" status.

6.3.4.3 Example: "Not Applicable" indicates that the particular screen, module, or record does not contain any federally-required or state-required fields and is considered neither complete nor incomplete.

6.3.4.3.1 "Not Applicable" may also indicate that no rules have been applied to OWITS requiring the display of a status for the record.

6.3.4.4 The status column may also include a "Details" link for some records.

6.3.4.4.1 The "Details" link appears when some portions of the record are incomplete.

6.3.4.4.2 Click the "Details" link to see what fields are not filled or what additional steps must be taken.

6.3.4.4.3 A small pop-up window will appear listing the information or steps that are missing.

6.3.4.4.3.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

6.3.4.4.4 Open the record (using the "Review" link in the Actions column) to locate and complete the missing data fields or steps.

6.3.4.4.5 When finished, close the pop-up window.

6.3.4.4.6 Clicking a "Details" link when a details pop-up window is already open will cause the contents of the pop-up window to be replaced.

6.3.5 *Actions* – includes actions that can be performed on or to the activity record, usually consisting of "Delete" and/or "Review" commands.

6.3.5.1 Clicking the "Review" link will open the list, table, or screen associated with the activity (6.3.1).

7.0 Intake

7.1 Use of the Intake module is required.

7.1.1 Prior to completing the Intake module, it may be necessary to determine whether the selected facility has the programs into which the client will be enrolled.

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7.1.2 Program details can be found in Agency > Agency List > Facility List > Programs.

7.1.2.1 For detailed instructions regarding Programs, see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

7.1.2.2 Note that clicking on the links in the Action column of the Facility List screen may change the context facility in the Locator.

7.1.2.3 Note that users will only be able to see records for facilities to which they have been granted access.

7.1.3 If the program the client will need is not available in the selected facility, the program will need to be added to the selected facility or the Intake record will need to be created in another facility.

7.1.4 If the program the client will need is available in the selected facility, the Intake record can be created.

7.2 In the Navigation View, navigate to Client List > Episode List.

7.2.1 It is also possible to navigate to the new intake creation screen by clicking the "Activity List" link in the Navigation View or in the Client List table.

7.2.2 If no episode or intake record has been created for this client, or if the client has not been enrolled in the maximum number of available treatment domains, OWITS will automatically display the Episode List.

7.3 Click the "Start New Episode" link in the Episode List heading.

7.4 The Intake screen will display, which consists of the following fields:

7.4.1 *Intake Facility*

7.4.1.1 This field will automatically populate with the name of the current facility.

7.4.1.2 Select the name of the facility at which the client will be receiving treatment or services for a specific problem or program.

7.4.1.3 If a facility other than the context facility (displayed in the Locator) is selected, the episode will be opened in the selected facility.

7.4.1.3.1 When the Intake record is saved with a facility other than the context facility, it will be viewable only by staff members who have access to and are signed into the selected facility.

7.4.2 *Intake Staff*

7.4.2.1 This field will automatically populate with the name of the current user.

7.4.2.2 Change this field to the name of the person who collected the intake data only if that person is not the current user.

7.4.2.3 To view the full name and contact information of the person currently selected, click the small "contact card" icon to the right of this field.

7.4.2.3.1 The staff member's name, email address, and phone number(s) will appear in a pop-up window.

7.4.2.3.2 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

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7.4.2.3.3 Close the pop-up when finished.

7.4.3 *Initial Contact*

7.4.3.1 Select the option that best describes the method of contact first used to establish a meaningful connection between the client and the facility.

7.4.3.2 A meaningful connection is one by which facility staff members were able to identify the person as a client or potential client and collect some identifying information, such as name and phone number.

7.4.4 *Residence*

7.4.4.1 Select the county in which the client currently resides.

7.4.4.2 Select "Other" if the client's current residence is outside Oregon.

7.4.5 *Source of Referral*

7.4.5.1 Select the option which best describes what caused the client to come into contact with the facility.

7.4.5.2 Example: Select "Self Help Groups" if Alcoholics Anonymous encouraged a client to seek professional addiction treatment.

7.4.5.3 Example: Select "Self" if the client voluntarily walked in and requested help.

7.4.6 *Case #*

7.4.6.1 This field will automatically populate with a number.

7.4.6.2 The Case Number refers to the number of times a completed Intake has been recorded for the client in the current agency (see 5.4.2.1).

7.4.6.3 Example: A client begins receiving services for substance abuse treatment in an agency that offers both substance abuse and mental health treatment services. This is his first visit. His Intake record will indicate Case #1. If he also begins receiving services for mental health treatment the next day in any facility belonging to the same agency, a new Intake record will be created as Case #2. If he completes the programs, and if a clinician discharges him closes his case, and if he then returns three years later to begin receiving a new series of services for substance abuse treatment, a new Intake record will be created as Case #3.

7.4.6.4 All of the client's cases in the current agency will appear on the Episode List (5.0).

7.4.7 *Case Status*

7.4.7.1 This field will automatically populate with a value that describes whether the case (episode) is open or closed.

7.4.7.2 If the case is closed, this field will be read-only.

7.4.7.3 It is not necessary to select or change an option in this field.

7.4.8 *Initial Contact Date*

7.4.8.1 Enter the date on which the initial contact (7.4.3) occurred.

7.4.9 *Intake Date*

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7.4.9.1 Enter the date on which the client was accepted for treatment or services or the date on which the data entered into this screen was collected.

7.4.9.2 The Intake Date should be on or after the Initial Contact Date (7.4.8).

7.4.9.3 The Intake Date should not be in the future.

7.4.9.3.1 CAUTION: OWITS will allow this date to be future-dated, but entering a future date in this field can cause errors in other modules.

7.4.9.4 OWITS will not allow other treatment or service records (Admission, Program Enrollment, etc.) associated with this Intake to be created for this client if their dates are prior to the Intake Date.

7.4.10 *Pregnant*

7.4.10.1 Indicate whether the client is currently pregnant.

7.4.10.2 "Not Applicable" may be automatically selected for male clients.

7.4.11 *Due Date*

7.4.11.1 If the client is pregnant, enter the date on which the baby is expected to be born.

7.4.11.2 This date may be estimated.

7.4.11.3 This field may be unavailable for male clients.

7.4.12 *Referral Contact*

7.4.12.1 If the client was referred by a person (such as a medical professional, a parole officer, or a friend or relative), select that person's name in this field.

7.4.12.2 The options in the Referral Contact field come from data entered in the Collateral Contacts screen.

7.4.12.3 If a desired name is not available in this field, click the "Add Referral Contact Info" link.

7.4.12.3.1 The Collateral Contacts screen will display.

7.4.12.3.2 Add collateral contacts as needed (see OWITS Reference Manual, Volume 4: Client Profile).

7.4.12.3.3 Click Finish to return to the Intake screen.

7.4.12.3.4 Using the Navigation View links to exit the Collateral Contacts screen when accessed from the Intake screen will cancel any unsaved progress.

7.4.13 *Prenatal Treatment*

7.4.13.1 Indicate whether the client is or will be receiving additional treatment specifically for the health and well-being of an unborn child.

7.4.13.2 This may include prenatal treatment from other sources such as an obstetrician or a primary care physician.

7.4.13.3 Select "No" for male clients.

7.4.14 *Injection Drug User*

7.4.14.1 Indicate whether the client uses drugs by intravenous or intramuscular injection.

7.4.14.2 Do not include injection drugs that are used in accordance with a prescription.

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7.4.14.3 Select "Denies" if it is known or suspected that the client uses or abuses drugs by injection but claims that he or she does not.

7.4.14.3.1 Specific criteria for using the "Denies" option must be determined by the agency.

7.4.15 *Infectious Disease Risk Assessment (IDRA)*

7.4.15.1 This field is used to indicate whether the client has been assessed for infectious diseases such as Hepatitis, sexually transmitted infections, HIV, AIDS, and Tuberculosis.

7.4.15.1.1 OWITS does not contain an infectious disease risk assessment.

7.4.15.1.2 Agencies must provide the specific instructions, criteria, and protocol for infectious disease risk assessments.

7.4.15.2 Select the option that most accurately indicates whether an IDRA was performed and the results thereof.

7.4.15.3 Select "IDRA NOT Completed" if the client was not screened for infectious diseases.

7.4.15.3.1 A required "Comment" box will appear.

7.4.15.3.2 Explain why the IDRA was not completed and add any additional relevant information.

7.4.15.4 Select "Low-to-No Risk, No Referral" only when the client is at minimal or no risk for infectious disease risk exposure.

7.4.15.5 Select "Moderate-to-High Risk, No Referral" when the client is at risk of infectious disease exposure but was not referred for treatment or services related to infectious diseases.

7.4.15.5.1 A required "Comment" box will appear.

7.4.15.5.2 Document why no referral was made and add any additional relevant information.

7.4.15.6 Select "Moderate-to-High Risk, Referral Made" when the client is at risk of infectious disease exposure and was referred for treatment or services related to infectious diseases.

7.4.16 *Problem Area*

7.4.16.1 Select the option that best describes the reason the client is seeking treatment or services at this facility.

7.4.17 *Presenting Problem (in Client's Own Words)*

7.4.17.1 Type the client's explanation for seeking treatment or services at this facility.

7.4.17.2 Use the client's own words as much as possible.

7.4.17.3 If the client cannot or will not provide this information, it may be collected from other sources such as the referral contact or entered by the user conducting the intake.

7.4.17.3.1 This field can be edited at any time before the episode is closed (see 7.4.21).

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7.4.17.3.2 Return to this screen when more accurate information is available and update this field.

7.4.17.3.3 Example: A receptionist enters "Seeking substance abuse treatment" to complete the Intake record before the client arrives for his or her first appointment. After the appointment, a clinician updates this field with the client's actual statement regarding his or her problem.

7.4.18 *Special Initiative*

7.4.18.1 If applicable, select options that identify any additional services with which the client might need assistance or from which the client might benefit.

7.4.19 *Inter-Agency Service*

7.4.19.1 If applicable, select options that indicate services the client is receiving or is identified as receiving from other state and county organizations.

7.4.20 *Domains*

7.4.20.1 Select the treatment domain for the programs into which the client will be enrolled.

7.4.20.2 Only one domain may be selected.

7.4.20.3 If the client will be participating in programs in more than one domain, an additional Intake record must be created for each.

7.4.20.3.1 Example: If a client will be taking part in Mental Health treatment programs and Substance Abuse treatment programs, he or she will need two Intake records—one with the Mental Health domain and one with the Substance Abuse domain.

7.4.20.3.2 Example: If a client will only be taking part in ATR services, he or she will need only one Intake record.

7.4.20.3.3 Facilities may or may not provide treatment or services in more than one treatment domain (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

7.4.21 *Date Closed*

7.4.21.1 Closing an Intake completes the treatment or service episode.

7.4.21.2 Client activity cannot be recorded after this date has been entered and saved.

7.4.21.3 When creating a new Intake, leave this field blank.

7.4.21.4 For details regarding closing and reopening cases, see OWITS Reference Manual, Volume 9: Client Discharge.

7.5 Some OWITS users will also have additional actions available.

7.5.1 These additional actions will appear in the Actions bar at the bottom of the screen.

7.5.2 Additional actions include:

7.5.2.1 *Move Intake*

7.5.2.1.1 Intake records can only be moved by OWITS system administrators.

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7.5.2.1.2 To request that an Intake record be moved, submit an OWITS support ticket or send an email to owits.support@state.or.us.

7.5.2.1.3 For details regarding the process of moving an Intake record, see OWITS Reference Manual, Volume 14: Tier 2 System Administration.

7.5.2.2 *Delete Intake*

7.5.2.2.1 Intake records can only be deleted by OWITS system administrators.

7.5.2.2.2 Intake records cannot be deleted if the episode has any other activity recorded.

7.5.2.2.3 To request that an Intake record be deleted, submit an OWITS support ticket or send an email to owits.support@state.or.us.

7.5.2.2.4 For details regarding the process of deleting an Intake record, see OWITS Reference Manual, Volume 14: Tier 2 System Administration.

7.5.3 When all the required fields have been filled, click Save to apply the Intake record and to open the treatment episode.

7.6 Click Finish to return to the Activity List.

8.0 Vital Signs

8.1 Use of the Vital Signs module is optional.

8.2 Vital Signs records physiological data about the client, such as height, weight, and blood pressure.

8.3 Using the Navigation View, navigate to Client List > Activity List > Vital Signs.

8.4 The Vital Signs List screen will display.

8.4.1 To add a Vital Signs record, click the "Add New" link in the Vital Signs List header.

8.4.2 Complete the available fields in the Vital Signs Profile section.

8.4.2.1 *Height*

8.4.2.1.1 In the first of these two fields, enter the client's height in feet (rounded down).

8.4.2.1.2 In the second of these two fields, enter the number of inches of the client's height above the number of feet entered in the previous field.

8.4.2.1.3 Example: 5 Feet, 11 Inches

8.4.2.1.4 If any vital signs records have already been entered, these fields will automatically populate with the most recent height measurement, which can be edited as needed.

8.4.2.2 *Weight*

8.4.2.2.1 Enter the client's weight in pounds.

8.4.2.3 *BMI*

8.4.2.3.1 When the Vital Signs Profile is saved, this field will automatically calculate the client's body mass index based on the height and weight entered (8.4.2.1 and 8.4.2.2).

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8.4.2.4 *Blood Pressure (systolic/diastolic)*

8.4.2.4.1 In the first of these two fields, enter the client's systolic blood pressure measure.

8.4.2.4.2 In the second of these two fields, enter the client's diastolic blood pressure measure.

8.4.2.4.3 Enter only whole numbers.

8.4.2.4.4 Example: 120 / 90

8.4.2.5 *Dietary Consult Order*

8.4.2.5.1 Indicate whether a dietary consultation has been or will be ordered for the client based on the results of this Vital Signs record.

8.4.2.6 *Signs Taken On*

8.4.2.6.1 Enter the date on which these vital signs were recorded.

8.4.2.7 *Performed By*

8.4.2.7.1 This field will automatically populate with the name of the current user.

8.4.2.7.2 If the vital signs were taken by another staff member, select his or her name in this field.

8.4.2.7.3 Field values will be limited to active staff members assigned to the current facility.

8.4.2.8 *Follow Up BMI Management*

8.4.2.8.1 Indicate whether the client has received or will receive additional consultation or treatment designed to bring his or her body mass index into a more normal, acceptable, or healthy range.

8.4.2.9 *Created By*

8.4.2.9.1 This field will automatically populate with the name of the user who created this record.

8.4.2.10 *Created Date*

8.4.2.10.1 This field will automatically populate with the date on which this record was created and saved.

8.4.2.11 *Updated By*

8.4.2.11.1 This field will automatically populate with the name of the user who most recently modified this record.

8.4.2.12 *Updated Date*

8.4.2.12.1 This field will automatically populate with the date on which this record was most recently modified.

8.4.3 Click Save to apply the vital signs record to the client's Activity List.

8.4.3.1 The BMI field will update.

8.4.3.2 Warning messages may appear indicating that the measurements entered fall outside an expected range.

8.4.3.2.1 Verify that the data entered is incorrect.

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8.4.3.2.2 These warning messages are designed to help detect and prevent invalid data, but they will not prevent the record from saving.

8.4.3.2.3 Example: "Weight falls outside of the expected range of 5% of the most recently recorded weight."

8.4.4 Click Finish to exit the Vital Signs Profile section.

8.4.5 Repeat steps 8.4.1 through 8.4.4 as needed to enter additional vital signs records.

8.5 To edit an existing vital signs record, click the "Review" link in the Actions column.

8.5.1 Edit the fields as needed.

8.5.2 Click Save to apply the changes to the record.

8.5.3 Click Finish to exit the Vital Signs Profile section.

8.6 To remove an existing vital signs record, click the "Delete" link in the Actions column.

8.6.1 OWITS will confirm the delete command.

8.6.2 The selected vital signs record will be deleted.

8.6.3 This action cannot be undone.

8.7 A graph can be generated charting changes in the client's height and weight for the first 20 years of his or her life.

8.7.1 This graph will only display if Vital Signs data has been entered for that period and if the client is currently 20 years old or younger.

8.7.2 Click the "Growth Chart" link in the Vital Signs List header.

8.7.3 A pop-up window will open.

8.7.3.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

8.7.4 Microsoft SilverLight will load.

8.7.5 Two graphs will appear, displaying growth charts for both height and weight.

8.7.5.1 Colored lines indicate average or expected growth rates.

8.7.5.2 A solid black line indicates the client's growth rates with white circles identifying individual data points.

8.7.6 When finished, close the pop-up window.

8.7.7 CAUTION: Attempting to view the growth chart when no valid data has been entered may cause errors that force Internet Explorer to close.

8.8 Click Finish to return to the Activity List.

9.0 Lab / Radiology

9.1 Use of the Lab / Radiology module is optional.

9.2 This section is used for creating and/or recording laboratory and radiology orders.

9.2.1 Because OWITS is not a medical electronic health record, this section is minimal and should be used for reference purposes only.

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9.2.2 The test types currently available include HIV, Hepatitis, and Tuberculosis (9.6.2.1).

9.2.3 If additional test types are needed, submit a request using the OWITS Support Ticket module or send an email to owits.support@state.or.us.

9.3 Using the Navigation View, navigate to Client List > Activity List > Lab/Radiology.

9.4 The Orders/Results screen will display.

9.5 The Order List table shows previous lab and radiology orders entered.

9.5.1 This list can be filtered by the order status using the Status field above.

9.6 Add lab and radiology orders as needed.

9.6.1 Click the "Add New" link in the Order List heading.

9.6.2 Complete the Order Profile section, which consists of the following fields:

9.6.2.1 *Name*

9.6.2.1.1 Select the type of testing that will be or has been performed.

9.6.2.2 *Order Date*

9.6.2.2.1 Enter the date on which the testing was ordered.

9.6.2.2.2 This is not necessarily the same as the date on which the testing was performed.

9.6.2.3 *Status*

9.6.2.3.1 Select the option that best describes the current status of the order.

9.6.2.3.2 Active – An order that is currently in force for a test that will be or is being performed.

9.6.2.3.3 Discontinued – An order that is complete because it has been cancelled or because the testing has been performed.

9.6.2.3.4 Modified – An order that is currently in force but that has been changed since its original creation.

9.6.2.4 *Comments*

9.6.2.4.1 Enter any additional details about the lab and/or radiology orders relevant to the test to be performed or relevant to the client's needs.

9.6.2.4.2 This may include the type of testing required, such as a blood draw, saliva sample, etc.

9.6.2.4.3 This may include the date and time on which the testing is expected or scheduled to occur.

9.6.2.4.4 This may include the results of the test performed.

9.6.2.5 *Created On*

9.6.2.5.1 This field will automatically populate with the date on which this record was created and saved.

9.6.2.6 *Created By*

9.6.2.6.1 This field will automatically populate with the name of the user who created this record.

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9.6.2.7 *Updated On*

9.6.2.7.1 This field will automatically populate with the date on which this record was most recently modified.

9.6.2.8 *Updated By*

9.6.2.8.1 This field will automatically populate with the name of the user who most recently modified this record.

9.6.3 Click Save.

9.6.3.1 The record will be saved to the Order List table above (9.5).

9.7 To modify existing orders, click the "Review" link in the Actions column for the desired orders.

9.7.1 Fields (detailed in 9.6.2.1 through 9.6.2.4) may be modified or updated as needed.

9.7.2 The Status field should be changed to "Modified" or "Discontinued" as appropriate to the change(s) being made.

9.7.3 Click Save.

9.8 To delete existing orders, click the "Delete" link in the Actions column for the desired orders.

9.8.1 OWITS will confirm the delete command.

9.8.2 The selected orders will be deleted.

9.8.3 This action cannot be undone.

9.9 Return to the Activity List or other modules using the Navigation View links.

10.0 Client Eligibility

10.1 Use of the Client Eligibility module is optional.

10.2 This module was designed for use by the state of Idaho and is currently under evaluation by AMH for use in Oregon.

10.3 Because it is still being evaluated, its use has not been outlined in this manual.

10.4 Agencies may use it at their discretion unless or until notified otherwise.

10.5 Return to the Activity List or other modules using the Navigation View links.

11.0 Fee Determination

11.1 Use of the Fee Determination module is optional.

11.2 This module can be used to determine a self-pay client's ability or inability to pay for services rendered.

11.2.1 Financial calculations performed by the fields on this screen are based on federal poverty levels.

11.2.2 Federal poverty levels are maintained by OWITS system administrators (see OWITS Reference Manual, Volume 14: Tier 2 System Administration).

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11.2.3 Individual agencies and facilities must determine how the results produced by this module will be used.

11.3 Using the Navigation View, navigate to Client List > Activity List > Fee Determination.

11.4 The Fee Determination List table will display.

11.5 To create a fee determination record, click the "Add New" link in the Fee Determination List heading.

11.5.1 The fee determination's Profile screen will display, which consists of the following fields:

11.5.1.1 *Effective Date*

11.5.1.1.1 Enter the date on which the financial values added in the fields below are or were first applicable to the client.

11.5.1.1.2 This is generally the date on which the necessary information for the fee determination was collected.

11.5.1.1.3 This field will become read-only when the Save button is clicked.

11.5.1.2 *Monthly Income (from all sources)*

11.5.1.2.1 Enter the client's total monthly gross income.

11.5.1.2.2 Include all income sources, whether earned, accrued, gifted, or illegal.

11.5.1.2.3 OWITS will convert all whole numbers entered into a dollar amount.

11.5.1.2.4 OWITS will round decimals to the nearest hundredth.

11.5.1.2.5 OWITS will accept monthly income values up to $76 trillion.

11.5.1.3 *Number in Family (including client)*

11.5.1.3.1 Enter the number of people currently or most frequently living with the client, comprising the client's family or household.

11.5.1.3.2 Include the client in this number.

11.5.1.3.3 Do not include individuals living with the client who do not contribute to the client's expenses (housing, groceries, transportation, etc.) and who do not depend upon the client's income for any of their support.

11.5.1.3.4 If the client lives in a group home, institution, hospital, prison, or other non-private residence, enter 1.

11.5.1.4 *Court Ordered Obligations*

11.5.1.4.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to pay court expenses.

11.5.1.4.2 Agencies must individually determine what court expenses are allowable as deductions for determining the client's ability to pay for services.

11.5.1.5 *Dependent Support*

11.5.1.5.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to support his or her dependent spouse, child(ren), or others.

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11.5.1.5.2 Agencies must individually determine what dependent expenses are allowable as deductions for determining the client's ability to pay for services.

11.5.1.6 *Child Care Expenses Necessary for Parental Employment*

11.5.1.6.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to pay for child care.

11.5.1.6.2 Include only child care expenses that must be paid in order for the child(ren)'s parent(s) to obtain and maintain employment.

11.5.1.6.3 Agencies must individually determine what child care expenses are allowable as deductions for determining the client's ability to pay for services.

11.5.1.7 *Medical Expenses*

11.5.1.7.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to pay medical expenses.

11.5.1.7.2 Include only medical expenses not covered by other funds such as private health insurance, Medicaid, etc.

11.5.1.7.3 Agencies must individually determine what medical expenses are allowable as deductions for determining the client's ability to pay for services.

11.5.1.8 *Transportation*

11.5.1.8.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to for necessary transportation.

11.5.1.8.2 Agencies must individually determine what transportation costs are allowable as deductions for determining the client's ability to pay for services.

11.5.1.9 *Extraordinary Rehabilitative Expenses*

11.5.1.9.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to pay for rehabilitation where those costs exceed the limits of any other form of payment or coverage.

11.5.1.9.2 Agencies must individually determine what rehabilitation expenses are allowable as deductions for determining the client's ability to pay for services.

11.5.1.10 *State and Federal Tax Payments (including FICA taxes)*

11.5.1.10.1 Enter the dollar amount deducted (automatically or at will) from the client's monthly income used to pay the client's income, property, and other taxes.

11.5.1.10.2 Include payroll deductions used to fund Social Security and Medicare, as required by the Federal Insurance Contributions Act.

11.5.1.10.3 Agencies must individually determine what taxes are allowable as deductions for determining the client's ability to pay for services.

11.5.1.11 *Total Monthly Deductions*

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11.5.1.11.1 This is a calculation field and will automatically populate when values have been entered into other fields above.

11.5.1.11.2 To avoid errors, do not manually enter data into this field.

11.5.1.11.3 This field adds all of the amounts from the deductions fields above.

11.5.1.12 *Has client signed paper form?*

11.5.1.12.1 Indicate whether the client has signed a form related to the information collected for this fee determination.

11.5.1.12.2 Agencies that do not use paper forms for this purpose may select "Yes" if the client has seen and approved the fee determination, the data entered for it, and the results thereof.

11.5.1.12.3 "Yes" must be selected for data entered in this form to copy or otherwise connect to other OWITS modules.

11.5.1.13 *Has staff member signed form?*

11.5.1.13.1 Indicate whether a staff member has also signed a form related to the information collected for this fee determination.

11.5.1.13.2 Agencies that do not use paper forms for this purpose may select "Yes" if a staff member has seen and approved this fee determination, the data entered for it, and the results thereof.

11.5.1.13.3 "Yes" must be selected for data entered in this form to copy or otherwise connect to other OWITS modules.

11.5.1.14 *Gross Annual Income*

11.5.1.14.1 This is a calculation field and will automatically populate.

11.5.1.14.2 To avoid errors, do not manually enter data into this field.

11.5.1.14.3 This field multiplies the client's monthly income (11.5.1.2) by 12.

11.5.1.15 *Total Annual Deductions*

11.5.1.15.1 This is a calculation field and will automatically populate.

11.5.1.15.2 To avoid errors, do not manually enter data into this field.

11.5.1.15.3 This field multiplies the client's total monthly deductions (11.5.1.11) by 12.

11.5.1.16 *Adjusted Annual Income*

11.5.1.16.1 This is a calculation field and will automatically populate.

11.5.1.16.2 To avoid errors, do not manually enter data into this field.

11.5.1.16.3 This field subtracts the client's annual deductions (11.5.1.15) from the client's gross annual income (11.5.1.14).

11.5.1.17 *Fee Percentage*

11.5.1.17.1 This is a calculation field and will automatically populate.

11.5.1.17.2 To avoid errors, do not manually enter data into this field.

11.5.1.17.3 This field compares the data displayed in the other fields on this screen to the federal poverty level.

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11.5.1.17.4 The value displayed in this field is the percentage of treatment and service expenses for which the self-pay client may be expected to pay out of pocket.

11.5.1.17.5 Example: A self-pay client would normally be billed $150 per month (or $1,800 per year) for services. When a fee determination is performed, "40" is displayed in this Fee Percentage field. Therefore, based on values entered in the rest of the fee determination, the agency can reasonably expect the client to pay 40% of the cost of services ($60 per month or $720 per year, in this case) without seriously jeopardizing his or her financial situation (descending to or below the federal poverty level).

11.5.1.17.6 Agencies and facilities must determine individually how the value in this field is to be interpreted and used.

11.5.2 When all of the fields from Monthly Income (11.5.1.2) through State and Federal Tax Payments (11.5.1.10) have been filled, click the "Calculate Fee Percentage" link.

11.5.2.1 The calculation fields (11.5.1.11 and 11.5.1.14 through 11.5.1.17) will automatically populate.

11.5.2.2 Click the "Calculate Fee Percentage" link again when any of the income or deduction values are changed.

11.5.2.3 After clicking the "Calculate Fee Percentage" link once, clicking the Save button will cause this screen to complete the calculations again.

11.5.3 Click Save.

11.5.4 Click Finish to return to the Fee Determination List screen.

11.5.5 The fee determination record will display in the Fee Determination List table.

11.5.5.1 The effective date and the values from the calculation fields will be displayed.

11.5.5.2 If "No" is selected in either or both of the signature indicator fields (11.5.1.12 and 11.5.1.13), "In Progress" will display in the Status column.

11.6 To edit the details of an "In Progress" fee determination, click the "Review" link in the Actions column for the desired record.

11.6.1 Modify the data fields as needed.

11.6.2 The Effective Date field will be read-only.

11.6.3 When "Yes" is selected in both of the signature indicator fields (11.5.1.12 and 11.5.1.13) and the record is saved, all fields will become read-only and "Complete" will display in the Status column of the Fee Determination List table.

11.6.4 Click Finish to return to the Fee Determination List screen.

11.7 To view the details of a "Completed" fee determination, click the "Review" link in the Actions column for the desired record.

11.7.1 All fields will be read-only.

11.7.2 Click Finish to return to the Fee Determination List screen.

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11.8 To delete a completed fee determination, click the "Delete" link in the Actions column for the desired record.

11.8.1 OWITS will confirm the delete command.

11.8.2 The selected fee determination record will be deleted.

11.8.3 This action cannot be undone.

11.9 Return to the Activity List or other modules using the Navigation View links.

12.0 Drug Testing

12.1 Use of the Drug Testing module is recommended for most agencies.

12.2 This section is used to track clients' drug tests and drug-specific results.

12.3 Using the Navigation View, navigate to Client List > Activity List > Drug Testing.

12.4 The Drug Test Result List section will display drug tests that fit the criteria specified in the Drug Test Result Search section.

12.4.1 In the From Date and To Date fields, enter a date range in which to search for drug test results.

12.4.1.1 These fields automatically populate with values that will search for drug test results entered within the most recent 30 days.

12.4.2 Click Go.

12.4.3 Any available drug test results that fit within the date range entered above will display in the Drug Test Result List table.

12.4.3.1 In black text beneath the label Drug Test Result List, a calculation of total results and total positive tests listed in the table will display.

12.4.3.1.1 Example: "Total Tests: 2 Total Positive Tests: 1"

12.4.3.1.2 Only "Positive – Confirmed" and "Positive – Unconfirmed" results are counted (see 12.5.4.2).

12.4.3.2 Each row indicates a single drug test.

12.4.3.3 Drugs will be listed in the column of the selected results.

12.4.3.4 The Outcome column summarizes the result of the test attempt.

12.4.3.5 The Comment column displays a portion of the additional information entered by the user(s) who entered the drug test results.

12.4.4 To view the details of a drug test, click the Review link in the Actions column.

12.4.4.1 When finished, click Cancel to return to the Drug Test Results screen.

12.4.4.2 Do not Save or Finish unless data has been changed.

12.4.4.3 CAUTION: Making changes to drug test data that cannot be substantiated by drug test documentation is not recommended.

12.4.4.4 WARNING: Changes made to the "Client Outcome" field may result in the loss of data entered in other fields.

12.4.5 If drug test data was entered incorrectly, it can be deleted.

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12.4.5.1 Click the Delete link the Actions column on the line of the incorrect test.

12.4.5.1.1 OWITS will confirm the delete command.

12.4.5.1.2 The selected drug test will be deleted.

12.4.5.1.3 This action cannot be undone.

12.4.5.2 WARNING: Drug test data is often required by the courts. Drug test data should not be deleted unless it does not belong or was entered incorrectly and can be replaced.

12.4.6 A printer-friendly version of multiple drug test results can be created as needed.

12.4.6.1 In the Drug Test Result Search section, enter a date range that contains the desired drug test results (see 12.4.1).

12.4.6.2 Click Go.

12.4.6.3 Drug test results that fit the specified date range will display in the Drug Test Result List.

12.4.6.4 Click the "Generate Report" link at the top of the screen.

12.4.6.4.1 A pop-up browser window will open.

12.4.6.4.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

12.4.6.4.2 The pop-up window will display all of data currently displayed in the Drug Test Result List table, followed by the detailed drug test results for each entry.

12.4.6.4.3 Use the Adobe PDF print and save icons (not the Internet Explorer print or save functions) to print or save the PDF.

12.4.6.4.4 Close the pop-up window when finished.

12.5 To add a new Drug Test Result record, click the "Add Test Result" link in the Drug Test Result List heading.

12.5.1 Enter data into the Drug Test Result Profile section, which consists of the following fields:

12.5.1.1 *Specimen #*

12.5.1.1.1 Enter the unique identifier assigned to the sample collected.

12.5.1.1.2 This field accepts letters, numbers, and special characters such as hyphens.

12.5.1.2 *Date*

12.5.1.2.1 Enter the date on which the specimen was collected or scheduled to be collected.

12.5.1.3 *Client Outcome*

12.5.1.3.1 Select the option that best describes the outcome of the attempt to collect a sample.

12.5.1.3.2 If one of the following values is selected, OWITS assumes that a specimen was collected and that results are or will be available.

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12.5.1.3.2.1 Specimen Collected

12.5.1.3.2.2 Specimen Diluted

12.5.1.3.2.3 Specimen Rejected

12.5.1.3.2.4 Other

12.5.1.3.2.5 Low Creatinine

12.5.1.3.3 If one of the following options is selected, OWITS assumes that a specimen was not collected and that no results will be entered.

12.5.1.3.3.1 Failed to Appear

12.5.1.3.3.2 Excused Absence

12.5.1.3.3.3 Refused to Provide Specimen

12.5.1.3.3.4 Unable to Provide Specimen

12.5.1.3.3.5 Unusable/Untestable Specimen

12.5.1.4 *Specimen Type*

12.5.1.4.1 Select the option that best describes the type of sample on which the drug test will be performed.

12.5.1.4.2 This field will only be available if "Specimen Collected" or "Other" is selected as the Client Outcome (12.5.1.3).

12.5.1.5 *Staff*

12.5.1.5.1 This field will automatically populate with the name of the current user.

12.5.1.5.2 Other options that appear in this field will be staff members assigned to the current facility.

12.5.1.5.3 Change the name in this field only if the staff member supplying the data for the drug test results is not the current user.

12.5.1.6 *Facility*

12.5.1.6.1 The facility selected in this field indicates the location of the client's treatment episode to which this drug test applies.

12.5.1.6.2 This field will automatically populate with the name of the current facility.

12.5.1.6.3 Other options that appear in this field will be facilities to which the current user has access.

12.5.1.6.4 Change the facility in this field only if the drug test was performed for the client records in a different facility.

12.5.1.7 *Location*

12.5.1.7.1 Select the option that best describes the location at which the drug test specimen (sample) was collected.

12.5.1.8 *Blood Alcohol Content*

12.5.1.8.1 This field will become available if Alcohol is selected as a drug type (12.5.4.1).

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12.5.1.8.2 Enter the client's blood alcohol content measurement as indicated by the drug test.

12.5.1.8.3 OWITS will automatically enter a zero before the decimal.

12.5.1.8.4 This field will accept BAC levels measured to seven decimal places.

12.5.1.9 *Marijuana Content*

12.5.1.9.1 This field will become available if Marijuana is selected as a drug type (12.5.4.1).

12.5.1.9.2 Enter the client's blood THC content in ng/mL (nanograms per milliliter).

12.5.1.9.3 OWITS will automatically enter a zero before the decimal.

12.5.1.9.4 This field will round up to the nearest hundredth.

12.5.1.10 *Comments*

12.5.1.10.1 Enter any additional information about the drug test.

12.5.1.10.2 The first 30 characters (including spaces) entered into this field will display in the Comments column of the Drug Test Result screen (12.4.3.5).

12.5.2 When all of the required and other relevant fields have been filled, click Save.

12.5.3 The value in the Client Outcome field (12.5.1.3) will determine the next step(s).

12.5.3.1 If the Client Outcome field contains a value that indicates no test results, click Finish.

12.5.3.2 If the Client Outcome field contains a value that indicates that test results are available, drug test results can be added.

12.5.4 If applicable, use the Add Drug Tests section to specify the substances that were tested for and/or detected and their result.

12.5.4.1 In the Drug Type field, click select one or more substances.

12.5.4.1.1 Hold the CTRL key while clicking to select more than one substance.

12.5.4.1.2 Hold the SHIFT key while clicking to select a range of substances.

12.5.4.2 In the Test Result field, select the option that best describes the outcome of the test for the drugs selected in the Drug Type field (12.5.4.1).

12.5.4.2.1 "Positive – Confirmed" indicates that the substance was detected and that additional tests or testing criteria indicate that the substance was indeed present and that it was correctly identified.

12.5.4.2.2 "Negative" indicates that the substance was not detected.

12.5.4.2.3 "Unknown" may be used indicate that the substance may or may not have been present but that the test did not clearly indicate the presence or absence of the substance, or it may be used to indicate that the substance was specifically tested for but that results are not yet available.

12.5.4.2.4 "Positive – Unconfirmed" indicates that the substance was detected but that additional tests or testing criteria were not applied, have not yet been applied, or did not conclusively identify the substance and/or its presence.

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12.5.4.2.5 "Positive – Excused" indicates that the substance was detected and confirmed but that it is not counted against the client (such as testing positive for marijuana due to authorized medicinal use of it).

12.5.4.3 Click the Add button.

12.5.4.3.1 The selected drug types (12.5.4.1) and the selected test results (12.5.4.2) will be copied to the Drug Test Results section below (12.5.5).

12.5.4.3.2 The selected drug types will no longer appear in the Drug Type field unless the entry is removed from the Drug Test Results section (12.5.5.1).

12.5.4.4 Repeat steps 12.5.4.1 through 12.5.4.3 until all applicable drug types and their associated test results have been added.

12.5.5 The Drug Test Results section at the bottom of the screen displays all selected drug types and the test result that was associated with each.

12.5.5.1 To delete a drug type and its test result, click the Remove link in the Actions column.

12.5.5.1.1 The selected drug result will be removed.

12.5.5.1.2 The substance will reappear in the Drug Type field above (12.5.4.1) as an available selection.

12.5.5.2 Existing drug test results can be modified.

12.5.5.2.1 Place a check mark in the white box next to the drug type for which the test result will be changed.

12.5.5.2.1.1 Placing a check mark in the white box in the header row of this table will place a check mark in all of the boxes below it.

12.5.5.2.1.2 Removing a check mark from the white box in the header row of this table will remove all check marks below it.

12.5.5.2.2 In the Test Result field within the blue Drug Test Results header, select the test result (see 12.5.4.2.1 through 12.5.4.2.4) that will be applied to the drug types selected with check marks.

12.5.5.2.3 Click the Edit Test Result link.

12.5.5.2.4 The selected test result will be applied to all of the drug types selected with check marks.

12.5.6 When all of the necessary drug test data has been entered, click Save.

12.5.7 Click Finish to return to the Drug Test Result screen.

12.6 Existing drug test results can be modified (12.4.4) or deleted (12.4.5) if necessary.

12.7 The Drug Test Result List table can be exported for use or reference outside OWITS.

12.7.1 In the blue Drug Test Result List header, click the Export link while holding the CTRL key.

12.7.2 The screen will reload and a pop-up browser window will appear.

12.7.2.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

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12.7.3 A dialogue box will appear prompting to open, save, or cancel the document export process.

12.7.3.1 Click Open to view the exported data in the pop-up browser window in a format similar to a Microsoft Excel spreadsheet.

12.7.3.2 Click Save to save the file to the local computer as a Microsoft Excel spreadsheet.

12.7.3.3 Click Cancel to stop the export process.

12.7.4 Release the CTRL key.

12.7.5 When finished, close the pop-up window if it has not already closed itself.

12.8 Return to the Activity List or other modules using the Navigation View links.

13.0 Wait List

13.1 Use of the Wait List module is recommended for most agencies.

13.2 The Wait List module is used to track clients who will be enrolled in a program (see 18.0) that is currently unavailable.

13.2.1 Programs may be unavailable due to a variety of reasons, the most common of which is a lack of capacity (all available spaces are filled).

13.2.2 Agencies and facilities must individually determine when clients are placed on and removed from waiting lists.

13.3 Using the Navigation View, navigate to Client List > Activity List > Wait List.

13.4 The Client Waiting List screen will display.

13.4.1 The Client Waiting List table shows whether the client is currently on a waiting list for a program within the current facility.

13.4.2 The Client Waiting List table does not show whether the client is on a waiting list for programs at other agencies or facilities.

13.4.3 To view all client waiting list records for the agency, navigate to Agency > Agency List > Wait List (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs and Staff Records).

13.5 Add the client to waiting lists as needed.

13.5.1 To add the current client to a waiting list for a program within the selected facility, click the “Put Client on Waiting for Another Program” link in the Client Waiting List heading.

13.5.2 The Wait List screen will display, which consists of the following fields:

13.5.2.1 *Agency*

13.5.2.1.1 This read-only field will automatically populate with the context agency.

13.5.2.1.2 Users with access to client records in multiple agencies may change their context agency by navigating to My Settings > Change Facility and following the prompts.

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13.5.2.2 *Facility*

13.5.2.2.1 This read-only field will automatically populate with the context facility.

13.5.2.2.2 The context facility determines what programs are available to the client.

13.5.2.2.3 If the desired program is in a facility other than the context facility, the wait list must be created within the client's episode in that facility or by referring the client from the context facility to the facility with the desired program.

13.5.2.2.3.1 Users with access to client records in multiple facilities may change their context facility by navigating to My Settings > Change Facility and following the prompts.

13.5.2.2.3.2 For detailed referral instructions, see OWITS Reference Manual, Volume 8: Consents and Referrals.

13.5.2.3 *Select Program*

13.5.2.3.1 In this drop-down menu, select the name of the program for which the client is waiting.

13.5.2.3.2 OWITS will not prevent users from adding clients to waiting lists for programs for which they are not eligible, such as male clients waiting for a program for women or adult clients waiting for a program for children.

13.5.2.3.3 If the desired program is not available, it may be in a facility other than the context facility (see 13.5.2.2.3).

13.5.2.4 *Select Staff*

13.5.2.4.1 If the client will be working with a specific staff member in the selected program, select that staff member's name.

13.5.2.4.2 Only the names of staff members assigned to the context facility will be available.

13.5.2.4.3 For details on staff facility assignments, see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

13.5.2.5 *Modality*

13.5.2.5.1 This read-only field will automatically populate with the modality of the selected program.

13.5.2.5.2 For an explanation of program modality, see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

13.5.2.6 *Wait Start Date*

13.5.2.6.1 Enter the date on which the client expressed interest in, became eligible for, or otherwise began waiting to enroll in the selected program.

13.5.2.7 *Wait End Date*

13.5.2.7.1 Leave this field blank if the client is still waiting for the program.

13.5.2.7.2 When the client is ready to enroll in the program, or when the program becomes available for the client, enter the date on which the client's wait for this program ended.

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13.5.2.7.3 This date cannot be in the future.

13.5.2.7.4 This may be the date on which the client enrolled in the program, the date on which the client concluded treatment (if not enrolled prior to the conclusion of treatment), the date the client voluntarily withdrew from the waiting list, etc.

13.5.2.8 *Added to Wait List By*

13.5.2.8.1 This field will automatically populate with the name of the current user.

13.5.2.8.2 If another facility staff member had the client's name added to this waiting list, change the name in this field.

13.5.2.8.3 The available names will be staff members assigned to this facility.

13.5.2.9 *Dually Diagnosed?*

13.5.2.9.1 Select "Yes" if the client is receiving treatment for both mental health and substance abuse problems within the agency or facility.

13.5.2.10 *Patient is Injecting*

13.5.2.10.1 This read-only field will automatically populate with the response selected for the Injection Drug User field (7.4.14) on the Intake screen for the current episode.

13.5.2.11 *Patient is Pregnant*

13.5.2.11.1 This read-only field will automatically populate with the response selected for the Pregnant field (7.4.10) on the Intake screen for the current episode.

13.5.2.12 *Due Date*

13.5.2.12.1 This read-only field will automatically populate with the response entered in the Due Date field (7.4.11) on the Intake screen for the current episode.

13.5.2.12.2 In this case, due date refers to a pregnant client's expected delivery date.

13.5.2.13 *Assistance Needed to Place This Client*

13.5.2.13.1 Indicate whether any outside information or action is required before a client can be enrolled in the selected program.

13.5.2.13.2 Example: If the client is on probation, selecting "Yes" would indicate that the probation officer must be contacted before this program enrollment can be completed.

13.5.2.14 *Referred to Interim Services*

13.5.2.14.1 Indicate whether the client has been referred to another agency or facility for treatment or services that will be provided while the client is waiting for the selected program.

13.5.2.15 *Removed from Wait List By*

13.5.2.15.1 This field will become available when a date is entered for the Wait End Date (13.5.2.7).

13.5.2.15.2 Select the name of the staff member who enrolled the client in the program.

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13.5.2.15.3 The available names will be staff members assigned to the context facility.

13.5.2.16 *Reason*

13.5.2.16.1 This field will become available when a date is entered for the Wait End Date (13.5.2.7).

13.5.2.16.2 Select the option that best describes the reason the client's name was removed from the waiting list.

13.5.2.17 *Comments*

13.5.2.17.1 Enter any additional information relevant to this client regarding why he or she was placed on the waiting list for this program.

13.5.2.17.2 Enter any additional information relevant to this client regarding why he or she was removed from the waiting list for this program.

13.5.3 Click Save.

13.5.4 Click Finish to return to the Client Waiting List screen.

13.6 Complete the Admission record series (17.0) for the waiting client, if needed.

13.6.1 If the client does not yet have an open Admission record in this episode, one can be created via the "Admit Client" link on the Wait List Profile screen.

13.6.1.1 From the Client Waiting List screen, click the "Review" link in the Actions column for the desired waiting list entry.

13.6.1.2 Click the "Admit Client" link under the Comments field near the bottom of the screen.

13.6.1.3 The Admission series will begin with the Admission Profile screen (17.3.3).

13.6.2 The Admission series will open.

13.6.2.1 Some of the Admission fields will automatically populate with the client's data entered into other OWITS modules, such as the Fee Determination (11.0) and the Mental Health Assessment (16.0).

13.6.3 Complete the Admission series as appropriate for the client.

13.6.4 Click Finish to return to the Activity List.

13.7 Close the Wait List entry.

13.7.1 In the Navigation View, navigate to Client List > Activity List > Wait List.

13.7.2 Click the "Review" link in the Actions column for the Wait List entry for the program into which the client will enroll.

13.7.3 Verify that all of the fields have been correctly filled, including the following:

13.7.3.1 *Wait End Date* (13.5.2.7)

13.7.3.2 *Removed from Wait List By* (13.5.2.15)

13.7.3.3 *Reason* (13.5.2.16)

13.7.4 Click Save.

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13.7.5 Click Finish to return to the Client Waiting List screen.

13.8 After a Wait List entry has been closed (13.7), enroll the client in the appropriate program.

13.8.1 See 18.0 for details regarding program enrollments.

13.8.2 The Program Enrollment screen will produce an informational message if the client is not eligible for the selected program, such as male clients entering a program for women or adult clients entering a program for children.

13.8.3 The Days on Wait List field (18.4.2.4) may automatically populate with the number of days the client's name was on the waiting list, based on the difference between the program's Start Date field (18.4.2.5) and the waiting list's Wait Start Date field (13.5.2.6).

13.8.3.1 The Days on Wait List value can be changed if needed.

13.9 Review previous Wait List entries as needed.

13.9.1 From the Client Waiting List screen, click the "Review" link in the Actions column for the desired waiting list entry.

13.9.2 If the client has been removed from the wait list, the data fields will all be read-only.

13.9.3 When finished, click Finish to return to the Client Waiting List screen.

13.10 Return to the Activity List or other modules using the Navigation View links.

14.0 TX Team

14.1 Use of the Treatment Team module is recommended for most agencies.

14.2 The Treatment Team module can be used to specify which agency OWITS users can see and access the client's record.

14.2.1 Users who do not have the "Non-Treatment Team Access" role (in the Account Information section of their staff profile) will not be able to view or modify the client's record until they are added to the client's treatment team.

14.2.2 Users who do have the "Non-Treatment Team Access" role will be able to see all client records except those that have been specifically hidden from them (see 14.7.2.6).

14.2.3 For detailed information regarding roles and role attributes in staff profiles, see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

14.3 Treatment teams are used to designate specific agency staff members and collateral contacts who will work with, assist, or otherwise support the client during treatment.

14.4 The treatment team record is episode and facility dependent.

14.4.1 A treatment team created for a client in one facility will not copy to the client's treatment records in another facility.

14.4.2 A treatment team created for a client during his or her first episode (5.2.1) will not copy to any subsequent cases, whether in the same facility or not.

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14.5 To access the client's treatment team, use the Navigation View links to navigate to Client List > Activity List > TX Team.

14.5.1 The treatment team can also be added, viewed, and modified through the final screen of the admission series (17.3.23).

14.5.2 Specific instructions regarding the TX Team module are described in this section.

14.6 The Treatment Team screen will appear.

14.6.1 The table at the top of the screen displays existing treatment team members.

14.6.2 Column headings refer to field labels in the team member details section below.

14.7 Individual staff members and/or collateral contacts may be added to the treatment team one at a time.

14.7.1 Click the "Add Team Member" link on the right side of the screen.

14.7.2 Complete the following fields as applicable.

14.7.2.1 *Staff Name*

14.7.2.1.1 Select the name of the staff member who will be added to the client's treatment team.

14.7.2.1.2 Only the names of staff members assigned to the current facility will be available.

14.7.2.1.3 If a name is selected in this field, do not select a name in the Non Staff Name field below (14.7.2.2); treatment team members can only be added one at a time.

14.7.2.2 *Non Staff Name*

14.7.2.2.1 Select the name of the collateral contact who will be added to the client's treatment team.

14.7.2.2.2 Only the names of collateral contacts added to this client's profile will be available.

14.7.2.2.3 To add or modify collateral contacts, click the "Add Contact" link.

14.7.2.2.3.1 The Collateral Contacts screen will display.

14.7.2.2.3.2 Add collateral contacts as needed (see OWITS Reference Manual, Volume 4: Client Profile).

14.7.2.2.3.3 Click Finish to return to the TX Team screen.

14.7.2.2.3.4 Using the Navigation View links to exit the Collateral Contacts screen when accessed from the TX Team screen will cancel any unsaved progress.

14.7.2.2.4 If a name is selected in this field, do not select a name in the Staff Name field above (14.7.2.1); treatment team members can only be added one at a time.

14.7.2.3 *Role/Relation*

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14.7.2.3.1 Select the option that best describes the selected treatment team member's responsibilities within the treatment team.

14.7.2.3.2 The option selected in this field will be associated with the treatment team member's name in other OWITS modules or screens where the treatment team applies, such as the client's treatment plan (see 23.0).

14.7.2.4 *Review Member*

14.7.2.4.1 Select "Yes" if the treatment team member will take any part in creating or reviewing the client's treatment plans (see 23.0).

14.7.2.4.2 Selecting "Yes" will cause a signature line to appear on the treatment plan report for this treatment team member (see 23.7.4.2.1).

14.7.2.5 *Primary Care Staff*

14.7.2.5.1 Select "Yes" if the treatment team member is primarily responsible within the agency for the client's treatment and/or record management.

14.7.2.5.2 Only one treatment team member can be designated as Primary Care Staff for the client per facility, per episode.

14.7.2.5.3 The selection in this field will affect some of the system-generated reports (see OWITS Reference Manual, Volume 10: Running Reports).

14.7.2.6 *Deny Access to Client Records*

14.7.2.6.1 Select "Yes" for individuals who have access to OWITS but who are not permitted to view or modify the records for the current client.

14.7.2.6.2 This section may be used to block staff member access to client records if the client is related to the staff member or if the client's records should be otherwise hidden from the staff member.

14.7.2.6.3 Signature lines will appear on the necessary reports regardless of the option selected in this field if other requirements for signature lines are met.

14.7.2.6.4 CAUTION: Though users are capable of denying themselves access to client records, to avoid errors, each user should leave this field marked "No" if his or her own name has been selected in either the Staff Name (14.7.2.1) or Non Staff Name (14.7.2.2) field above.

14.7.2.7 *Treatment Sub-Teams*

14.7.2.7.1 Move "Recovery" from the left box to the right box if the treatment team member will take any part in creating or reviewing the client's recovery plans (see 27.5.2.4).

14.7.2.8 *Start Date*

14.7.2.8.1 Enter the date on which the treatment team member first became involved with the client for this treatment episode.

14.7.2.9 *End Date*

14.7.2.9.1 Enter the date on which the treatment team member concluded or will conclude his or her involvement with the client for this treatment episode.

14.7.2.9.2 Signature lines will no longer appear on reports generated after this date.

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14.7.2.9.3 When using the Treatment Staff or Primary Care Staff fiends on the Client Search screen (Client List), note that the client will continue to be included in the search results until the latest date entered in this End Date field in any episode (see OWITS Reference Manual, Volume 12: Troubleshooting).

14.7.2.10 *Notes*

14.7.2.10.1 Enter any additional relevant information relative to the treatment team member's relationship to the client, responsibilities within the treatment team, etc.

14.7.3 Click Save to add the treatment team member to the Treatment Team table above.

14.7.4 Repeat steps 14.7.1 through 14.7.3 as needed until all treatment team members have been added.

14.8 Preconfigured treatment teams can be used to add multiple treatment team members at once.

14.8.1 To add multiple team members at once, click the "Assign Group" link toward the left of the screen.

14.8.1.1 To use the group assignment function, treatment team groups must be created in advance.

14.8.1.2 Treatment team groups are created at the agency level (Agency > TX Team Groups).

14.8.1.3 For details regarding creating treatment team groups, see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

14.8.2 If treatment team groups have been configured for this facility, their names will appear in the "Available Groups" box.

14.8.3 Select one or more of the available groups and use the arrows to move them to the "Selected Groups" field.

14.8.4 Click the Assign button.

14.8.5 The treatment team group members will be assigned to the client's treatment team.

14.8.5.1 Treatment team members' details will be copied from the treatment team group as they were initially created.

14.8.5.2 Treatment team members' entries can be individually modified for this specific treatment plan (see 14.9).

14.9 Existing treatment teams can be modified as needed.

14.9.1 To edit the details for a treatment team member, click the "Review" link in the Actions column for the desired team member.

14.9.2 Modify the data fields as needed.

14.9.2.1 Treatment team members cannot be removed or deleted.

14.9.2.2 Access to the client records can be denied if the treatment team member should not be able to see or modify them (14.7.2.6).

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14.9.2.3 Add an end date (14.7.2.9) to indicate the date after which the person's involvement in the treatment team no longer applies.

14.9.3 Click Save.

14.10 Click Finish to return to the Activity List.

14.10.1 The creation of a treatment team will not appear in the client's activity list.

14.10.2 Treatment teams can be modified at any time by navigating to the TX Team module.

15.0 Screening

15.1 Use of the Screening module is recommended for most agencies.

15.2 Screenings are tools within OWITS designed to assist agency staff members in evaluating a client's problems and needs.

15.3 For specific instructions regarding the screening tools, see OWITS Reference Manual, Volume 6: Screenings and Assessments.

15.4 Return to the Activity List or other modules using the Navigation View links.

16.0 Assessments

16.1 Use of the Assessments module is recommended for most agencies.

16.2 Assessments are tools within OWITS designed to assist agency staff members in evaluating the efficacy and progress of a client's treatment.

16.3 For specific instructions regarding the assessment tools, see OWITS Reference Manual, Volume 6: Screenings and Assessments.

16.4 Return to the Activity List or other modules using the Navigation View links.

17.0 Admission

17.1 Use of the Admission module is required.

17.2 In the Navigation View, navigate to Client List > Activity List > Admission.

17.3 The Admission series contains detailed information about the client's current status.

17.3.1 The domain selected at Intake (7.4.20) will determine some of the screens and data fields available within other activity records.

17.3.2 Some of the Admission fields may be automatically populated with data from other OWITS modules, such as a Fee Determination (11.0) or a Mental Health Assessment (see OWITS Reference Manual, Volume 6: Screenings and Assessments).

17.3.3 The Admission series begins with the Admission Profile screen, which contains the following fields:

17.3.3.1 *Potential Client for SA*

17.3.3.1.1 Select "Yes" if the client might need or will be receiving Substance Abuse treatment or services.

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17.3.3.1.2 Select "Yes" if the client's problem or situation might qualify him or her for Substance Abuse treatment services outside the scope of this Admission.

17.3.3.1.3 This field is specific to the Substance Abuse domain.

17.3.3.2 *Basis for Decision (SA)*

17.3.3.2.1 Select the option that best describes how the "Yes" or "No" conclusion was reached in the previous field (17.3.3.1).

17.3.3.2.2 This field is specific to the Substance Abuse domain.

17.3.3.3 *Potential Client for MH*

17.3.3.3.1 Select "Yes" if the client might need or will be receiving Mental Health treatment or services.

17.3.3.3.2 Select "Yes" if the client's problem or situation might qualify him or her for Mental Health treatment services outside the scope of this Admission.

17.3.3.3.3 This field is specific to the Substance Abuse domain.

17.3.3.4 *Basis for Decision (MH)*

17.3.3.4.1 Select the option that best describes how the "Yes" or "No" conclusion was reached in the previous field (17.3.3.3).

17.3.3.4.2 This field is specific to the Substance Abuse domain.

17.3.3.5 *Potential Client for TBI*

17.3.3.5.1 Select "Yes" if the client might need or will be receiving treatment or services for a Traumatic Brain Injury.

17.3.3.5.2 Select "Yes" if the client's problem or situation might qualify him or her for treatment or services for a Traumatic Brain Injury outside the scope of this Admission.

17.3.3.5.3 This field is specific to the Substance Abuse domain.

17.3.3.6 *Basis for Decision (TBI)*

17.3.3.6.1 Select the option that best describes how the "Yes" or "No" conclusion was reached in the previous field (17.3.3.5).

17.3.3.6.2 This field is specific to the Substance Abuse domain.

17.3.3.7 *Days on Waiting List*

17.3.3.7.1 Enter the number of days the client's name was on a waiting list before he or she could begin receiving treatment or services.

17.3.3.7.2 The client does not necessarily have to be recorded in the OWITS Wait List (13.0) for data to be entered in this field.

17.3.3.7.3 This field is specific to the Substance Abuse domain.

17.3.3.8 *Est. Duration of TX (Days)*

17.3.3.8.1 Enter an estimate of the number of days client will be receiving treatment or services for the current problem.

17.3.3.8.2 This field is specific to the Substance Abuse domain.

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17.3.3.9 *Treating Here For*

17.3.3.9.1 Select the option that best describes the type of treatment or services the client will be receiving in the context facility.

17.3.3.9.2 Select SA for Substance Abuse.

17.3.3.9.3 Select MH for Mental Health.

17.3.3.9.4 Select MH/SA for both Substance Abuse and Mental Health.

17.3.3.9.4.1 Ensure client has two Intake records created in the context facility, one for each treatment domain (see 7.4.20.3).

17.3.3.9.4.2 Do not select this option if the client is receiving both substance abuse and mental health treatment in the context agency but in different facilities.

17.3.3.10 *Client Type*

17.3.3.10.1 Select the option that best describes the kind of services the client will receive.

17.3.3.11 *Admission Type*

17.3.3.11.1 Select "Admission" (in the Substance Abuse domain) or "New Client" (in the Mental Health domain) if the client has never had an admission recorded in the context facility before.

17.3.3.11.2 Select "Admission" (in the Substance Abuse domain) or "New Client" (in the Mental Health domain) if the client is beginning an entirely new episode of treatment even if he or she has had an admission recorded in the context facility before.

17.3.3.11.3 Select "Transfer/Change in Service" (in the Substance Abuse domain) or "Re-admitted Client" (in the Mental Health domain) if the client is continuing treatment.

17.3.3.11.3.1 Continuing treatment might include clients referred to the context facility from a different facility, agency, or organization.

17.3.3.11.3.2 Continuing treatment might include clients with an existing intake in one treatment domain who are also receiving treatment in another domain.

17.3.3.12 *Admission Staff*

17.3.3.12.1 This field will automatically populate with the name of the current user.

17.3.3.12.2 Change this field to the name of the person who collected the admission data only if that person is not the current user.

17.3.3.13 *Admission Date*

17.3.3.13.1 Enter the date on which the client began or will begin receiving treatment or services.

17.3.3.13.2 The Admission Date should be on or after the Intake Date.

17.3.3.13.3 The Admission Date cannot be in the future.

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17.3.3.13.4 OWITS will not allow other treatment or service records associated with this admission (such as program enrollments) to be created for this client if those dates are prior to the date in this field.

17.3.3.14 *Codependent/Collateral*

17.3.3.14.1 Select "Yes" if the client is seeking services because of problems arising from his or her relationship with an alcohol or drug user *and* has been admitted for service to a treatment facility *and* has his or her own client profile.

17.3.3.14.2 If the client does not meet the criteria above, select "No."

17.3.3.14.3 This field is specific to the Substance Abuse domain.

17.3.3.15 *Number of Prior SA TX Admissions*

17.3.3.15.1 Enter the number of times the client has previously been admitted to any agency or facility for substance abuse treatment.

17.3.3.15.2 This value may be estimated.

17.3.3.16 *Number of SA Hospitalizations in Past 6 Months*

17.3.3.16.1 Enter the number of times the client has been hospitalized due to problems caused by or related to substance abuse in the six months prior to the current admission.

17.3.3.16.2 This value may be estimated.

17.3.3.17 *Number of Prior MH TX Admissions*

17.3.3.17.1 Enter the number of times the client has previously been admitted to any agency or facility for mental health treatment.

17.3.3.17.2 This value may be estimated.

17.3.3.18 *Number of Prior MH Hospitalizations*

17.3.3.18.1 Enter the number of times the client has been hospitalized due to problems related to mental health during his or her lifetime.

17.3.3.18.2 This value may be estimated.

17.3.3.19 *Number of Months Since Last Discharge*

17.3.3.19.1 Enter the number of months between the current admission date (17.3.3.13) and the date on which the client most recently completed treatment or services.

17.3.3.19.2 Include treatment or services at other agencies or facilities.

17.3.3.19.3 If the client has never received treatment or services for mental health or substance abuse problems in the past, enter 0 or leave this field blank.

17.3.3.19.4 If the client is currently receiving treatment or services for mental health or substance abuse problems, enter 0 or leave this field blank.

17.3.3.19.5 This value may be estimated.

17.3.3.20 *Client Reported Health Status*

17.3.3.20.1 Select the option that best represents how the client would describe his or her general health.

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17.3.3.20.2 Individual agencies and facilities may determine specific definitions for each option.

17.3.3.21 *Mental Health Problem*

17.3.3.21.1 Indicate whether the client has or may have a diagnosable mental health problem *in addition to* a substance abuse problem.

17.3.3.21.2 The option selected in this field will automatically populate the "Psychiatric Problem in Addition to Alcohol/Drug Problem" field on the Program Enrollment screen (18.4.3.3.6).

17.3.3.21.3 This field is specific to the Substance Abuse domain.

17.3.3.22 *Pharmacotherapy Planned*

17.3.3.22.1 Indicate whether the client will receive pharmacological therapy as part of the program or service to which he or she is currently being admitted.

17.3.3.22.2 For state and federal reporting purposes, this field specifically refers to Methadone and other opioid replacement therapy medications.

17.3.3.22.3 If the client will receive pharmacotherapy with a substance or medication other than Methadone or other opioid replacement therapy medications, select "No" in this field and record the medications on the Medications screen (see 25.0).

17.3.3.22.4 The option selected in this field will automatically populate the "Methadone Used as Part of TX" field on the Program Enrollment screen (18.4.3.3.5).

17.3.3.22.5 This field is specific to the Substance Abuse domain.

17.3.3.23 *Education*

17.3.3.23.1 Select the option that best describes the client's educational history.

17.3.3.23.2 "Years completed" up to 16 refers to educational levels completed, not an actual count of years spent in schooling.

17.3.3.24 *Number of times the client has attended a self-help program.*

17.3.3.24.1 Select the option that best describes the client's attendance (if any) in a self-help program in the 30 days prior to the date of admission (17.3.3.13) for treatment or services.

17.3.3.24.2 Include attendance at Alcoholics Anonymous and other self-help or mutual support groups focused on recovery from substance abuse.

17.3.3.24.3 This value may be estimated.

17.3.3.24.4 This field is specific to the Substance Abuse domain.

17.3.4 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.5 Click the Right Arrow to advance to the Financial/Household screen, which contains the following fields:

17.3.5.1 *Employment Status*

17.3.5.1.1 Select the option that best describes the client's current employment status.

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17.3.5.1.2 If this value does not match the client's employment history (in Client List > Client Profile > Employment History), update the client's employment history (see OWITS Reference Manual, Volume 4: Client Profile) after completing the Admission series.

17.3.5.2 *Months Employed in Last Six Months*

17.3.5.2.1 If client was employed during all of the six months prior to the admission date, enter 6.

17.3.5.2.2 If client was employed for a portion of the six-month period prior to the admission date, enter the number of months employed (1-5).

17.3.5.2.3 If client was not employed during any of the six-month period prior to the admission date, enter 0.

17.3.5.2.4 This refers to any type of employment.

17.3.5.2.5 This value may be estimated.

17.3.5.2.6 This field is specific to the Substance Abuse Domain.

17.3.5.3 *Months employed or in Voc/Ed Training in last 12 months*

17.3.5.3.1 If client was employed during all of the 12 months prior to the admission date, enter 12.

17.3.5.3.2 If client was employed for a portion of the 12-month period prior to the admission date, enter the number of months employed (1-11).

17.3.5.3.3 If client was not employed during any of the 12-month period prior to the admission date, enter 0.

17.3.5.3.4 This refers to any type of employment.

17.3.5.3.5 This value may be estimated.

17.3.5.3.6 This field may automatically populate from a related question in the Mental Health Assessment (see OWITS Reference Manual, Volume 6: Screenings and Assessments).

17.3.5.3.7 This field is specific to the Mental Health Domain.

17.3.5.4 *Employer*

17.3.5.4.1 If the client is currently employed, enter the name of the employer.

17.3.5.4.2 If this value does not match the client's employment history (in Client List > Client Profile > Employment History), update the client's employment history (see OWITS Reference Manual, Volume 4: Client Profile) after completing the Admission series.

17.3.5.5 *Annual Household Income*

17.3.5.5.1 Select the option that best fits the client's current household income as calculated over a 12-month period.

17.3.5.5.2 Include income from others living in the same household if that income is used to support the client or the household as a whole.

17.3.5.5.3 Do not include income from others living in the same household if that income is not in any way used to support the client.

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17.3.5.6 *Number of Employers in Last 12 Months*

17.3.5.6.1 Enter the number of organizations or individuals by which the client was employed during the last 12 months.

17.3.5.6.2 Count only individual companies, corporations, large organizations, or private individuals, not the client's manager(s) or supervisor(s).

17.3.5.6.3 Enter 0 if the client was not employed during the last 12 months.

17.3.5.6.4 This field is specific to the Mental Health domain.

17.3.5.7 *Gross Annual Household Income*

17.3.5.7.1 This read-only field will automatically populate with the value in the "Gross Annual Income" field on the Fee Determination screen (11.5.1.14) if a Fee Determination record has been completed and signed.

17.3.5.7.2 This field is specific to the Mental Health domain.

17.3.5.8 *School Attendance*

17.3.5.8.1 Select the option that best describes whether and how often the client currently attends public or private school.

17.3.5.8.2 Select "Not Applicable" if the client is not currently attending public or private school.

17.3.5.8.3 This field is specific to the Mental Health domain.

17.3.5.9 *Co-Occurring Health Problem*

17.3.5.9.1 Indicate whether the client has a medical or physiological health problem in addition to a mental health problem.

17.3.5.9.2 This field is specific to the Mental Health domain.

17.3.5.10 *Primary Income Source*

17.3.5.10.1 Select the option that best describes the source of the largest part of the client's income regardless of whether it is earned, accrued, gifted, or illiegal.

17.3.5.10.2 This field is specific to the Substance Abuse domain.

17.3.5.11 *Expected Payment Source*

17.3.5.11.1 Select the option that best describes how the current treatment or services will be paid.

17.3.5.12 *Insurance Type*

17.3.5.12.1 Select the option that best describes the client's health insurance situation.

17.3.5.13 *Other Income Sources*

17.3.5.13.1 In the Substance Abuse domain, if the client receives income from sources other than the one indicated in Primary Income Source (17.3.5.10), select them in these option transfer boxes.

17.3.5.13.2 In the Mental Health domain, select all of the client's income sources (if any) in these option transfer boxes.

17.3.5.14 *Household Composition*

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17.3.5.14.1 Select the option that best describes the makeup of the client's household.

17.3.5.14.2 Household consists of people (roommates, family, etc.) who live in the same residence (house, apartment, etc.) with the client.

17.3.5.14.3 If multiple selections are applicable, select the option that describes the majority of the makeup of the client's household.

17.3.5.15 *Living Arrangement*

17.3.5.15.1 Select the option that best describes the client's housing situation.

17.3.5.15.2 Select "Lives in Own Home" if the client lives alone in a house or rental property that is paid for by private funds from client, client's relatives, or others in client's household.

17.3.5.16 *Marital Status*

17.3.5.16.1 Select the option that best describes the client's current marital status.

17.3.5.17 *# of People Living With Client*

17.3.5.17.1 Enter the number of people currently or most frequently living with the client in the Living Arrangement (17.3.5.15) and Household Composition (17.3.5.14) indicated above.

17.3.5.17.2 Do not include the client in this number.

17.3.5.17.3 Enter 0 if the client lives in a group home, institution, hospital, prison, or other non-private residence.

17.3.5.18 *Relation to Client*

17.3.5.18.1 Referring to the "# of People Living With Client" field (17.3.5.17), select the descriptions that best fit those people.

17.3.5.18.2 Example: If client lives with his or her mother, aunt, and two brothers, select Aunt(s), Brother(s), and Mother in these option transfer boxes.

17.3.5.18.3 Example: Select "Self" if client lives alone or if the "# of People Living With Client" field contains 0.

17.3.6 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.7 Click the Right Arrow to advance to the Youth screen, which should only be completed if the client's age at admission is 17 years old or younger, including the following fields:

17.3.7.1 *Client is a Student*

17.3.7.1.1 Use this field to indicate whether the client is currently a student enrolled in public or private education at or below the GED level.

17.3.7.2 *Client is a Gang Member*

17.3.7.2.1 Use this field to indicate whether client is a member of a gang.

17.3.7.2.2 If the client is an adult (18 years old or older), this field may still be used to indicate that he or she is a member of a gang.

17.3.7.3 *Guardian Name*

17.3.7.3.1 Select the name of the client's legal guardian.

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17.3.7.3.2 This field may include one of the client's parents.

17.3.7.3.3 The options in the Guardian field come from data entered in the Collateral Contacts screen.

17.3.7.3.4 If a desired name is not available in this field, click the "Add School Contacts" link.

17.3.7.3.4.1 The Collateral Contacts screen will appear.

17.3.7.3.4.2 Add collateral contacts as needed (see OWITS Reference Manual, Volume 4: Client Profile).

17.3.7.3.4.3 Click Finish to return to the Admission > Youth screen.

17.3.7.3.4.4 Using the Navigation View links to exit the Collateral Contacts screen when accessed from the Admission > Youth screen will cancel any unsaved progress.

17.3.7.4 *Guardian Type*

17.3.7.4.1 Select the option that best describes the guardian indicated in the Guardian Name field (17.3.7.3).

17.3.7.5 *School Name*

17.3.7.5.1 If client is a student at or below the GED level, enter the name of the public or private school he or she currently attends.

17.3.7.6 *School Contact*

17.3.7.6.1 If client is a student, select the name of an individual at the client's school who may be able to provide additional information or support.

17.3.7.6.2 The options in the School Contact field come from data entered in the Collateral Contacts screen.

17.3.7.6.3 If a desired name is not available in this field, click the "Add School Contacts" link.

17.3.7.6.3.1 The Collateral Contacts screen will appear.

17.3.7.6.3.2 Add collateral contacts as needed (see OWITS Reference Manual, Volume 4: Client Profile).

17.3.7.6.3.3 Click Finish to return to the Admission > Youth screen.

17.3.7.6.3.4 Using the Navigation View links to exit the Collateral Contacts screen when accessed from the Admission > Youth screen will cancel any unsaved progress.

17.3.7.7 *Attending Grade*

17.3.7.7.1 Enter the client's current grade level.

17.3.7.8 *Current GPA*

17.3.7.8.1 Enter the client's current grade point average.

17.3.7.8.2 Decimals are allowed in this field.

17.3.7.8.3 This value may be estimated.

17.3.7.9 *Days Suspended in Last 30 Days*

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17.3.7.9.1 Enter the number of days the client was suspended from school during the 30-day period prior to the admission date (17.3.3.13).

17.3.7.10 *Days Absent in Last 30 Days*

17.3.7.10.1 Enter the number of days the client was absent from school for reasons other than suspension or other disciplinary actions during the 30-day period prior to the admission date (17.3.3.13).

17.3.7.11 *POSIT Scores*

17.3.7.11.1 If a POSIT assessment has been conducted for the client, enter the scores in the eleven fields in this section.

17.3.7.11.2 POSIT scores must be less than or equal to 26.

17.3.7.11.3 POSIT scores may contain decimals.

17.3.7.11.4 The POSIT assessment tool is not currently available in OWITS.

17.3.8 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.9 Click the Right Arrow to advance to the Substance Abuse screen, which contains the following fields.

17.3.9.1 *Substance*

17.3.9.1.1 Select the Primary Substance identified as a problem for the client.

17.3.9.1.1.1 If the client is receiving treatment or services for only one substance, select it as the Primary Substance.

17.3.9.1.1.2 If the client is receiving treatment or services for multiple substances, the Primary Substance must be the substance identified as the client's most significant problem.

17.3.9.1.2 Clients must have at least a primary substance for admission into a program or service within the Substance Abuse domain.

17.3.9.1.2.1 If the admission is for a program or service within the Mental Health domain and if the client does not have any identified substance abuse problems, select None as the Primary Substance.

17.3.9.1.2.2 Secondary and tertiary substances will also display None.

17.3.9.1.3 Selecting a primary substance opens the Secondary Substance field for entry; if no secondary substance is identified, select None.

17.3.9.1.4 Selecting a secondary substance opens the Tertiary Substance field for entry; if no tertiary substance is identified, select None.

17.3.9.1.5 Nicotine cannot be selected as a primary, secondary, or tertiary substance, regardless of its relative severity, but it can be selected in the Other Addictions field (17.3.9.11) and detailed on the Tobacco screen (17.3.11).

17.3.9.2 *Severity*

17.3.9.2.1 Select the option that best describes the degree to which the substance use or abuse affects the client.

17.3.9.2.2 If the related substance is None, this field will display N/A.

17.3.9.3 *Frequency*

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17.3.9.3.1 Select the option that best describes how often the client uses or abuses the substance.

17.3.9.3.2 If the related substance is None, this field will display N/A.

17.3.9.4 *Method*

17.3.9.4.1 Select the option that best describes the route by which the client takes the substance into his or her body.

17.3.9.4.2 If multiple methods apply, select the method that is most frequently used.

17.3.9.4.3 If the related substance is None, this field will display N/A.

17.3.9.5 *Detailed Drug Code*

17.3.9.5.1 If a single specific drug is tracked for the selected substance (17.3.9.1), this field will display the name of the drug.

17.3.9.5.2 If multiple specific drugs are tracked for the selected substance, this field will appear blank.

17.3.9.5.2.1 Select the option that best describes the specific drug the client uses.

17.3.9.5.2.2 Example: Selecting a substance of "Barbiturates" will result in four specific drug options in this field.

17.3.9.5.3 This field is specific to the Substance Abuse domain.

17.3.9.6 *At what age did the client first use the substances indicated above?*

17.3.9.6.1 Enter the age at which the client used the substance(s) selected above (17.3.9.1) for the first time.

17.3.9.6.2 These values may be estimated.

17.3.9.6.3 These values cannot be higher than the client's current age.

17.3.9.6.4 If None is selected for the secondary or tertiary substances above, the associated fields in this section will be unavailable.

17.3.9.6.5 These fields are specific to the Substance Abuse domain.

17.3.9.7 *Number of days since last use of the substances indicated above.*

17.3.9.7.1 Enter the number of days between the admission date (17.3.3.13) and the date the client most recently used each of the substances.

17.3.9.7.2 These fields are specific to the Substance Abuse domain.

17.3.9.8 *Number of Days Abstinent in Last 30 Days*

17.3.9.8.1 Enter the number of days in the last 30 days that the client has not used any of the three substances selected above (17.3.9.1).

17.3.9.8.2 This field is specific to the Substance Abuse domain.

17.3.9.9 *Number of Days in Support Group in Last 30 Days*

17.3.9.9.1 Enter the number of days in the last 30 days that the client attended support group meetings.

17.3.9.9.2 This field is specific to the Substance Abuse domain.

17.3.9.10 *Number of Days Attended AA/NA/Similar Meetings in Last 30 Days*

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17.3.9.10.1 Enter the number of days in the last 30 days that the client attended support group meetings with groups that have a specific substance abuse focus.

17.3.9.10.2 This value should be less than or equal to the value in the support group field above (17.3.9.9).

17.3.9.10.3 This field is specific to the Substance Abuse domain.

17.3.9.11 *Other Addictions*

17.3.9.11.1 Use these option transfer boxes to indicate other addictions that are problems for the client that are not reported as primary, secondary, or tertiary substances.

17.3.9.11.2 This may include alcohol if client does not have a significant problem with or addiction to it, or if client will not receive treatment or services related to it.

17.3.9.11.3 This may include nicotine, which is not reported as a primary, secondary, or tertiary substance.

17.3.9.11.4 This field also includes non-substance addictions such as gambling, pornography, social media, video games, etc.

17.3.9.11.5 Example: A client uses barbiturates, methamphetamines, and cocaine. He will be receiving treatment for at least one of those substances. He also smokes marijuana and drinks a few beers with his friends on Saturday nights, but he will not be receiving treatment for those substances. Alcohol and marijuana could be selected in the Other Addictions boxes.

17.3.9.11.6 Example: A client uses cocaine, methamphetamines, inhalants, alcohol, marijuana, and synthetic opiates. She also exhibits addictive behavior related to the Facebook and Twitter websites. Because cocaine, methamphetamines, and alcohol are her most severe substance abuse problems, those would be identified as Primary, Secondary, and Tertiary. The other substances and "Social Media" would be selected in the Other Addictions boxes.

17.3.9.11.7 This field is specific to the Substance Abuse domain.

17.3.9.12 *Comments*

17.3.9.12.1 Enter any additional information regarding the client's substance use.

17.3.9.12.2 This field may include the client's attitude toward the substance use.

17.3.9.12.3 It may be useful to also include medications currently prescribed to the client, though medications can be tracked as part of the Treatment module (25.0).

17.3.9.12.4 This field is specific to the Substance Abuse domain.

17.3.10 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.11 Click the Right Arrow to advance to the Tobacco questionnaire, which contains the following fields:

17.3.11.1 *Have you ever used Tobacco/Nicotine products?*

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17.3.11.1.1 Indicate whether the client has used tobacco.

17.3.11.1.2 Selecting "Yes" will make additional fields available.

17.3.11.2 *Smoker Status*

17.3.11.2.1 Select the option that best describes how often the client uses a tobacco product.

17.3.11.2.2 Include chewing tobacco or other forms of tobacco that are not smoked.

17.3.11.2.3 If "No" is selected above (17.3.11.1), this field will display "Never Smoked."

17.3.11.3 *At what age did you first use tobacco/nicotine products?*

17.3.11.3.1 Select the option that best fits the age at which the client used any form of tobacco for the first time.

17.3.11.3.2 If "No" is selected above (17.3.11.1), this field will display "NA."

17.3.11.4 *In the past 30 days, what tobacco/nicotine product did you use most frequently?*

17.3.11.4.1 Indicate the tobacco product used most often by the client during the 30 days prior to the admission date (17.3.3.13).

17.3.11.4.2 Select "None" if the client has not used tobacco in the 30 days prior to the admission date.

17.3.11.4.3 If "No" is selected above (17.3.11.1), this field will display "NA."

17.3.11.4.4 This field is specific to the Substance Abuse domain.

17.3.11.5 *Other Please Describe*

17.3.11.5.1 If this field is available, enter a description of the tobacco product used most often by the client during the 30 days prior to the admission date (17.3.3.13).

17.3.11.5.2 This field will only be available if "Other" is selected as the tobacco product (17.3.11.4).

17.3.11.5.3 This field is specific to the Substance Abuse domain.

17.3.11.6 *In the past 30 days, how often did you use tobacco/nicotine products?*

17.3.11.6.1 Select the option that best describes the daily frequency of the client's use of any or all tobacco products.

17.3.11.6.2 If "None" or "No" is selected in the fields above, this field will display "NA."

17.3.11.7 *In the past 30 days, how many cigarettes did you smoke per week?*

17.3.11.7.1 Enter the average number of cigarettes the client smoked each week during the 30-day period prior to the admission date.

17.3.11.7.2 Count cigarettes only.

17.3.11.7.3 This value may be estimated.

17.3.11.7.4 If "No" is selected above (17.3.11.1), this field will display 0.

17.3.12 When all the required fields (and others, if applicable) have been filled, click Save.

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17.3.13 Click the Right Arrow to advance to the Legal screen, which contains the following fields:

17.3.13.1 *Legal Status*

17.3.13.1.1 Use this option transfer box to indicate whether the client's admission is related to any legal proceedings involving the client.

17.3.13.1.2 Use this field to indicate whether the client is receiving treatment or services related to a DUII diversion or conviction.

17.3.13.1.3 Select as many options as necessary to fully describe the client's legal situation.

17.3.13.1.4 Select "None" or leave the Selected Legal Status box blank if this admission is not related to any legal proceedings.

17.3.13.2 *# of Arrests in Lifetime*

17.3.13.2.1 Enter the total number of times the client has been arrested.

17.3.13.2.2 Count all arrests regardless of the outcome (release, acquittal, conviction, etc.).

17.3.13.2.3 Enter 0 if the client has never been arrested.

17.3.13.2.4 This value may be estimated.

17.3.13.2.5 This field is specific to the Substance Abuse domain.

17.3.13.3 *# of Arrests in Past 12 Months*

17.3.13.3.1 Enter the number of times the client has been arrested in the 12-month period prior to the admission date (17.3.3.13).

17.3.13.3.2 Count all arrests regardless of the outcome (release, acquittal, conviction, etc.).

17.3.13.3.3 This value may be estimated.

17.3.13.3.4 This value must be less than or equal to the # of Arrests in Lifetime field (17.3.13.2).

17.3.13.4 *# of Arrests in Past 30 Days*

17.3.13.4.1 Enter the number of times the client has been arrested in the 30-day period prior to the admission date (17.3.3.13).

17.3.13.4.2 Count all arrests regardless of the outcome (release, acquittal, conviction, etc.).

17.3.13.4.3 This value may be estimated.

17.3.13.4.4 This value must be less than or equal to the Number of Arrests in Past 12 Months field (17.3.13.3).

17.3.14 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.15 Click the Right Arrow to advance to the Assessment Scores screen.

17.3.15.1 All the fields on this screen will populate from the DENS ASI or ASI Lite assessments (see OWITS Reference Manual, Volume 6: Screenings and Assessments).

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17.3.15.2 Click the Load Latest Assessment Scores link to automatically fill the fields.

17.3.15.2.1 Scores from the DENS ASI or ASI Lite assessment most recently completed within the current episode (case) will appear in these fields.

17.3.15.3 Click the Clear Assessment Scores link to make the fields blank.

17.3.15.3.1 If a new DENS ASI or ASI Lite assessment has been completed within the current episode (case), click this link to clear the fields, then click the Load Latest Assessment Scores link to populate with the current scores.

17.3.16 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.17 Click the Right Arrow to advance to the ASAM screen.

17.3.17.1 The ASAM screen consists of data entry fields to assist users in completing and recording assessments that evaluate the client based on the six ASAM dimensions.

17.3.17.2 The ASAM screen in the Admission series should be used for the results of the primary or initial ASAM assessment performed for the client.

17.3.17.2.1 Other modules such as Treatment Review (24.0) and Discharge (26.0) include ASAM screens for follow-up results.

17.3.17.3 OWITS does not contain an ASAM assessment.

17.3.17.4 Provider agencies are encouraged to use the ASAM assessment tools that best fit their business needs and enter the results into OWITS using this and other ASAM screens.

17.3.17.5 The ASAM is generally only performed for substance abuse clients.

17.3.17.5.1 Mental health providers may use the ASAM screens if desired.

17.3.17.6 Additional information is available under the "ASAM Notes" link near the bottom of the screen.

17.3.17.6.1 Click this link to open a pop-up window containing a PDF document.

17.3.17.6.2 This document contains additional details about the ASAM assessment and the six dimensions.

17.3.17.6.3 Because this document was not prepared specifically for Oregon or for any specific agency, not all of the information will apply to agencies in Oregon.

17.3.17.7 See Appendix E – ASAM Levels of Care for a brief description of each of the ASAM levels of care.

17.3.17.8 A printable report of this screen, including the full text entered into the text boxes, can be generated as needed.

17.3.17.8.1 Click the Printable View icon at the top of the screen.

17.3.17.8.2 A pop-up window will open containing exactly the same fields and content as currently displayed in the main OWITS window.

17.3.17.8.3 Use the Internet Explorer print functions to print this screen.

17.3.17.8.4 When printed, the "As Indicated By" text boxes (17.3.18.3) will expand to include all text that has been entered into them.

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17.3.18 The ASAM screen consists of the following fields:

17.3.18.1 *Dimension*

17.3.18.1.1 This column lists the six dimensions of the ASAM criteria, including:

17.3.18.1.2 *Dimension 1 – Acute Intoxication and/or Withdrawal Potential*

17.3.18.1.3 *Dimension 2 – Biomedical Conditions and Complications*

17.3.18.1.4 *Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications*

17.3.18.1.5 *Dimension 4 – Readiness to Change*

17.3.18.1.6 *Dimension 5 – Relapse, Continued Use, or Continued Problem Potential*

17.3.18.1.7 *Dimension 6 – Recovery / Living Arrangement*

17.3.18.2 *Level of Care*

17.3.18.2.1 In this drop-down menu, select an option for each of the six categories listed under the "Dimension" heading.

17.3.18.2.2 "Level of Care" refers to the intensity of the clinical attention, treatment, or services that best fit the client's needs as they relate to the each dimension.

17.3.18.2.3 In the Admission series, this selection should refer to the client's initial ASAM evaluation in the current episode.

17.3.18.3 *As Indicated By*

17.3.18.3.1 In this text box, enter a summary, narrative, or other explanation that details the clinical process, evaluation, or evidence that led to the determination of the selected level of care for each dimension listed under the "Dimension" heading.

17.3.18.3.2 In the Admission series, this text should refer to the client's initial ASAM evaluation in the current episode.

17.3.18.4 *Recommended Level of Care*

17.3.18.4.1 Select the option that indicates the level of care most appropriate for the client's overall individual needs.

17.3.18.4.2 The option selected in this field applies to overall treatment, not a single dimension.

17.3.18.4.3 The option selected in this field may differ from the level of care available to the client or provided for the client by the agency.

17.3.18.5 *Actual Level of Care*

17.3.18.5.1 Select the option that indicates the level of care that will be provided to the client by the agency.

17.3.18.5.2 The option selected in this field applies to overall treatment, not a single dimension.

17.3.18.5.3 The option selected in this field may differ from the level of care that would be the least restrictive, most safe, or otherwise ideal level of care for the client's individual needs.

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17.3.18.6 *Clinical Override*

17.3.18.6.1 If the actual level of care (17.3.18.5) differs from the recommended level of care (17.3.18.4), select an option in this field that identifies a reason for the difference.

17.3.18.6.2 This is generally used when the client or a clinician determines that the recommended level of care cannot or should not be the actual level of care provided.

17.3.18.6.3 If applicable, use the Comments field below (17.3.18.7) to explain the clinical override.

17.3.18.7 *Comments*

17.3.18.7.1 Enter any additional information related to the ASAM assessment and results.

17.3.18.7.2 Ideally, information entered into this text box should play a part in facilitating treatment planning and recovery goals.

17.3.19 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.20 Click the Right Arrow to advance to the Diagnosis screen.

17.3.20.1 A diagnosis is not required in order to save the admission record.

17.3.20.2 A diagnosis is required before OWITS will recognize the admission record as complete.

17.3.20.3 Note that the contents of all diagnosis drop-down menus in this section are sorted alphabetically.

17.3.20.4 A spreadsheet that can be used for sorting and filtering diagnosis codes can be found on the OWITS Forum (http://owits.boards.net).

17.3.21 The Diagnosis screen consists of the following fields and sections:

17.3.21.1 *Primary*

17.3.21.1.1 Select the option that best describes the primary diagnosis of the client's problem.

17.3.21.2 *Secondary*

17.3.21.2.1 Select the option that best describes the secondary diagnosis of the client's problem.

17.3.21.3 *Tertiary*

17.3.21.3.1 Select the option that best describes the tertiary diagnosis of the client's problem.

17.3.21.4 *Axis I*, *Axis II*, *Axis III*, and *Axis IV*

17.3.21.4.1 Use these sections if specific diagnoses have been identified for the client on one or more of the four DSM axes.

17.3.21.4.1.1 Diagnoses will be required on all four axes even if only one has been identified.

17.3.21.4.1.2 Each axis includes options to specify that no diagnosis has been made for that axis.

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17.3.21.4.2 Click the Edit Axis Evaluation link.

17.3.21.4.3 In the Axis field, select Axis I.

17.3.21.4.3.1 Selecting Axis I in this field will filter the Diagnosis field (below) to show only Axis I diagnoses.

17.3.21.4.4 In the Diagnosis field, select the option that matches the client's Axis I diagnosis.

17.3.21.4.4.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis I (DSM)" if the diagnosis for this axis will be added later.

17.3.21.4.4.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis I (DSM)" if no diagnosis has been or will be identified for this axis.

17.3.21.4.5 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

17.3.21.4.5.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

17.3.21.4.6 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

17.3.21.4.7 Click the Add to Axis link in the gray bar labeled Axis I.

17.3.21.4.8 In the Axis field, select Axis II.

17.3.21.4.8.1 Selecting Axis II in this field will filter the Diagnosis field (below) to show only Axis II diagnoses.

17.3.21.4.9 In the Diagnosis field, select the option that matches the client's Axis II diagnosis.

17.3.21.4.9.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis II (DSM)" if the diagnosis for this axis will be added later.

17.3.21.4.9.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis II (DSM)" if no diagnosis has been or will be identified for this axis.

17.3.21.4.10 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

17.3.21.4.10.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

17.3.21.4.11 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

17.3.21.4.12 Click the Add to Axis link in the gray bar labeled Axis II.

17.3.21.4.13 In the Axis field, select Axis III.

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17.3.21.4.13.1 Selecting Axis III in this field will filter the Diagnosis field (below) to show only Axis III diagnoses.

17.3.21.4.14 In the Diagnosis field, select the option that matches the client's Axis III diagnosis.

17.3.21.4.14.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis III (DSM)" if the diagnosis for this axis will be added later.

17.3.21.4.14.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis III (DSM)" if no diagnosis has been or will be identified for this axis.

17.3.21.4.15 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

17.3.21.4.15.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

17.3.21.4.16 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

17.3.21.4.17 Click the Add to Axis link in the gray bar labeled Axis III.

17.3.21.4.18 In the Axis field, select Axis IV.

17.3.21.4.18.1 Selecting Axis IV in this field will filter the Diagnosis field (below) to show only Axis IV diagnoses.

17.3.21.4.19 In the Diagnosis field, select the option that matches the client's Axis IV diagnosis.

17.3.21.4.19.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis IV (DSM)" if the diagnosis for this axis will be added later.

17.3.21.4.19.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis IV (DSM)" if no diagnosis has been or will be identified for this axis.

17.3.21.4.20 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

17.3.21.4.20.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

17.3.21.4.21 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

17.3.21.4.22 Click the Add to Axis link in the gray bar labeled Axis IV.

17.3.21.4.23 Click Finish to return to the Diagnosis screen.

17.3.21.5 *Axis V*

17.3.21.5.1 Enter the client's most recent GAF score.

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17.3.21.5.2 This must be a number between 0 and 100.

17.3.21.6 *Highest GAF Score in Last Year*

17.3.21.6.1 This field may automatically populate with the highest score entered into the Axis V field (17.3.21.5) in all other Diagnosis screens between the current date and the current episode's intake date or in the twelve months prior to the current date, whichever is shorter.

17.3.21.6.2 Enter the highest score the client has received on the Global Assessment of Functioning scale in the last year, or replace the auto-populated value if it is incorrect.

17.3.21.6.3 This must be a number between 0 and 100.

17.3.21.6.4 The Global Assessment of Functioning scale is not currently available in OWITS.

17.3.21.6.5 This field is specific to the Mental Health domain.

17.3.22 When all the required fields (and others, if applicable) have been filled, click Save.

17.3.23 Click the Right Arrow to advance to the Treatment Team screen.

17.3.23.1 This screen functions in the same way the standalone Treatment Team screen (Client List > Activity List > TX Team) functions.

17.3.23.2 Add treatment team members as needed to the client's record for this episode (case).

17.3.23.3 For specific instructions regarding modifying the client's treatment team, see 14.0.

17.3.24 When all applicable treatment team members have been added, click Save.

17.3.24.1 It may be necessary to click Save multiple times due to table updates that occur on this screen.

17.4 Click Finish to complete the Admission series and return to the Activity List

17.5 The Admission can be reviewed and modified any time prior to completing a Discharge record and closing the case (see OWITS Reference Manual, Volume 9: Client Discharge).

17.5.1 Navigate to Client List > Activity List.

17.5.2 Click the "Review" link in the Actions column of the Admission line.

17.5.3 Using the blue arrows or the Navigation View links, navigate to the desired Admission screen(s) and modify data as needed.

17.5.4 Click Finish to return to the Activity List.

17.6 Open printer-friendly version of the entire Admission series.

17.6.1 Navigate to Client List > Activity List.

17.6.2 Click the "Review" link in the Actions column of the Admission line.

17.6.3 On any screen within the Admission series, click the "Generate Report" icon at the top of the screen.

17.6.3.1 A pop-up browser window will open.

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17.6.3.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

17.6.3.2 The pop-up window will display all of the data fields from all screens in the Admission series, including a table displaying all of the client's program enrollments (similar to 18.3.1).

17.6.3.3 This text can be printed using the Internet Explorer printing functions.

17.6.4 Close the pop-up window when finished.

17.7 Click Finish to return to the Activity List.

18.0 Program Enrollments

18.1 Use of the Program Enroll module is required.

18.2 The Client Profile (see OWITS Reference Manual, Volume 4: Client Profile), Intake (7.0), and Admission (17.0) records must be completed before a Program Enrollment can be created.

18.3 In the Navigation View, navigate to Activity List > Program Enroll.

18.3.1 The Program Enrollment screen will display, including a table that lists the programs into which the client has enrolled during the current episode.

18.3.2 Review this table to verify that the client is not already enrolled in the desired program.

18.3.2.1 If a date appears in the End Date column, the client has previously enrolled in the program and has been disenrolled from it (see OWITS Reference Manual, Volume 9: Client Discharge).

18.3.2.2 Clients can be enrolled in multiple programs at the same time.

18.3.2.3 Clients can only enroll in a single program multiple times but only if the enrollment and disenrollment dates do not overlap.

18.3.2.4 Clients cannot be enrolled in any programs in the current episode after a Discharge record (26.0) has been completed.

18.4 To enroll the selected client in a program offered by the selected facility, click the "Add Enrollment" link in the Program Enrollment heading.

18.4.1 The Program Enroll screen will display.

18.4.2 The program enrollment includes the following fields:

18.4.2.1 *Facility*

18.4.2.1.1 This field will automatically populate with the context facility.

18.4.2.1.2 Though it is not generally recommended, users with access to multiple facilities in the context agency are capable of enrolling a client in a program at another facility.

18.4.2.1.3 Changing the value in this field will change the list of available programs in the Program Name field below.

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18.4.2.1.4 WARNING: Enrolling clients in programs managed by other facilities is a simple process that can cause complex errors and additional difficulty, and, as such, it should be used rarely and with caution.

18.4.2.1.5 For instructions regarding enrolling clients in programs managed by other facilities, see 18.5.

18.4.2.2 *Program Name*

18.4.2.2.1 Select the name of the program in which the client will be participating.

18.4.2.2.2 When a Program Enrollment is selected, a new section may appear labeled "TEDS/NOMS Status at Program Enrollment" (18.4.3.3).

18.4.2.2.2.1 This section will appear for programs set to report state and federal data.

18.4.2.2.2.2 This state and federal reporting setting is part of the program's profile (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

18.4.2.2.3 Upon selecting a program name, the Program Enrollment screen will produce an informational message if the client is not eligible for a gender-specific program, such as male clients entering a program for women, but it will not prevent clients from being enrolled.

18.4.2.2.4 Upon selecting a program name, the Program Enrollment screen will produce an informational message if the client is not eligible for an age-specific program, such as adult clients entering a program for adolescents, but it will not prevent clients from being enrolled.

18.4.2.2.5 If the desired program is not available, verify that the correct facility was selected in the Facility field above (see also 18.5).

18.4.2.2.6 If the desired program is not available from any of the available facilities, a system administrator may need to verify that the facility profile is complete, that the program profile is complete, or that the user has the correct access rights (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

18.4.2.2.7 CAUTION: Because this field changes to a read-only status upon saving, confirm that the correct program has been selected before clicking Save or Finish.

18.4.2.3 *Program Staff*

18.4.2.3.1 This field automatically populates with the name of the current user.

18.4.2.3.2 Change this field to the name of the person who collected the program enrollment data only if that person is not the current user.

18.4.2.4 *Days on Wait List*

18.4.2.4.1 Enter the number of days the client's name was on a waiting list to participate in this program.

18.4.2.4.2 Enter 0 if the client did not have to wait for an open space in the program.

18.4.2.4.3 If a Wait List record was created for this client to be enrolled in this program, this field may automatically populate (see 13.8.3).

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18.4.2.4.4 Selecting a program or changing the program selection (18.4.2.2) will cause this screen to reload and clear this field.

18.4.2.4.5 CAUTION: To avoid errors related to multiple enrollments, do not click Save or Finish on this screen without confirming that this field is filled.

18.4.2.5 *Start Date*

18.4.2.5.1 Enter the date on which the client began or will begin the program.

18.4.2.5.2 The Start Date should be on or after the Admission Date (17.3.3.13).

18.4.2.5.3 The Start Date may be in the future.

18.4.2.5.4 This date may be edited at any time until the case is closed (7.4.21) as long as it is on or before the discharge date (26.6.1).

18.4.2.6 *End Date*

18.4.2.6.1 This field will be completed at the same time the Discharge and Disenroll screens are completed (see OWITS Reference Manual, Volume 9: Client Discharge).

18.4.2.6.2 If the client has not completed or otherwise ceased participation in the program, leave this field blank.

18.4.2.6.3 This date may be edited at any time until the case is closed as long as it is on or before the discharge date (26.6.1) and on or after the Start Date (18.4.2.5).

18.4.2.7 *Termination Reason*

18.4.2.7.1 This field will be completed at the same time the Discharge and Disenroll screens are completed (see OWITS Reference Manual, Volume 9: Client Discharge).

18.4.2.7.2 If the client has not completed or otherwise ceased participation in the program, leave this field blank.

18.4.2.8 *Notes*

18.4.2.8.1 Enter any additional information about the client's enrollment in this program not captured elsewhere on this screen.

18.4.2.8.2 Include whether the client qualifies for special funding or other unique considerations.

18.4.3 In the "TEDS/NOMS Status at Program Enrollment" section, most of the fields will automatically populate with data from the Admission series (17.0).

18.4.3.1 If any of the data in the available (yellow or pale yellow) fields has changed since admission, correct it on this screen.

18.4.3.2 If any of the data in the unavailable (gray) fields has changed since admission, it must be changed in the Admission screens.

18.4.3.3 The TEDS/NOMS Status at Program Enrollment fields consist of the following:

18.4.3.3.1 *Enrollment Type* – Read-Only – Populates based on a selection at Admission (17.3.3.11).

18.4.3.3.2 *DSM Diagnosis* – Read-Only – Populates from Admission (17.3.21.1)

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18.4.3.3.3 *# of Arrests in Last 30 Days* – Read-Only – Populates from Admission (17.3.13.4)

18.4.3.3.4 *Pregnant at Enrollment* – Editable – Populates from Intake (7.4.10)

18.4.3.3.5 *Methadone Used as Part of TX* – Editable – Populates from Admission (17.3.3.22)

18.4.3.3.6 *Psychiatric Problem in Addition to Alcohol/Drug Problem* – Read-Only – Populates from Admission (17.3.3.21)

18.4.3.3.6.1 In a Mental Health domain enrollment, this field will be blank.

18.4.3.3.7 *# of Times You Have Participated in a Self Help Group in the Last 30 Days* – Editable – Populates from Admission (17.3.3.24)

18.4.3.3.8 *Marital Status* – Read-Only – Populates from Admission (17.3.5.16)

18.4.3.3.9 *Living Arrangement* – Read-Only – Populates from Admission (17.3.5.15)

18.4.3.3.10 *Employment Status* – Editable – Populates from Admission (17.3.5.1)

18.4.3.3.11 *Highest Education Level Completed* – Read-Only – Populates from Admission (17.3.3.23)

18.4.3.3.12 *Primary Income Src* – Editable – Populates from Admission (17.3.5.10)

18.4.3.3.13 *Expected Payment Src* – Editable – Populates from Admission (17.3.5.11)

18.4.3.3.14 *Health Insurance* – Editable – Populates from Admission (17.3.5.12)

18.4.3.3.15 *Drug Type* (Primary, Secondary, and Tertiary) – Read-Only – Populates from Admission (17.3.9.1)

18.4.3.3.16 *Detailed Drug* (Primary, Secondary, and Tertiary) – Read-Only – Populates from Admission (17.3.9.5)

18.4.3.3.16.1 In a Mental Health domain enrollment, these fields will be blank.

18.4.3.3.17 *Freq of Use* (Primary, Secondary, and Tertiary) – Read-Only – Populates from Admission (17.3.9.3)

18.4.3.3.18 *Route of Intake* (Primary, Secondary, and Tertiary) – Read-Only – Populates from Admission (17.3.9.4)

18.4.3.3.19 *Age of First Use* (Primary, Secondary, and Tertiary) – Read-Only – Populates from Admission (17.3.9.6)

18.4.3.3.19.1 In a Mental Health domain enrollment, these fields will be blank.

18.4.4 Confirm that the correct program was selected in the Program Name field (18.4.2.2).

18.4.4.1 The Program Name field cannot be edited after the Program Enrollment has been saved.

18.4.4.2 If an incorrect program was selected, change it now.

18.4.5 When all of the required fields have been filled, click Save.

18.4.6 To enroll the client in another program, click the "Enroll in Concurrent Program" link in the Actions bar.

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18.4.7 When all Program Enrollment records are complete, click Finish to return to the Program Enrollment list.

18.5 Clients can be enrolled in programs at facilities other than the context facility.

18.5.1 Users who have access to multiple facilities will see the names of those facilities in the Facility field (18.4.2.1).

18.5.2 Selecting a facility other than the context facility will change the list of available programs (18.4.2.2) to those of the selected facility.

18.5.3 Enroll clients in programs at other facilities (following steps 18.4 through 18.4.7) only if the programs are the only aspects of treatment that the client will receive from the other facility, only if all encounter records related to those programs will be created in the context facility, and only if the appropriate release-of-information consents are in place.

18.5.3.1 WARNING: Enrolling clients in programs managed by other facilities is a simple process that can cause complex errors and additional difficulty, and, as such, it should be used rarely and with caution.

18.5.4 OWITS users at the selected other facility may be able to see the client's profile, but they will not be able to see the client's program enrollment or any other records.

18.5.4.1 Users with access to multiple facilities including the context facility will be able to access the client's records.

18.5.4.2 Client records can be shared across facilities using the Consent module (see OWITS Reference Manual, Volume 8, Consent and Referrals).

18.5.5 The client must be disenrolled from the program in the context facility's records (see OWITS Reference Manual, Volume 9: Client Discharge).

18.5.6 This process allows clients to enroll in programs across domains without having separate treatment records.

18.5.6.1 Example: A client in a mental health facility can enroll in a substance abuse program.

18.5.6.2 Example: A client in a substance abuse facility can enroll in a mental health program.

18.5.6.3 Agencies must individually determine when a client should enroll in programs across facilities and when a client must complete the full intake, admission, and enrollment process in multiple facilities.

18.5.6.3.1 This decision may be based on location (a client who lives in Medford is not likely to enroll in programs at a Eugene facility).

18.5.6.3.2 This decision may be based on client need (a client receiving mental health treatment who wants to stop smoking may enroll across facilities for a smoking cessation program while a client in substance abuse treatment who is diagnosed with a mental illness or personality disorder may need separate treatment records in multiple facilities).

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18.5.6.3.3 It is generally recommended that clients should enroll only in programs offered by the context facility and admitted separately (with Intake and Admission records) for programs at other facilities.

18.6 If the client was incorrectly enrolled into a non-TEDS program, the enrollment record can be deleted.

18.6.1 Navigate to the Program Enrollment list (18.3.1).

18.6.2 Identify the erroneous program enrollment in the list.

18.6.2.1 In the Actions column, click "Review" to see details.

18.6.2.2 Click Cancel or Finish to return to the Program Enrollment list.

18.6.3 Click the "Delete" link in the Actions column.

18.6.3.1 OWITS will confirm the delete command.

18.6.3.2 The selected enrollment will be deleted.

18.6.3.2.1 A program enrollment cannot be deleted if it is for a program that reports TEDS and/or NOMS data (see 18.4.2.2.2.2).

18.6.3.2.2 If a client is incorrectly enrolled in a program that reports TEDS or NOMS data, the client must be administratively disenrolled from the program.

18.6.3.2.3 For details on disenrolling clients from programs, see OWITS Reference Manual, Volume 9: Client Discharge.

18.6.3.3 This action cannot be undone.

18.7 On the Program Enrollment list screen, click Finish to return to the Activity List.

18.8 Some nuisance errors and troubleshooting can be avoided by updating the client's entry on Group Rosters (see OWITS Reference Manual, Volume 7: Groups and Group Notes) immediately after completing or modifying the client's Program Enrollment records.

19.0 Problem List

19.1 Use of the Problem List module is optional.

19.2 This module serves as a repository for all DSM-IV diagnoses applied to the client's record for the current episode.

19.2.1 Diagnoses are captured in several other modules, including the Admission series (17.0) and most of the Assessments (16.0).

19.2.2 Diagnoses captured on the Diagnosis screens in those modules are copied to this module and displayed.

19.2.3 This copy-and-display process is automatic.

19.3 Using the Navigation View, navigate to Client List > Activity List > Problem List.

19.4 The Problem List table will display.

19.4.1 This list can be filtered by the status of the diagnosis using the Status field above.

19.4.1.1 Select the desired status.

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19.4.1.2 Click Go.

19.4.2 All diagnoses are identified as "Active" status (19.6.3.2.2) when copied from other modules.

19.4.3 The status for each diagnosis can be changed using this module (19.6.3.2).

19.5 The table will show the diagnosis, the date it was added to the client's record, the date it no longer applied to the client (if applicable), and the original source.

19.5.1 The Effective Date Range column will show only the date the diagnosis was added to the client's record unless an expiration date has also been added in this module (19.6.3.4).

19.5.2 The Original Source column names the module from which the diagnosis was collected.

19.6 Add new diagnoses as needed.

19.6.1 Click the "Add New" link in the Problem List heading.

19.6.2 The Problem Profile section at the bottom of the screen will become available.

19.6.3 The Problem Profile section includes the following fields:

19.6.3.1 *Diagnosis*

19.6.3.1.1 Select the diagnosis that will be applied to the client's record.

19.6.3.1.2 Diagnoses include DSM-IV codes and are sorted alphabetically.

19.6.3.1.3 A spreadsheet that can be used for sorting and filtering diagnosis codes can be found on the OWITS Forum (http://owits.boards.net).

19.6.3.2 *Status*

19.6.3.2.1 Select the option that best describes the current state of the diagnosis.

19.6.3.2.2 "Active" indicates a diagnosis that currently applies to the client and/or the client's current situation.

19.6.3.2.3 "Inactive" indicates a diagnosis that has applied to the client and/or the client's situation in the past, does not currently apply, but may apply again in the future.

19.6.3.2.3.1 This status requires an expiration date (19.6.3.4).

19.6.3.2.3.2 Example: Alcohol Dependence might be an inactive diagnosis for a client who is not currently drinking but has the potential to relapse.

19.6.3.2.3.3 Example: Bipolar Disorder might be an inactive diagnosis for a client who has felt "normal" (has not experienced a manic or depressive episode) for a longer duration than expected.

19.6.3.2.4 "Resolved" indicates a diagnosis that was applied to the client and/or the client's situation but that no longer applies and is not expected to return.

19.6.3.2.4.1 This status requires an expiration date (19.6.3.4).

19.6.3.2.4.2 Example: Caffeine-Induced Anxiety Disorder might be a resolved diagnosis for a client who has significantly restricted or ceased all caffeine consumption.

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19.6.3.2.4.3 Example: A client with a situational anxiety disorder (such as social phobias) might have a resolved diagnosis if he or she has developed effective coping strategies and no longer experiences significant distress as a result of the disorder.

19.6.3.2.5 The diagnosis status can be updated as needed.

19.6.3.3 *Effective Date*

19.6.3.3.1 Enter the date on which the diagnosis first or most recently applied to the client and/or the client's situation.

19.6.3.4 *Expiration Date*

19.6.3.4.1 Do not enter a date into this field or modify an existing date in this field when adding a new diagnosis with an "Active" status (19.6.3.2.2).

19.6.3.4.2 Entering a date into this field with "Active" in the Status field (19.6.3.2) and clicking Save or Finish will produce an error message stating "Expiration Date should be null."

19.6.3.4.3 This field is used with the "void" function (19.8) and with the "Inactive" and "Resolved" statuses.

19.6.3.4.4 The functionality of this field is further explained in 19.7.

19.6.3.5 *Original Source*

19.6.3.5.1 This read-only field will automatically populate with "Diagnosis List," indicating that this diagnosis was manually entered and is independent of all other OWITS modules.

19.6.3.5.2 To enter a diagnosis with a different Original Source value, use the Diagnosis screens in the other modules, such as the Admission series (17.0) or the Behavioral Health Assessment (see OWITS Reference Manual, Volume 6: Screenings and Assessments).

19.6.3.6 *Determined By*

19.6.3.6.1 Select the name of the staff member who is responsible for adding this diagnosis to the client's record.

19.6.3.6.2 This field will automatically populate with the name of the current user.

19.6.3.6.3 The names available in this field will be the staff members assigned to the current facility.

19.6.3.6.4 If the diagnosis was ordered by someone other than a staff member, such as a non-staff physician or a collateral contact, select the name of the staff member who was given the instructions to add the diagnosis.

19.6.3.7 *Created By*

19.6.3.7.1 This field will automatically populate with the name of the user who created this record.

19.6.3.8 *Created Date*

19.6.3.8.1 This field will automatically populate with the date on which this record was created and saved.

19.6.3.9 *Updated By*

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19.6.3.9.1 This field will automatically populate with the name of the user who most recently modified this record.

19.6.3.10 *Updated Date*

19.6.3.10.1 This field will automatically populate with the date on which this record was most recently modified.

19.6.3.11 *Comments*

19.6.3.11.1 Enter any additional information relevant to this diagnosis.

19.6.3.11.2 This may include the name of the person who identified the diagnosis if that person's name was not available in the Determined By field (19.6.3.6).

19.6.3.11.3 This may include the diagnostic criteria used to identify the diagnosis.

19.6.4 Click Save.

19.6.5 Click Finish to apply the diagnosis to the Problem List table above.

19.6.5.1 The Problem List table will not update until the Finish button is clicked.

19.7 Modify existing diagnoses as needed.

19.7.1 Click the "Review" link in the Actions column of the desired diagnosis.

19.7.2 Diagnoses with a value in the Original Source field other than "Diagnosis List" allow the following fields to be edited:

19.7.2.1 *Status*

19.7.2.2 *Expiration Date*

19.7.2.2.1 Do not enter a date into this field when modifying a diagnosis unless also changing the Status field to "Inactive" (19.6.3.2.3) or "Resolved" (19.6.3.2.4).

19.7.2.2.2 If adding an expiration date to an "Inactive" or "Resolved" diagnosis, click Save and Finish only after all desired changes have been made.

19.7.2.3 *Comments*

19.7.3 Diagnoses with "Diagnosis List" in the Original Source field allow the following fields to be edited:

19.7.3.1 *Diagnosis*

19.7.3.2 *Status*

19.7.3.3 *Effective Date*

19.7.3.4 *Expiration Date*

19.7.3.4.1 Do not enter a date into this field when modifying a diagnosis unless also changing the Status field to "Inactive" (19.6.3.2.3) or "Resolved" (19.6.3.2.4).

19.7.3.4.2 If adding an expiration date to an "Inactive" or "Resolved" diagnosis, click Save and Finish only after all desired changes have been made.

19.7.3.5 *Determined By*

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19.7.3.6 *Comments*

19.7.4 When the diagnosis data has been updated as needed, click Save.

19.7.5 Click Finish to apply the diagnosis to the Problem List table above.

19.7.5.1 The Problem List table will not update until the Finish button is clicked.

19.8 Mark invalid diagnoses as "void."

19.8.1 Click the "Review" link in the Actions column of the desired diagnosis.

19.8.2 Enter the current date into the Expiration Date field (19.6.3.4).

19.8.2.1 Any past date entered into this field will be replaced with the current date at the end of the void process.

19.8.3 Click the "Void" link in the Administrative Actions box at the bottom of the screen.

19.8.3.1 Do not click Save or Finish.

19.8.3.2 Clicking Save or Finish will not allow a void reason to be added and may produce an error message.

19.8.4 The "Client Problem Void Reason" screen will display with the following fields:

19.8.4.1 *Void Reason*

19.8.4.1.1 Enter the reason for marking this diagnosis void.

19.8.4.1.2 This may include misdiagnoses, such as a child with Asperger's Syndrome mistakenly diagnosed as schizophrenic.

19.8.4.1.3 This may include inaccurate diagnoses, such as a general diagnosis of Alcohol Intoxication Delirium for a client whose condition could be further specified as Alcohol-Induced Psychotic Disorder with Hallucinations.

19.8.4.1.4 This may include diagnoses that are no longer relevant to the client, such as "Housing Problems" if the client obtains stable housing that is expected to remain stable for an extended period of time.

19.8.4.1.5 This field may also include the name of the person who determined that the void was necessary if his or her name is not available in the Determined By field below (19.8.4.2).

19.8.4.2 *Determined By*

19.8.4.2.1 Select the name of the staff member who is responsible for voiding this diagnosis from the client's record.

19.8.4.2.2 This field will automatically populate with the name of the current user.

19.8.4.2.3 The names available in this field will be the staff members assigned to the current facility.

19.8.4.2.4 If the void (or cancellation or expiration) was ordered by someone other than a staff member, such as a non-staff physician or a collateral contact, select the name of the staff member who was given the instructions to void the diagnosis.

19.8.5 Click Yes to return to the Problem List and Problem Profile screen.

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19.8.5.1 CAUTION: Clicking Yes on this screen completes the void process, which cannot be undone.

19.8.5.2 The Yes button functions as the Save or Finish button would on other screens.

19.8.5.3 The No button functions as the Cancel button would on other screens.

19.8.6 The Problem Profile fields will all become read-only.

19.8.6.1 The Expiration Date field will display the current date.

19.8.7 Click Finish.

19.8.7.1 CAUTION: Clicking Cancel will *not* undo void action.

19.8.7.2 In this case, clicking Cancel is the same as clicking Finish.

19.8.8 A voided diagnosis will remain on the client's record but will display in the Problem List module with an expiration date and a "Voided" status.

19.8.9 If a diagnosis was voided in error, it must be re-entered as a new diagnosis, though a past date may be entered for the Effective Date (19.6.3.3) if necessary.

19.9 Generate HL7 text for individual diagnoses as needed.

19.9.1 Click the "Review" link in the Actions column of the desired diagnosis.

19.9.2 Click the "Generate HL7" link below the Comments field.

19.9.3 HL7 text will display in the large read-only (gray) box below the Comments field.

19.9.3.1 HL7 refers to the non-profit organization Health Level Seven International.

19.9.3.2 The "Generate HL7" link creates text that conforms to the standards and protocol developed by Health Level Seven International for communicating diagnosis information with other HL7-compliant healthcare record systems.

19.9.4 Copy the HL7 text from OWITS and paste it into other programs as needed.

19.9.4.1 Highlight the text in the gray box.

19.9.4.2 Press CTRL+C or right-click and select "Copy" from the menu.

19.9.4.3 Switch to the desired program into which this text will be copied.

19.9.4.4 Press CTRL+V or right-click and select "Paste" from the menu.

19.9.5 Click Cancel or Finish when finished.

19.9.6 The HL7 text will remain until a different diagnosis is reviewed.

19.10 Return to the Activity List or other modules using the Navigation View links.

20.0 Encounters

20.1 Use of the Encounters module is required.

20.2 Encounter notes are used to record and (if applicable) bill for specific instances of services or treatment provided to individual clients, such as assessments, counseling sessions, medication administration, and so on.

20.3 A client must be enrolled in a program for an encounter record to be created.

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20.3.1 Encounters cannot be created for clients who have not been enrolled in a program during the current episode.

20.3.2 Encounters can be created for clients who have been previously enrolled in a program (or programs) during the current episode, but the encounter's start date (20.5.3.9) must be on or after the enrollment date (18.4.2.5) of the selected program (20.5.3.5), and the encounter's end date (20.5.3.10) must be on or before the end date (18.4.2.6) of the selected program.

20.4 In the Navigation View, navigate to Client List > Activity List > Encounters.

20.5 Create a new Encounter record when specific instances of treatment or services have been provided to the client.

20.5.1 Click the "Add Encounter Record" in the Encounter List heading.

20.5.1.1 Encounters can also be created by navigating to Client List > Activity List > Notes and clicking the "Add New Encounter Note" link in the Notes List heading.

20.5.2 Encounters consist of a series of three screens.

20.5.3 The Profile screen consists of the following fields:

20.5.3.1 *Note Type*

20.5.3.1.1 Select the option that best describes the purpose for creating this encounter.

20.5.3.1.2 Example: "Case Management Note" may be used for evaluative services such as assessments and screenings.

20.5.3.1.3 Example: "Medication Administration Progress Note" may be used for services that include the administration or prescription of medication or other treatment of a medical nature.

20.5.3.1.4 Example: "Progress Notes" may be used for services related to the client's progression toward recovery, such as therapy, counseling, and group sessions.

20.5.3.1.5 Agencies and facilities must individually determine which note types are to be used in certain situations.

20.5.3.2 *ENC ID*

20.5.3.2.1 This field will automatically populate with a number that OWITS will use internally to identify the encounter note.

20.5.3.3 *Created Date*

20.5.3.3.1 This field will automatically populate with the date on which this record was created and saved.

20.5.3.4 *Service*

20.5.3.4.1 Select the option that best describes the service that was rendered to the client.

20.5.3.4.2 Service descriptions also include procedure codes as defined in the Medicaid Procedure Codes and Reimbursement Rates documentation

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(located under the "Mental Health" and "Chemical Dependency" headings here: http://www.oregon.gov/oha/amh/Pages/tools-providers.aspx).

20.5.3.4.3 Carefully read the details of the service descriptions to ensure the correct option is selected.

20.5.3.4.4 Entering a Start Date 20.5.3.9 prior to selecting a Service will ensure that any service codes that were not valid on the date of the encounter will not be visible in the drop-down menu.

20.5.3.5 *Program Name*

20.5.3.5.1 Select the name of the program in which or for which the selected service was rendered.

20.5.3.5.2 The encounter record must be associated with a program enrollment (see 20.3).

20.5.3.5.3 If the service was not part of a specific program, or if the service could be considered part of multiple programs, select the name of the program with which the selected service best fits.

20.5.3.6 *Service Location*

20.5.3.6.1 Select the option that best describes where the service was rendered.

20.5.3.6.2 This field will automatically populate with the service location selected in the profile of the context facility (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

20.5.3.7 *Emergency*

20.5.3.7.1 Indicate whether this service was rendered in an emergency situation.

20.5.3.7.2 Individual agencies and facilities must determine the criteria by which a situation is considered an emergency.

20.5.3.8 *Pregnant*

20.5.3.8.1 Indicate whether the client was pregnant at the time of service.

20.5.3.8.2 This field may automatically populate based on the client's sex and/or based on the option selected in the "Pregnant" field on the Intake screen (7.4.10).

20.5.3.8.3 For male clients, this field may be read-only.

20.5.3.9 *Start Date*

20.5.3.9.1 Enter the date on which the service was rendered.

20.5.3.9.2 If the service spanned multiple dates (including overnight), enter the date on which the service started.

20.5.3.10 *End Date*

20.5.3.10.1 Enter the date on which the service was concluded.

20.5.3.10.2 If the service began and ended on the same day, this date must match the Start Date.

20.5.3.11 *Start Time*

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20.5.3.11.1 Enter the time of day at which the service was started.

20.5.3.11.2 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

20.5.3.11.3 Example: 08:30 AM

20.5.3.11.4 Example: 03:25 PM

20.5.3.11.5 Example: 1630

20.5.3.12 *End Time*

20.5.3.12.1 Enter the time of day at which the service was concluded.

20.5.3.12.2 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

20.5.3.12.3 Example: 08:30 AM

20.5.3.12.4 Example: 03:25 PM

20.5.3.12.5 Example: 1630

20.5.3.13 *Duration*

20.5.3.13.1 In the first field, enter a number that can be used to describe the amount of time between the service Start Date or Start Time and the service End Date or End Time.

20.5.3.13.2 In the second field, select the unit of measure that fits with the number entered in the first field.

20.5.3.13.3 Example: If the client received a five-hour assessment, enter 5 in the first Duration field and select Hrs in the second Duration field.

20.5.3.14 *Number of Service Units / Sessions*

20.5.3.14.1 Enter a number that represents the number of individual services rendered during this encounter that match the option selected in the Service field (20.5.3.4) above.

20.5.3.14.2 Example: Because acupuncture sessions are measured in fifteen-minute increments, if a client received 45-minute acupuncture therapy session, then the user creating the Encounter Profile would enter a value of 3 in this field (45 ÷ 15 = 3).

20.5.3.15 *Diagnoses for this Service*

20.5.3.15.1 In the Primary, Secondary, and Tertiary fields, select the diagnoses of the client's problem(s).

20.5.3.15.2 These fields will automatically populate based on data entered in the Admission series (17.3.20), but they can be changed if necessary.

20.5.3.15.3 A spreadsheet that can be used for sorting and filtering diagnosis codes can be found on the OWITS Forum (http://owits.boards.net).

20.5.3.16 *Rendering Staff*

20.5.3.16.1 This field will automatically populate with the name of the current user.

20.5.3.16.2 Change this field to the name of the person who provided the service to the client only if that person is not the current user.

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20.5.3.16.3 If multiple people provided the service to the client, select the name of the person who provided the majority of the service or the person who has the responsibility for providing the selected service.

20.5.3.16.4 Because some services are required to be rendered by staff members who possess specific credentials, it may be necessary to ensure that the staff member's profile includes those credentials (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

20.5.3.17 *Supervising Staff*

20.5.3.17.1 If applicable, select the name of the person supervising the service delivery.

20.5.3.18 *Referring Physician*

20.5.3.18.1 If applicable, select the name of the physician associated with this service.

20.5.3.18.2 The names available in this field will be the names of physicians entered into the Non-Staff Physician section of the agency record (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

20.5.3.19 *Unsigned Notes*

20.5.3.19.1 Enter any desired information that will be applied to this encounter record.

20.5.3.19.2 This may include a narrative description, list, or other text that details the activity or services related to this note record and the client's response.

20.5.3.19.3 If additional prompts are necessary for the note details, leave this field blank and use the Add Note function instead (20.5.4).

20.5.3.19.4 If this field is sufficient for the note details, click the Sign Note button in the lower right corner to move the contents of this field to the Signed Notes field (20.5.3.20) and apply an electronic signature.

20.5.3.20 *Signed Notes*

20.5.3.20.1 Signed notes are notes that have been entered into the Unsigned Notes field (20.5.3.19) and electronically signed.

20.5.3.20.2 Signed notes cannot be edited or deleted.

20.5.3.20.3 Signatures will include the user's professional credentials.

20.5.3.20.4 Because some services are required to be rendered by staff members who possess specific credentials, it may be necessary to ensure that the staff member's profile includes those credentials (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

20.5.3.21 *Allow disclosure?*

20.5.3.21.1 OWITS will allow or prevent the sharing of this note based on the option selected in this field.

20.5.3.21.2 Select "No" to indicate that this note cannot be shared with other organizations.

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20.5.3.21.3 Select "Yes" to indicate that this note can be shared with other agencies, facilities, or organizations as part of the consent (29.0) and referral (30.0) processes.

20.5.3.21.3.1 Selecting "Yes" will not automatically share this information.

20.5.3.21.4 For details regarding the consent and referral processes and regarding sharing client information, see OWITS Reference Manual, Volume 8: Consent and Referrals.

20.5.4 Enter additional notes in a template as needed.

20.5.4.1 Click the Add Note button below the Unsigned Notes field.

20.5.4.2 The Append Encounter Notes screen will display.

20.5.4.3 In the Append Notes field, template text will display, prompting for specific clinical, treatment, or service information.

20.5.4.3.1 The template text is determined by the selection in the Note Type field (20.5.3.1).

20.5.4.3.2 If the incorrect template text is displayed, click Cancel to return to the Encounter Profile screen and select a different Note Type.

20.5.4.3.3 Not all Note Types have template text.

20.5.4.3.4 Additional note templates can be requested by sending the desired text to owits.support@state.or.us.

20.5.4.4 Add to this text as appropriate.

20.5.4.5 Click Finish to copy the text in this field to the Unsigned Notes field on the Encounter Profile screen (20.5.3.19).

20.5.4.5.1 If the Append Notes field is left blank, clicking Finish will produce an error message.

20.5.4.5.2 If the template text in the Append Notes field has not been changed or added to, clicking Finish will produce an error message.

20.5.4.6 Click the Sign Note button below the Unsigned Notes field to move the contents of this field to the Signed Notes field (20.5.3.20) and apply an electronic signature.

20.5.4.6.1 It is possible to save the Encounter Profile without signing the notes.

20.5.4.6.2 Some users may enter the notes and save the record for supervisors, clinicians, or other users to open and sign at a later time.

20.5.5 Click Save.

20.5.5.1 The encounter will be applied to the client's record.

20.5.6 When all the required fields (and others, if possible) are filled, click the Right Arrow to advance to the Encounter Note screen.

20.5.6.1 Goals (23.4.8.1.2), Objectives (23.4.8.1.3), and Interventions (23.4.8.1.4) from the client's treatment plan can be added to the encounter note if needed.

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20.5.6.2 The listed goals, objectives, and interventions are populated from all active and signed-off treatment plans (see 23.6) that are effective on or after the encounter's start date (20.5.3.9).

20.5.6.3 To include goals in the encounter note, click the "Add Goals" link in the Associated Goals heading.

20.5.6.3.1 A list of existing goals will display.

20.5.6.3.2 Place a check mark in the white box in the first column next to the goals that will be associated with the planned service.

20.5.6.3.3 Placing a check mark in the white box in the header row of this table will place a check mark in all of the boxes below it.

20.5.6.3.4 Removing a check mark from the white box in the header row of this table will remove all check marks below it.

20.5.6.3.5 When all desired goals have been selected, click Finish to return to the Encounter Notes screen.

20.5.6.4 To include objectives in the encounter note, click the "Add Objectives" link in the Associated Objectives heading.

20.5.6.4.1 A list of existing objectives will display.

20.5.6.4.2 Place a check mark in the white box in the first column next to the objectives that will be associated with the planned service.

20.5.6.4.3 Placing a check mark in the white box in the header row of this table will place a check mark in all of the boxes below it.

20.5.6.4.4 Removing a check mark from the white box in the header row of this table will remove all check marks below it.

20.5.6.4.5 When all desired objectives have been selected, click Finish to return to the Encounter Notes screen.

20.5.6.5 To include interventions in the encounter note, click the "Add Interventions" link in the Associated Interventions heading.

20.5.6.5.1 A list of existing interventions will display.

20.5.6.5.2 Place a check mark in the white box in the first column next to the interventions that will be associated with the planned service.

20.5.6.5.3 Placing a check mark in the white box in the header row of this table will place a check mark in all of the boxes below it.

20.5.6.5.4 Removing a check mark from the white box in the header row of this table will remove all check marks below it.

20.5.6.5.5 When all desired interventions have been selected, click Finish to return to the Encounter Notes screen.

20.5.6.6 In the Goal Progress field at the top of the screen, select the option that best describes the client's current overall progress toward the achievement of the goals in the Associated Goals table.

20.5.7 When the Encounter Notes are completed, click Save.

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20.5.8 Click the Right Arrow to advance to the Ancillary Services screen, which consists of the following fields:

20.5.8.1 *Ancillary Services*

20.5.8.1.1 Use these option transfer boxes to select any additional services the client received along with or directly connected to the service selected in the Encounter Profile screen.

20.5.8.2 *Medications*

20.5.8.2.1 Use these option transfer boxes to select any medications administered to the client as a part of or directly associated with the service selected in the Encounter Profile screen.

20.5.8.2.2 After selecting a medication in the left box but before moving it to the right box, also select an option in the Frequency field to indicate how often the patient received the selected medication.

20.5.8.2.3 All medications listed in this field can also be recorded in more detail using the Medications section of the Treatment module (25.0).

20.5.9 When the Ancillary Services record is completed, click Save.

20.5.10 Click Finish to return to the Encounter List screen.

20.6 Search and review existing encounters.

20.6.1 On the Encounter List screen, existing encounter notes can be searched and reviewed.

20.6.2 In the Start Date and End Date fields at the top of the screen, enter the range of dates on which the desired encounters were entered.

20.6.2.1 These dates default to a range that will show encounters entered in the most recent year (365 days).

20.6.2.2 Click Go to execute the search.

20.6.2.3 Click Clear to remove dates from the fields.

20.6.3 Encounter records matching the search criteria will display in the Encounter List table.

20.6.4 To see the details of an encounter, click the "Review" link in the Actions column of the desired record.

20.6.5 Additional details can be added to encounter notes until they are released to billing (see 20.7).

20.6.5.1 See 20.5.3.19 for instructions on entering unformatted notes.

20.6.5.2 See 20.5.4 for instructions on entering notes based on templates.

20.6.5.3 Click Finish to return to the Miscellaneous Notes List screen.

20.7 When an Encounter record is complete, it can be released and billed.

20.7.1 Navigate to the Encounters screen.

20.7.2 Locate the desired Encounter record.

20.7.3 Click the "Review" link in the Actions column to view the Encounter Profile.

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20.7.4 Verify that the Encounter record is complete.

20.7.4.1 All yellow (required) fields must be filled.

20.7.4.2 White (not required) fields should also be filled, if applicable.

20.7.5 Click the "Release to Billing" link in the Actions box.

20.7.6 The Release to Billing screen will display.

20.7.6.1 Complete the fields on this screen as appropriate and click Finish.

20.7.7 Encounters cannot be edited, modified, or deleted after they have been released unless they are rejected from the billing claim lists.

20.7.8 For detailed instructions regarding releasing encounters to billing and the rest of the release and billing processes, see OWITS Reference Manual, Volume 11: Billing.

20.8 Generate a printer-friendly version of the encounter record as needed.

20.8.1 From the Encounters List screen, locate the desired Encounter record.

20.8.2 Click the "Review" link in the Actions column of the desired record to view the Encounter Profile.

20.8.3 On any one of the three screens that comprise the encounter, click the "Generate Report" icon at the top of the screen.

20.8.3.1 A pop-up browser window will open.

20.8.3.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

20.8.3.2 The pop-up window will display all of the data fields from all screens in the Admission series, including lines for a staff member's signature and credentials along with a signature date.

20.8.3.3 This text can be printed using the Internet Explorer printing functions.

20.8.4 Close the pop-up window when finished.

20.8.5 Click Finish to return to the Encounter List screen.

20.9 Some users may have the ability to delete encounters that have not been released to billing.

20.9.1 From the Encounters List screen, locate the desired Encounter record.

20.9.2 Click the "Review" link in the Actions column to view the Encounter Profile.

20.9.3 Click the "Delete" link in the Administrative Actions box near the bottom of the screen.

20.9.3.1 OWITS will confirm the delete command.

20.9.3.2 The encounter record will be deleted.

20.9.3.3 This action cannot be undone.

20.10 All encounters recorded for a single client can be viewed at once (see 22.8.3).

20.11 Return to the Activity List or other modules using the Navigation View links.

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21.0 Immunization

21.1 Use of the Immunization module is optional.

21.2 The options available in the fields in this module were customized for OWITS use.

21.2.1 The names of vaccines (21.7.1.1) were collected from the CDC's website.

21.2.2 The names of vaccine manufacturers (21.7.1.6) were collected from the CDC's website.

21.2.3 The measurements of vaccine amounts administered (21.7.1.2) were collected from Health Level Seven International's website.

21.2.4 To suggest values that should be added to these fields or changes that should be applied to existing values, please send an email with the suggested field contents to owits.support@state.or.us.

21.3 This module is used as an immunization record for clients in treatment.

21.3.1 Because OWITS is not a medical electronic health record, this section is minimal and should be used for reference purposes only.

21.3.2 This module is facility and episode specific, and data entered here will not be copied to other facilities or episodes.

21.4 In the Navigation View, navigate to Client List > Activity List > Immunization.

21.5 The Immunization screen will display.

21.6 Immunization records will appear in the Immunization List table.

21.7 To add an immunization record, click the "Add" link in the Immunization List heading.

21.7.1 In the Immunization Profile section below, complete the following fields:

21.7.1.1 *Vaccine Name*

21.7.1.1.1 Select the name of the vaccine that the client received.

21.7.1.1.2 Vaccines are sorted alphabetically.

21.7.1.1.3 Most listed vaccines include specific formulations as recorded and identified by the CDC.

21.7.1.1.4 If multiple options are available and if the formulation of the vaccine is unknown, select the option that includes the name of the vaccine followed by the word "unspecified" in parentheses.

21.7.1.2 *Administered Units*

21.7.1.2.1 Select the measurement that best describes how the volume of the vaccine is measured.

21.7.1.2.2 Values in this drop-down menu come from the list of the Unified Code for Units of Measure codes established by the Regenstrief Institute and the UCUM Organization.

21.7.1.2.3 Most codes are metric, such as *mL* for milliliters, *ug* for migrograms, etc.

21.7.1.3 *Administered Amount*

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21.7.1.3.1 Enter a number that indicates the amount of vaccine administered as related to the measurement selected in the Administered Units field above (21.7.1.2).

21.7.1.3.2 OWITS will accept values with up to two decimal spaces.

21.7.1.3.3 OWITS will round decimals beyond two decimal places to the nearest hundredth.

21.7.1.3.4 Example: If the client received five milliliters of vaccine, select "mL" in the Administered Units field and enter "5" in the Administered Amount field.

21.7.1.4 *Vaccine Lot Number*

21.7.1.4.1 If available, enter the lot number from which the vaccine was prepared.

21.7.1.5 *CVX*

21.7.1.5.1 This field will automatically populate with the CVX (Vaccine Administered) code associated with the vaccine selected in the Vaccine Name field (21.7.1.1).

21.7.1.6 *Manufacturer Name*

21.7.1.6.1 Select the name of the manufacturer of the vaccine.

21.7.1.6.2 This field specifies the name of the manufacturer of the vaccine substance itself, not any of the containers in which it is stored or shipped or any of the devices through which it is administered to a client.

21.7.1.7 *Vaccination Date*

21.7.1.7.1 Enter the date on which the vaccination was administered.

21.7.1.7.2 This date can be estimated.

21.7.1.7.3 This date cannot be in the future.

21.7.1.8 *Vaccination Time*

21.7.1.8.1 Enter the time of day at which the vaccination was administered.

21.7.1.8.2 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

21.7.1.8.3 Example: 08:30 AM

21.7.1.8.4 Example: 03:25 PM

21.7.1.8.5 Example: 1630

21.7.1.9 *Created By*

21.7.1.9.1 This field will automatically populate with the name of the user who created this record.

21.7.1.10 *Created Date*

21.7.1.10.1 This field will automatically populate with the date on which this record was created and saved.

21.7.1.11 *Updated By*

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21.7.1.11.1 This field will automatically populate with the name of the user who most recently modified this record.

21.7.1.12 *Updated Date*

21.7.1.12.1 This field will automatically populate with the date on which this record was most recently modified.

21.7.1.13 *Comments*

21.7.1.13.1 Enter any additional information relevant to the vaccination.

21.7.1.13.2 This may include the client's age at the time of vaccination.

21.7.1.13.3 This may include the location at which the vaccine was administered.

21.7.1.13.4 This may include any physiological reaction exhibited by the client in response to the vaccination.

21.7.2 Click Save to save the data added to the Immunization Profile.

21.7.3 Click Finish to apply the record to the Immunization List table above (21.6).

21.8 To modify existing immunization records, click the "Review" link in the Actions column of the Immunization List table for the desired immunization.

21.8.1 In the Immunization Profile section, modify the available data fields as needed.

21.8.2 Click Save to save the changes in the Immunization Profile.

21.8.3 Click Finish to apply the changes to the record in the Immunization List table above.

21.9 To delete existing immunization records, click the "Delete" link in the Actions column of the Immunization List table for the desired immunization.

21.9.1 OWITS will confirm the delete command.

21.9.2 The selected immunization record will be deleted.

21.9.3 This action cannot be undone.

21.10 Generate HL7 text for individual immunization records as needed.

21.10.1 Click the "Review" link in the Actions column of the desired immunization.

21.10.2 Click the "Generate HL7" link below the Comments field.

21.10.3 HL7 text will display in the large read-only (gray) box below the Comments field.

21.10.3.1 HL7 refers to the non-profit organization Health Level Seven International.

21.10.3.2 The "Generate HL7" link creates text that conforms to the standards and protocol developed by Health Level Seven International for communicating immunization information with other HL7-compliant healthcare record systems.

21.10.4 Copy the HL7 text from OWITS and paste it into other programs as needed.

21.10.4.1 Highlight the text in the gray box.

21.10.4.2 Press CTRL+C or right-click and select "Copy" from the menu.

21.10.4.3 Switch to the desired program into which this text will be copied.

21.10.4.4 Press CTRL+V or right-click and select "Paste" from the menu.

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21.10.5 Click Cancel or Finish when finished.

21.10.6 The HL7 text will remain until a different immunization is reviewed.

21.11 Use the Navigation View links to return to the Activity List or to navigate to other records.

22.0 Notes

22.1 Use of the Notes module is recommended for most agencies.

22.2 Provider agencies may use a program or a note to report ITRS clients.

22.2.1 For instructions on using the program option, see 18.3 and OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records.

22.2.2 To use the note option to report ITRS clients, see 22.6.2.1.5 with special emphasis on 22.6.2.1.5.1.

22.3 The Notes module allows users to enter additional information about the client and his or her treatment that may or may not directly apply to other OWITS modules.

22.3.1 This module consists of Encounter Notes and Miscellaneous Notes.

22.3.2 Encounter Notes can also be entered and reviewed through the Encounters module (20.0).

22.3.3 Miscellaneous Notes include a variety of note types and templates.

22.4 In the Navigation View, navigate to Client List > Activity List > Notes

22.5 The Notes Search and Notes List screen will display.

22.5.1 This screen displays both encounter notes and miscellaneous notes.

22.5.2 To view and search a table of only miscellaneous notes, click the Misc. Notes subheading in the Navigation View.

22.6 Add records of miscellaneous notes as needed.

22.6.1 Click the "Add New Misc. Note" link in the Notes List heading.

22.6.2 The Miscellaneous Notes screen will display, which includes the following fields:

22.6.2.1 *Note Type*

22.6.2.1.1 Select the option that best describes the note to be entered about the client.

22.6.2.1.2 This selection will determine the template that may be used for entering this note (22.6.3).

22.6.2.1.3 Example: "Case Management Note" includes a note template that directs the user to specify a description of the service provided to the client and to describe how the client was assisted by the service(s) provided.

22.6.2.1.4 Example: "Contact Note" does not include a note template but is intended to record general contact with the client during and related to the treatment episode, such as phone calls and email messages.

22.6.2.1.5 Example: "ITRS" includes a note template asking for the date on which an ITRS-qualified client enrolled in an ITRS-qualified program, the date

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on which he or she disenrolled from that program, the services that were provided as a part of that program, and the reason why the client disenrolled from the program.

22.6.2.1.5.1 CAUTION: If using this note to track client participation in ITRS, do not click the Sign Note button (22.6.3.6) until the client has disenrolled from the ITRS treatment.

22.6.2.1.6 Example: "Medication Administration" includes a note template that prompts the user to indicate whether the client complied with directions in regards to receiving medication, what side effects appeared, and whether the medication appeared to be effective.

22.6.2.2 *Program*

22.6.2.2.1 If the client is currently enrolled in a program, and if this note is related to that program (or one of the programs if the client is concurrently enrolled in more than one), select that program in this field.

22.6.2.2.2 Program enrollment is not required for creating a miscellaneous note.

22.6.2.3 *Frequency*

22.6.2.3.1 Select the option that best describes any recurrence of the activity described in this note.

22.6.2.3.2 Select "Incidental" if the noted activity occurs only once.

22.6.2.3.3 If the noted activity occurs regularly, select "Daily," "Weekly," "Monthly," or "Quarterly," as appropriate.

22.6.2.3.4 Select "Tracking" if the noted activity occurs repeatedly but irregularly, and if this note will be updated with related information as the activity recurs.

22.6.2.4 *Service Date*

22.6.2.4.1 Enter the date on which the activity or service related to this note occurred.

22.6.2.4.2 This field will automatically populate with the current date.

22.6.2.5 *Start Time*

22.6.2.5.1 Enter the time of day at which the activity or service related to this note began.

22.6.2.5.2 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

22.6.2.5.3 Example: 08:30 AM

22.6.2.5.4 Example: 03:25 PM

22.6.2.5.5 Example: 1630

22.6.2.6 *End Time*

22.6.2.6.1 Enter the time of day at which the activity or service related to this note was concluded or otherwise ended.

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22.6.2.6.2 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

22.6.2.6.3 Example: 08:30 AM

22.6.2.6.4 Example: 03:25 PM

22.6.2.6.5 Example: 1630

22.6.2.7 *Duration*

22.6.2.7.1 In the first field, enter a number that can be used to describe the amount of time between the service Start Date or Start Time and the service End Date or End Time.

22.6.2.7.2 In the second field, select the unit of measure that fits with the number entered in the first field.

22.6.2.7.3 Example: If the client received a five-hour assessment, enter 5 in the first Duration field and select Hrs in the second Duration field.

22.6.2.8 *Alert*

22.6.2.8.1 To highlight this alert as requiring attention from other users and/or clinicians, click the "Mark Alert" link next to this field.

22.6.2.8.1.1 The screen will refresh, and "Yes" will appear in this field.

22.6.2.8.1.2 The line for this miscellaneous note will appear highlighted in pale yellow on the Notes List and the Miscellaneous Notes List screens.

22.6.2.8.1.3 The client's name will appear in red text on the Client List screen (see OWITS Reference Manual, Volume 4: Client Profile).

22.6.2.8.2 To discontinue the highlighting, click the "Remove Alert" link next to this field.

22.6.2.8.2.1 The screen will refresh, and "No" will appear in this field.

22.6.2.8.2.2 The added colorization to the note tables and to the Client List screen will be removed.

22.6.2.9 *Was Report Sent to State*

22.6.2.9.1 If applicable, indicate whether a crisis report related to this note was sent to AMH and/or the Oregon State Hospital.

22.6.2.10 *Summary*

22.6.2.10.1 Enter a name or brief summary of the note.

22.6.2.10.2 This can be considered the title of the note.

22.6.2.10.3 The first 30 characters (including spaces) entered in this field will display in the Summary column of the Miscellaneous Notes List table (Client List > Activity List > Notes > Misc. Notes) or the Service/Summary column of the Notes List table (Client List > Activity List > Notes).

22.6.2.11 *Signed Notes*

22.6.2.11.1 Signed notes are notes that have been entered into the Unsigned Notes field (22.6.2.12.1) and electronically signed.

22.6.2.11.2 Signed notes cannot be edited or deleted.

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22.6.2.12 *Release these notes?*

22.6.2.12.1 OWITS will allow or prevent the sharing of this note based on the option selected in this field.

22.6.2.12.2 Select "No" to indicate that this note cannot be shared with other organizations.

22.6.2.12.3 Select "Yes" to indicate that this note can be shared with other agencies, facilities, or organizations as part of the consent (29.0) and referral (30.0) processes.

22.6.2.12.3.1 Selecting "Yes" will not automatically share this information.

22.6.2.12.4 For details regarding the consent and referral processes and regarding sharing client information, see OWITS Reference Manual, Volume 8: Consent and Referrals.

22.6.2.13 *Unsigned Notes*

22.6.2.13.1 Enter any desired information that will be applied to this note record.

22.6.2.13.2 This may include a narrative description, list, or other text that details the activity or services related to this note record and the client's response.

22.6.2.13.3 If additional prompts are necessary for the note details (such as those described in 22.6.2.1.3 through 22.6.2.1.6), leave this field blank and use the Add Note function instead (22.6.3).

22.6.2.13.4 If this field is sufficient for the note details, click the Sign Note button in the lower right corner to move the contents of this field to the Signed Notes field (22.6.2.11) and apply an electronic signature.

22.6.2.13.5 It is possible to save the Miscellaneous Note without signing the notes.

22.6.2.13.6 Some users may enter the notes and save the record for supervisors, clinicians, or other users to open and sign at a later time.

22.6.3 Enter additional notes in a template as needed.

22.6.3.1 Click the Add Note button in the lower right corner.

22.6.3.2 The Append Miscellaneous Notes screen will display.

22.6.3.3 In the Append Notes field, template text will display, prompting for specific clinical, treatment, or service information.

22.6.3.3.1 The template text is determined by the selection in the Note Type field (22.6.2.1).

22.6.3.3.2 If the incorrect template text is displayed, click Cancel to return to the Miscellaneous Notes screen and select a different Note Type.

22.6.3.3.3 Not all Note Types have template text.

22.6.3.3.4 Additional note templates can be requested by sending the desired text to owits.support@state.or.us.

22.6.3.4 Add to or modify this text as appropriate.

22.6.3.5 Click Finish to copy the text in this field to the Unsigned Notes field on the Miscellaneous Notes screen.

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22.6.3.5.1 If the Append Notes field is left blank, clicking Finish will produce an error message.

22.6.3.5.2 If the template text in the Append Notes field has not been changed or added to, clicking Finish will produce an error message.

22.6.3.6 Click the Sign Note button in the lower right corner to move the contents of this field to the Signed Notes field (22.6.2.11) and apply an electronic signature.

22.6.3.6.1 It is possible to save the Miscellaneous Note without signing the notes.

22.6.3.6.2 Some users may enter the notes and save the record for supervisors, clinicians, or other users to open and sign at a later time.

22.6.4 Click Save.

22.6.4.1 The miscellaneous note will be applied to the client's record.

22.6.4.2 All data fields on the Miscellaneous Notes screen other than the Unsigned Notes field (22.6.2.12.1) will become read-only.

22.6.4.3 Additional notes can be added to the miscellaneous note at any time.

22.6.4.4 A Delete button will appear next to the Cancel button (22.9).

22.6.5 Click Finish to return to the Miscellaneous Notes List screen.

22.7 Add records of encounter notes as needed.

22.7.1 On the Notes List screen (Client List > Activity List > Notes), click the "Add New Encounter Note" link in the Notes List heading.

22.7.2 OWITS will redirect to the Encounter screen (Client List > Activity List > Encounters > Profile).

22.7.3 Note that the client must have an Admission record (17.0) and a Program Enrollment (18.0) completed before an Encounter can be created.

22.7.4 Complete the encounter note.

22.7.5 For specific instructions on creating and entering encounters, see 20.5.

22.7.6 Clicking Cancel from the Encounter screen, even when accessed from the Notes module, will exit to the Encounter List screen (see 20.6.1).

22.8 Search and review existing notes.

22.8.1 On the Notes List screen (Client List > Activity List > Notes), all encounter notes and miscellaneous notes can be searched and reviewed.

22.8.1.1 In the Start Date and End Date fields at the top of the screen, enter the range of dates on which the desired notes were entered.

22.8.1.1.1 These dates default to a range that will show notes entered in the most recent year (365 days).

22.8.1.1.2 Click Go to execute the search.

22.8.1.1.3 Click Clear to remove dates from the fields.

22.8.1.2 Both encounter notes and miscellaneous notes matching the search criteria will display in the Notes List table.

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22.8.1.3 To see the details of the notes, click the "Review" link in the Actions column of the desired note.

22.8.1.4 Additional details can be added to miscellaneous notes as needed.

22.8.1.4.1 See 22.6.2.12.1 for instructions on entering unformatted notes.

22.8.1.4.2 See 22.6.3 for instructions on entering notes based on templates.

22.8.1.4.3 Click Finish to return to the Miscellaneous Notes List screen.

22.8.1.5 Additional details can be added to encounter notes until the notes are released to billing (see 20.7).

22.8.2 On the Miscellaneous Notes List screen (Client List > Activity List > Notes > Misc. Notes),

22.8.2.1 In the Start Date and End Date fields at the top of the screen, enter the range of dates on which the desired notes were entered.

22.8.2.1.1 These dates default to a range that will show notes entered in the most recent year (365 days).

22.8.2.1.2 Click Go to execute the search.

22.8.2.1.3 Click Clear to remove dates from the fields.

22.8.2.2 Miscellaneous notes matching the search criteria will display in the Miscellaneous Notes List table.

22.8.2.3 To see the details of the notes, click the "Review" link in the Actions column.

22.8.2.4 Additional details can be added to miscellaneous notes as needed.

22.8.2.4.1 See 22.6.2.12.1 for instructions on entering unformatted notes.

22.8.2.4.2 See 22.6.3 for instructions on entering notes based on templates.

22.8.2.4.3 Click Finish to return to the Miscellaneous Notes List screen.

22.8.3 On the Notes List screen (Client List > Activity List > Notes), all notes entered for the current client's current episode can be viewed and/or exported.

22.8.3.1 Click the "Print Notes" link in the Notes List heading.

22.8.3.2 In the Note Date field, enter a date range for the notes to be displayed by entering the earliest date to be searched and the latest date to be searched, separated by a colon.

22.8.3.2.1 Example: 01/01/2011:05/31/2012

22.8.3.3 Click Go to generate the report.

22.8.3.4 All encounter notes and miscellaneous notes that fit within the date range will display in a table.

22.8.3.5 The Client Treatment Notes table can be exported for external viewing and records.

22.8.3.5.1 Hold down the CTRL key.

22.8.3.5.2 Click the Export button near the upper left corner of the screen.

22.8.3.5.3 A dialogue box will appear offering the option to Open or Save the export file.

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22.8.3.5.3.1 Click Open to view the file in an Internet Explorer window that looks like a Microsoft Excel spreadsheet.

22.8.3.5.3.2 Click Save to save the file to the computer as a Microsoft Excel spreadsheet.

22.8.3.5.3.3 Click Cancel to stop the export process.

22.8.3.5.4 Select an option in the dialogue box.

22.8.3.5.5 Release the CTRL key.

22.8.3.5.6 View or save the exported data as needed.

22.8.3.6 Click Finish to return to the Notes List screen.

22.9 Delete miscellaneous notes as needed.

22.9.1 On the Notes List screen or the Miscellaneous Notes List screen, click the "Review" link in the Actions column for the desired miscellaneous note.

22.9.2 Click the Delete button (22.6.4.4).

22.9.3 OWITS will confirm the delete command.

22.9.4 The miscellaneous note will be deleted.

22.9.5 This action cannot be undone.

22.10 Return to the Activity List or other modules using the Navigation View links.

23.0 Treatment Plan

23.1 Use of the Treatment Plan module is recommended for most agencies.

23.2 Please note that this manual is only intended to instruct OWITS users regarding the recording and utilization of treatment plan records.

23.2.1 This manual does not provide clinical instructions for how to create and/or use treatment plans to serve clients.

23.2.2 Users are expected to follow guidelines established by their agency regarding the content and application of treatment plans.

23.3 Navigate to Client List > Activity List > Treatment > TX Plan.

23.3.1 The Treatment Plan List screen will display.

23.3.2 Intake (7.0), Admission (17.0), and Program Enrollment (18.0) records must be completed before a treatment plan can be created.

23.3.3 Treatment plans can be created to begin on future dates, but treatment plans cannot be created prior to the program enrollment date (18.4.2.5).

23.3.3.1 If the program enrollment date is in the future, OWITS will produce an error message stating that the client is not yet enrolled in a program.

23.4 To create a new treatment plan, click the "Add New Treatment Plan Record" link in the Treatment Plan List heading.

23.4.1 The Treatment Plan Profile screen will display, consisting of the following fields and tables:

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23.4.1.1 *Status Date*

23.4.1.1.1 This read-only field will display the date on which the Plan Status (23.4.1.11) was changed to its current value.

23.4.1.2 *Last Review Date*

23.4.1.2.1 This read-only field will automatically populate when a Treatment Review (24.0) is conducted on this treatment plan.

23.4.1.2.2 The date in this field will match the date in the Date of Review field on the Treatment Review Profile screen (24.5.2.4).

23.4.1.3 *Plan Number*

23.4.1.3.1 This read-only field will automatically populate with a number.

23.4.1.3.2 The plan number refers to the number of new treatment plans that have been created for the client in the current episode.

23.4.1.3.3 The value in this field will only increase for new treatment plans (23.4), not new versions of existing treatment plans (see 23.6.7 and 23.6.8).

23.4.1.3.4 Treatment plans are recorded sequentially in the order in which the plan records were created and saved.

23.4.1.3.5 The most recent plan will have the highest number.

23.4.1.4 *Plan Version*

23.4.1.4.1 This read-only field will automatically populate with a number.

23.4.1.4.2 The plan version refers to the number of times the plan has been revised (see 23.6.7 and 23.6.8).

23.4.1.5 *Created By*

23.4.1.5.1 This read-only field will automatically populate with the name of the user who created this record.

23.4.1.6 *Created Date*

23.4.1.6.1 This read-only field will automatically populate with the date on which this record was created and saved.

23.4.1.7 *Updated By*

23.4.1.7.1 This read-only field will automatically populate with the name of the user who most recently modified this record.

23.4.1.8 *Last Updated Date*

23.4.1.8.1 This read-only field will automatically populate with the date on which this record was most recently modified.

23.4.1.9 *Plan Name*

23.4.1.9.1 Enter a name for the treatment plan.

23.4.1.9.2 Plan names should at least suggest the contents or goals of the plan.

23.4.1.9.3 Plan names cannot exceed 256 characters, including spaces.

23.4.1.9.4 Agencies are individually responsible for determining the format and specificity of treatment plan names.

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23.4.1.10 *Plan Period (Days)*

23.4.1.10.1 Enter the number of days the plan is expected to be effective.

23.4.1.10.2 If a date has been entered into the Plan End Date field, when the treatment plan is saved, this field will automatically populate with the number of days between the Plan Start Date (23.4.1.12) and the Plan End Date (23.4.1.13).

23.4.1.11 *Plan Status*

23.4.1.11.1 This read-only field will automatically populate with values that describe whether the treatment has been prepared, completed, signed, or superseded.

23.4.1.11.2 "Active – Not Signed Off" indicates that the plan has been created but that it has not yet been approved by the client and/or by clinicians.

23.4.1.11.3 "Active – Signed Off" indicates that the plan has been approved by the client, by clinicians, and by others involved with the client's treatment.

23.4.1.11.4 "Inactive – Draft" indicates a new treatment plan record that is not yet complete.

23.4.1.11.5 "Inactive – Old Version" indicates a treatment plan record that has been replaced.

23.4.1.12 *Plan Start Date*

23.4.1.12.1 Enter the date on which the client will begin taking or following any of the steps outlined in the treatment plan.

23.4.1.12.2 This date may be in the future.

23.4.1.13 *Plan End Date*

23.4.1.13.1 Enter the date on which the plan is expected to conclude, expire, or otherwise come to an end.

23.4.1.13.2 If a number has been entered into the Plan Period field, when the treatment plan is saved, this field will automatically populate with the date that is the number of Plan Period days (23.4.1.10) from the Plan Start Date (23.4.1.12).

23.4.1.14 *Next Review Date*

23.4.1.14.1 Enter the date on which an agency staff member is expected to review the treatment plan and the client's progress.

23.4.1.15 *Client Participated in TX Plan Development*

23.4.1.15.1 Indicate whether the client took part in the planning and development of this treatment plan.

23.4.1.15.2 This indicator is required for state licensing purposes and administrative rule compliance.

23.4.1.16 *Administrative Actions*

23.4.1.16.1 This box contains links that can affect the treatment plan record.

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23.4.1.16.2 The "Create New Version" link can later be used to duplicate most of the data in the current treatment plan into a new treatment plan record that can be modified and saved as if new (see 23.6.8).

23.4.1.16.3 The "Sign Off" link can later be used to complete a saved treatment plan (23.6.5).

23.4.1.16.4 The "Perform Review" link can later be used to initiate a treatment plan review and create a review record accordingly (23.6.6.3).

23.4.1.17 *Treatment Team*

23.4.1.17.1 This table lists the agency staff members and the client's collateral contacts who have been assigned as the client's treatment team during the current episode in the current facility.

23.4.1.17.2 Only the names of treatment team members who have "Yes" displayed in the Review Member column will appear on the printed treatment plan report with a signature line (23.7.4.2.1).

23.4.1.17.3 To add to or modify the treatment team, click the "Add Team Member" link in the Treatment Team heading.

23.4.1.17.3.1 OWITS will redirect to the Treatment Team screen in the Admission record associated with the current episode (17.3.23).

23.4.1.17.3.2 Add or modify treatment team members as needed, following the instructions detailed in 14.0.

23.4.1.17.3.3 Click Finish to return to the Treatment Plan Profile screen.

23.4.1.17.3.4 Using the Navigation View links to exist the Treatment Team screen when accessed from the Treatment Plan Profile screen will cancel any unsaved progress.

23.4.2 When all the required fields (and others as appropriate) have been filled, click Save.

23.4.3 Click the right arrow to advance to the Overview screen, which consists of the following fields:

23.4.3.1 *Assessments Reviewed*

23.4.3.1.1 Use this text box to indicate what, if any, assessments have been conducted and reviewed as part of the development of this treatment plan.

23.4.3.1.2 Include the dates of the assessment(s) as appropriate.

23.4.3.1.3 Include any additional details that may be relevant to the client's situation.

23.4.3.2 *Presenting Problem (In Client's Own Words)*

23.4.3.2.1 This read-only field will automatically populate with the text entered into the matching field on the Intake screen (7.4.17).

23.4.3.3 *Strengths / Resources / Abilities / Interests / Barriers to Success*

23.4.3.3.1 Use this text box to list the client's behavioral, personality, and situational attributes that may help or hinder in his or her completion of the treatment plan.

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23.4.3.4 *Transfer / Discharge Criteria*

23.4.3.4.1 Use this text box to indicate the progress the client should make or tasks the client should complete before being eligible for transfer to a different agency or facility or before being discharged from treatment.

23.4.3.4.2 This field may also be used to indicate what landmarks the client could reach that would require him or her to transfer to a more intensive form of treatment.

23.4.3.5 *Client Comments Regarding Treatment Goals*

23.4.3.5.1 Enter any statements made by the client regarding the goals he or she has set or the results he or she expects to achieve as a result of treatment.

23.4.3.5.2 Use the client's own words whenever possible.

23.4.3.6 *Clinician Comments / Recommendations*

23.4.3.6.1 Enter any additional information from the clinician(s) responsible for developing this treatment plan.

23.4.3.6.2 This field may automatically populate with the text entered into the Recommendations field on the Patient History 3 screen of the most recent Behavioral Health Assessment (see OWITS Reference Manual, Volume 6: Screenings and Assessments).

23.4.4 When these fields have been completed as needed, click Save.

23.4.5 Click the right arrow to advance to the Diagnosis screen.

23.4.5.1 Note that the contents of all diagnosis drop-down menus in this section are sorted alphabetically.

23.4.5.2 A spreadsheet that can be used for sorting and filtering diagnosis codes can be found on the OWITS Forum (http://owits.boards.net).

23.4.5.3 Some of the fields on this screen will automatically populate with data entered in the Diagnosis screen of the most recent Admission, Mental Health Assessment, Behavioral Health Assessment, or other modules.

23.4.5.4 A Diagnosis is not required to save the treatment plan, but it is required to complete and sign off (23.6.5) the treatment plan.

23.4.6 The Diagnosis screen consists of the following fields and sections:

23.4.6.1 *Primary*

23.4.6.1.1 Select the option that best describes the primary diagnosis of the client's problem.

23.4.6.2 *Secondary*

23.4.6.2.1 Select the option that best describes the secondary diagnosis of the client's problem.

23.4.6.3 *Tertiary*

23.4.6.3.1 Select the option that best describes the tertiary diagnosis of the client's problem.

23.4.6.4 *Axis I, Axis II, Axis III,* and *Axis IV*

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23.4.6.4.1 Use these sections if specific diagnoses have been identified for the client on one or more of the four DSM axes.

23.4.6.4.1.1 Diagnoses will be required on all four axes even if only one has been identified.

23.4.6.4.1.2 Each axis includes options to specify that no diagnosis has been made for that axis.

23.4.6.4.2 Click the Edit Axis Evaluation link.

23.4.6.4.3 In the Axis field, select Axis I.

23.4.6.4.3.1 Selecting Axis I in this field will filter the Diagnosis field (below) to show only Axis I diagnoses.

23.4.6.4.4 In the Diagnosis field, select the option that matches the client's Axis I diagnosis.

23.4.6.4.4.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis I (DSM)" if the diagnosis for this axis will be added later.

23.4.6.4.4.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis I (DSM)" if no diagnosis has been or will be identified for this axis.

23.4.6.4.5 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

23.4.6.4.5.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

23.4.6.4.6 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

23.4.6.4.7 Click the Add to Axis link in the gray bar labeled Axis I.

23.4.6.4.8 In the Axis field, select Axis II.

23.4.6.4.8.1 Selecting Axis II in this field will filter the Diagnosis field (below) to show only Axis II diagnoses.

23.4.6.4.9 In the Diagnosis field, select the option that matches the client's Axis II diagnosis.

23.4.6.4.9.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis II (DSM)" if the diagnosis for this axis will be added later.

23.4.6.4.9.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis II (DSM)" if no diagnosis has been or will be identified for this axis.

23.4.6.4.10 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

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23.4.6.4.10.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

23.4.6.4.11 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

23.4.6.4.12 Click the Add to Axis link in the gray bar labeled Axis II.

23.4.6.4.13 In the Axis field, select Axis III.

23.4.6.4.13.1 Selecting Axis III in this field will filter the Diagnosis field (below) to show only Axis III diagnoses.

23.4.6.4.14 In the Diagnosis field, select the option that matches the client's Axis III diagnosis.

23.4.6.4.14.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis III (DSM)" if the diagnosis for this axis will be added later.

23.4.6.4.14.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis III (DSM)" if no diagnosis has been or will be identified for this axis.

23.4.6.4.15 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

23.4.6.4.15.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

23.4.6.4.16 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

23.4.6.4.17 Click the Add to Axis link in the gray bar labeled Axis III.

23.4.6.4.18 In the Axis field, select Axis IV.

23.4.6.4.18.1 Selecting Axis IV in this field will filter the Diagnosis field (below) to show only Axis IV diagnoses.

23.4.6.4.19 In the Diagnosis field, select the option that matches the client's Axis IV diagnosis.

23.4.6.4.19.1 Near the bottom of the drop-down menu, select "Diagnosis or Condition Deferred on Axis IV (DSM)" if the diagnosis for this axis will be added later.

23.4.6.4.19.2 At the bottom of the drop-down menu, select "No Diagnosis or Condition on Axis IV (DSM)" if no diagnosis has been or will be identified for this axis.

23.4.6.4.20 In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.

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23.4.6.4.20.1 Some instructions regarding the details that may be added to this field can be found in the DSM-IV, in the "Use of the Manual" section, under the "Severity and Course Specifiers" heading.

23.4.6.4.21 Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client's most significant problem.

23.4.6.4.22 Click the Add to Axis link in the gray bar labeled Axis IV.

23.4.6.4.23 Click Finish to return to the Diagnosis screen.

23.4.6.5 *Axis V*

23.4.6.5.1 Enter the client's most recent GAF score.

23.4.6.5.2 This must be a number between 0 and 100.

23.4.6.6 *Highest GAF Score in Last Year*

23.4.6.6.1 This field may automatically populate with the highest score entered into the Axis V field (23.4.6.5) in all other Diagnosis screens in the twelve months prior to the current date or the current episode's intake date, whichever is shorter.

23.4.6.6.2 Enter the highest score the client has received on the Global Assessment of Functioning scale in the last year, or replace the auto-populated value if it is incorrect.

23.4.6.6.3 This must be a number between 0 and 100.

23.4.6.6.4 The Global Assessment of Functioning scale is not currently available in OWITS.

23.4.7 When the Diagnosis screen has been completed, click Save.

23.4.8 Click the right arrow to advance to the Problems/Goals screen.

23.4.8.1 Functions can be initiated from this screen that will add records of problems, goals, objectives, and interventions to the treatment plan record.

23.4.8.1.1 Problem – A situation or issue in the client's life that is in need of improvement, often related to a clinical assessment of the client.

23.4.8.1.2 Goal – An ideal recovery point based on the problem, often identified by the client and set collaboratively by the clinician and the client, that is related to the client's life, current situation, treatment, etc., and that is reasonably achievable during treatment.

23.4.8.1.3 Objective – A small and measurable step or series of steps based on the goal, typically developed with the client, that are designed to help the client achieve the goal he or she has set.

23.4.8.1.4 Intervention – A specific action or service provided to the client by the clinician or other concerned individual(s) in an effort to help the client achieve an objective and/or goal or to otherwise bring about change.

23.4.8.1.5 Interventions are nested in the objectives, which are nested in the goals, which are nested in the problems (see Appendix F – Example of Treatment and Recovery Plan Hierarchies).

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23.4.8.2 The Problem Summary List field populates with any text that may have been entered into the BHA (Behavioral Health Assessment – see OWITS Reference Manual, Volume 6: Screenings and Assessments).

23.4.8.3 This table displays problems that have been added to the Treatment Plan.

23.4.8.4 In a new treatment plan, this table will be blank.

23.4.9 In the subsequent screens, add problems, goals, objectives and interventions as needed.

23.4.10 Click the "Add New Treatment Plan Problem Record" link in the Treatment Plan Problem heading.

23.4.11 The Problem Profile screen will display, which consists of the following fields:

23.4.11.1 *Problem #*

23.4.11.1.1 This read-only field will automatically populate with a number according to the total of problem records added to this treatment plan.

23.4.11.1.2 The first problem in this treatment plan will be 1, the second problem will be 2, the third problem will be 3, and so on.

23.4.11.2 *Problem Date*

23.4.11.2.1 Enter the date on which the client, clinician, staff member, or collateral contact identified the problem.

23.4.11.3 *Program Name*

23.4.11.3.1 Select the name of the program in which the client is enrolled that is associated with this treatment plan and/or problem.

23.4.11.4 *Problem Status*

23.4.11.4.1 Select the option that best describes how the problem is currently affecting the client.

23.4.11.4.2 Example: A "Deferred" problem is something the client and/or clinicians are not currently addressing.

23.4.11.4.3 Example: An "In Treatment" problem is something the client and/or clinicians are actively attempting to correct.

23.4.11.5 *Problem Category*

23.4.11.5.1 Select the categorical option that best describes the problem.

23.4.11.6 *Problem*

23.4.11.6.1 The option selected in the Problem Category field above (23.4.11.5) determines the options available in this field.

23.4.11.6.2 Select the specific option that best describes the client's problem.

23.4.11.6.3 Select "Other: See Comments" if none of the available options fit the client's problem.

23.4.11.7 *Description*

23.4.11.7.1 Enter a detailed description of the client's problem.

23.4.11.7.2 Use the client's own words, if possible.

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23.4.11.7.3 This is the field referred to in the "Other: See Comments" option in the Problem field (23.4.11.6).

23.4.11.8 *Strengths/Resources*

23.4.11.8.1 Use these option transfer boxes to identify attributes of the client's personality, behavior, or situation that will help him or her in solving or mitigating this problem.

23.4.11.8.2 Select "Other: See Comments" if the desired strengths or resources are not available.

23.4.11.9 *Description*

23.4.11.9.1 Enter a detailed description of the client's strengths and resources.

23.4.11.9.2 Use the client's own words, if possible.

23.4.11.9.3 This is the field referred to in the "Other: See Comments" option in the Strengths/Resources field (23.4.11.8).

23.4.12 When all the required fields have been filled (and others as appropriate), click Save.

23.4.12.1 If no goals, objectives, or interventions are to be added with this problem, skip to step 23.4.25.

23.4.12.2 Additional information can be added to the problem records as needed until the treatment plan has been signed off (see 23.6.5).

23.4.13 To enter a goal connected to the problem that is currently displayed, click the "Add Goal" link in the Goal List heading.

23.4.14 The Goal Profile screen will display, which consists of the following fields:

23.4.14.1 *Need #*

23.4.14.1.1 This read-only field will automatically populate with the value that appears in the Problem # field on the Problem Profile screen (23.4.11.1).

23.4.14.2 *Program Name*

23.4.14.2.1 This read-only field will automatically populate with the name of the program selected in the Program Name field on the Problem Profile screen (23.4.11.3).

23.4.14.3 *Functional Area*

23.4.14.3.1 This read-only field will automatically populate with the option selected in the Problem Category field on the Problem Profile screen (23.4.11.5).

23.4.14.4 *Needs*

23.4.14.4.1 This read-only field will automatically populate with the text entered into the first Description field on the Problem Profile screen (23.4.11.7).

23.4.14.5 *Strengths/Limits*

23.4.14.5.1 This read-only field will automatically populate with the text entered into the second Description field on the Problem Profile screen (23.4.11.9).

23.4.14.6 *Goal*

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23.4.14.6.1 The option selected in the Problem Category field (23.4.11.5) determines the options available in this field.

23.4.14.6.2 Select the option that best describes the client's goal.

23.4.14.6.3 Select "Other: See Comments" if none of the available options fit the client's goal.

23.4.14.7 *Goal Status*

23.4.14.7.1 Select the option that best describes what the client is doing or is going to do with this goal.

23.4.14.8 *Description*

23.4.14.8.1 Enter a detailed description of the client's goal.

23.4.14.8.2 This is the field referred to in the "Other: See Comments" option in the Goal field (23.4.14.6).

23.4.14.9 *Projected Achievement Date*

23.4.14.9.1 Enter the date on which the client or the clinician can reasonably expect the goal to be completed.

23.4.14.10 *Actual Achievement Date*

23.4.14.10.1 If the goal has been completed, enter the completion date.

23.4.14.11 *Deferred Date*

23.4.14.11.1 If a projected achievement date has not yet been set for this goal, enter the date on which the projected achievement date will be set.

23.4.14.11.2 This is most often used when additional steps are required before a client can begin attempting to reach this goal.

23.4.15 When all the required fields have been filled (and others as appropriate), click Save.

23.4.15.1 If no objectives or interventions are to be added with this goal, skip to step 23.4.24.

23.4.15.2 Additional information can be added to the goal records as needed until the treatment plan has been signed off (see 23.6.5).

23.4.16 To enter an objective connected to the goal that is currently displayed, click the "Add Objective" link in the Objective List heading.

23.4.17 The Objectives screen will display, which consists of the following fields:

23.4.17.1 *Problem#*

23.4.17.1.1 This read-only field will automatically populate with the value entered in the Problem # field on the Problem Profile screen (23.4.11.1).

23.4.17.2 *Date Assessed*

23.4.17.2.1 This read-only field will populate with the date entered in the Problem Date field on the Problem Profile screen (23.4.11.2).

23.4.17.3 *Problem Category*

23.4.17.3.1 This read-only field will populate with the option selected in the Problem Category field on the Problem Profile screen (23.4.11.5).

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23.4.17.4 *Strengths/Limits*

23.4.17.4.1 The first line of this read-only field will display the options selected and moved to the Selected Strengths/Resources option transfer box on the Problem Profile screen (23.4.11.8).

23.4.17.4.2 The second line of this read-only field will display the text entered in the second description box on the Problem Profile screen (23.4.11.9).

23.4.17.5 *Problem Description*

23.4.17.5.1 The first line of this read-only field will populate with the option selected in the Problem field on the Problem Profile screen (23.4.11.6).

23.4.17.5.2 The second line of this read-only field will populate with the text entered in the first description box on the Problem Profile screen (23.4.11.7).

23.4.17.6 *Goal*

23.4.17.6.1 The first line of this read-only field will populate with the option selected in the Goal field on the Goal Profile screen (23.4.14.6).

23.4.17.6.2 The second line of this read-only field will populate with the text entered in the Description field on the Goal Profile screen (23.4.14.8).

23.4.17.7 *Objective#*

23.4.17.7.1 This read-only field will automatically populate with a number according to the total number or objective records added to this goal in this problem and treatment plan.

23.4.17.7.2 The first objective in this goal will be 1, the second objective will be 2, the third will be 3, and so on.

23.4.17.7.3 Objectives created for other goals and/or other problems will begin again with 1.

23.4.17.8 *Create Date*

23.4.17.8.1 This field will automatically populate with the date on which this objective was created and saved.

23.4.17.9 *Objective*

23.4.17.9.1 The option selected in the Problem Category field (23.4.11.5) determines the options available in this field.

23.4.17.9.2 Select the option that best describes the client's objective associated with the goal to which it is correlated.

23.4.17.9.3 Select "Other: See Comments" if none of the available options fit the client's objective.

23.4.17.10 *Description*

23.4.17.10.1 Enter a detailed description of the client's objective.

23.4.17.10.2 This is the field referred to in the "Other: See Comments" option in the Objective field (23.4.17.9).

23.4.17.11 *Objective Status*

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23.4.17.11.1 Select the option that best describes how the client is progressing with this objective.

23.4.17.12 *Expected Achieve Date*

23.4.17.12.1 Enter the date on which the client or the clinician can reasonably expect the objective to be reached.

23.4.17.13 *Resolution Date*

23.4.17.13.1 If the objective has been reached or otherwise concluded, enter the completion date.

23.4.18 When all the required fields have been filled (and others as appropriate), click Save.

23.4.18.1 If no interventions are to be added with this objective, skip to step 23.4.23.

23.4.18.2 Additional information can be added to the objective records as needed until the treatment plan has been signed off (see 23.6.5).

23.4.19 To enter an intervention connected to the objective that is currently displayed, click the "Add Intervention" link in the Intervention heading.

23.4.20 The Intervention screen will display, which consists of the following fields:

23.4.20.1 *Problem#*

23.4.20.1.1 This read-only field will automatically populate with the value entered in the Problem # field on the Problem Profile screen (23.4.11.1).

23.4.20.2 *Problem Category*

23.4.20.2.1 This read-only field will automatically populate with the option selected in the "Problem Category" field on the Problem Profile screen (23.4.11.5).

23.4.20.3 *Description*

23.4.20.3.1 This read-only field will automatically populate with the option selected in the Problem field on the Problem Profile screen (23.4.11.6).

23.4.20.4 *Goal*

23.4.20.4.1 This read-only field will automatically populate with the option selected in the Goal field on the Goal Profile screen (23.4.14.6).

23.4.20.5 *Objective#*

23.4.20.5.1 This read-only field will automatically populate with the value generated in the Objective# field on the Objectives screen (23.4.17.7).

23.4.20.6 *Objective*

23.4.20.6.1 The first line of this read-only field will populate with the option selected in the Objective field on the Objectives screen (23.4.17.9).

23.4.20.6.2 The second line of this read-only field will populate with the text entered in the Description field on the Objectives screen (23.4.17.10).

23.4.20.7 *Objective Create Date*

23.4.20.7.1 This read-only field will automatically populate with the date generated in the Create Date field on the Objectives screen (23.4.17.8).

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23.4.20.8 *Objective Status*

23.4.20.8.1 This read-only field will automatically populate with the option selected in the Objective Status on the Objectives screen (23.4.17.11).

23.4.20.9 *Intervention#*

23.4.20.9.1 This read-only field will automatically populate with a number according to the total number of intervention records added to this objective in this goal, problem, and treatment plan.

23.4.20.9.2 The first intervention in this objective will be 1, the second intervention will be 2, the third intervention will be 3, and so on.

23.4.20.9.3 Interventions created for other objectives and/or other goals and/or other problems will begin again with 1.

23.4.20.10 (Unlabeled Drop-Down Menu)

23.4.20.10.1 The option selected in the Problem Category field (23.4.11.5) determines the options available in this field.

23.4.20.10.2 Select the option that best describes the intervention associated with the objective to which it is correlated.

23.4.20.10.3 Select "Other: See Comments" if none of the available options fit the intervention.

23.4.20.11 *Description*

23.4.20.11.1 Enter a detailed description of the intervention.

23.4.20.11.2 This is the field referred to in the "Other: See Comments" option in the unlabeled field beneath Intervention# (23.4.20.9).

23.4.20.12 *Create Date*

23.4.20.12.1 This read-only field will automatically populate with the date on which this objective was created and saved.

23.4.20.13 *Intervention Status*

23.4.20.13.1 Select the option that best describes the current state of the intervention.

23.4.20.14 *Staff*

23.4.20.14.1 Select the name of the staff member performing or primarily responsible for the intervention.

23.4.20.14.2 This field will automatically populate with the name of the current user, which can be changed as needed.

23.4.20.14.3 If the person performing or primarily responsible for the intervention is not a staff member, select the null value (blank) in this field.

23.4.21 When all of the required fields have been filled (and others as appropriate), click Save.

23.4.21.1 If needed, repeat steps 23.4.19 through 23.4.21 to add more interventions to the objective.

23.4.22 Click Finish to return to the Objectives screen.

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23.4.22.1 If needed, add more objectives.

23.4.22.2 Repeat steps 23.4.16 through 23.4.18 to add more objectives to the goal.

23.4.23 Click Finish to return to the Goal Profile screen.

23.4.23.1 If needed, add more goals.

23.4.23.2 Repeat steps 23.4.13 through 23.4.15 to add more goals to the problem.

23.4.24 Click Finish to return to the Problem Profile screen.

23.4.24.1 If needed, add more problems.

23.4.24.2 Repeat steps 23.4.10 through 23.4.12 to add more problems.

23.4.25 Click Finish to return to the Problems/Goals screen.

23.4.25.1 Problems, Goals, Objectives, and Interventions can be deleted from the Plan Outline screen in the TX Plan module (23.5.4) or in the TX Review module (24.5.7.2).

23.4.26 Click the right arrow to advance to the Planned Services screen.

23.4.26.1 Functions can be initiated from this screen that will add a list of services that the client will or may receive as a part of his or her treatment plan and clinical objectives associated with each.

23.4.27 Click the "Add New Planned Services Record" link in the Planned Services List heading.

23.4.28 The Planned Services screen will display, which consists of the following fields:

23.4.28.1 *Program Name*

23.4.28.1.1 Select the name of the program in which or for which the selected service was or will be rendered.

23.4.28.2 *Service*

23.4.28.2.1 The program selected in the "Program Name" field (23.4.28.1) will affect the options available in this field.

23.4.28.2.2 Select the option that best describes the service that was rendered to the client.

23.4.28.2.3 Carefully read the details of the service descriptions to ensure the correct option is selected.

23.4.28.2.4 Available services are determined by the modality of the program in which the client is enrolled.

23.4.28.3 *Measure Type*

23.4.28.3.1 This read-only field will automatically populate with "Duration" or "Unit" based on the selected service, indicating whether the service is calculated based on a duration or a quantity.

23.4.28.4 *Duration #*

23.4.28.4.1 Enter a number that can be used to describe the amount of time between the start and end of the service that was or will be rendered.

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23.4.28.4.2 Example: If the client participated in a 45-minute group counseling session, enter 45.

23.4.28.5 *Duration Type*

23.4.28.5.1 Select the unit of measure that fits with the number entered in the Duration # field above (23.4.28.4).

23.4.28.5.2 Example: if the client participated in a 45-minute group counseling session, select "Min" to denote minutes.

23.4.28.6 *# of Sessions*

23.4.28.6.1 Enter a number that represents the number of individual instances in which the selected service was or will be rendered.

23.4.28.6.2 Enter whole numbers only.

23.4.28.7 *Frequency*

23.4.28.7.1 Select the option that best describes how often the service was or will be rendered.

23.4.28.7.2 Select "Daily" if a service that was or will be rendered only once was selected in the Service field above (23.4.28.2).

23.4.28.8 *Staff*

23.4.28.8.1 Select the name of the staff member who provided or will provide the service selected in the Service field above (23.4.28.2).

23.4.28.8.2 Available staff names will be restricted to staff members assigned to the current facility.

23.4.28.9 *Service Location*

23.4.28.9.1 Select the option that best describes where the service was or will be rendered.

23.4.29 When all of the required fields have been filled (and others as appropriate), click Save.

23.4.29.1 To associate an objective with the planned service, click the "Add Objectives" link in the Associated Objectives heading.

23.4.29.2 A list of existing objectives will display.

23.4.29.2.1 Objectives (23.4.16) must be added as part of problem profiles before any objectives will be available from this option.

23.4.29.2.2 Objectives in this list are numbered according to the associated problem and goal.

23.4.29.2.3 Example: A number of 3.6.2 in the "Obj #" column of this table refers to the third problem, the sixth goal associated with the third problem, and the second objective associated with the sixth goal.

23.4.29.3 Place a check mark in the white box in the first column next to the objectives that will be associated with the planned service.

23.4.29.3.1 Placing a check mark in the white box in the header row of this table will place a check mark in all of the boxes below it.

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23.4.29.3.2 Removing a check mark from the white box in the header row of this table will remove all check marks below it.

23.4.29.4 When all desired objectives have been selected, click Finish to return to the Planned Services screen.

23.4.30 Repeat steps 23.4.27 through 23.4.29 as needed to add more planned services.

23.4.30.1 Planned services can be entered more than once if there is a difference in program, duration, frequency, staff, or service location.

23.4.30.2 Objectives may be associated with any or all planned services.

23.4.31 When all planned services have been recorded, click the right arrow to advance to the Plan Outline screen.

23.4.31.1 The plan outline is a display of the treatment plan and all of the layered problems, goals, objectives, and interventions associated with it.

23.4.31.2 For instructions on modifying the plan and its contents from this screen, see 23.5.4.2 through 23.5.4.7.

23.4.31.3 Click the "Printable View" icon at the top of the screen to open a pop-up window with a printer-friendly version of the plan outline.

23.4.31.3.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

23.4.31.3.2 Close the pop-up window when finished.

23.4.32 Click Finish to return to the Treatment Plan Profile screen.

23.4.33 Click Finish to return to the Activity List.

23.5 Review and modify existing treatment plans as needed.

23.5.1 Navigate to Client List > Activity List > Treatment > TX Plan.

23.5.2 The Treatment Plan List screen will display.

23.5.3 Click the "Review" link in the Actions column of the desired plan record.

23.5.4 If the plan has not been signed off (see 23.6.5), modify existing data fields as needed.

23.5.4.1 The Plan Outline screen (23.4.31) offers easy access to most aspects of the treatment plan for editing.

23.5.4.2 To view an existing Problem, Goal, Objective, or Intervention, click the "Review" link next to the desired item.

23.5.4.3 To remove an existing Problem, Goal, Objective, or Intervention, click the "Delete" link next to the desired item.

23.5.4.3.1 OWITS will confirm the delete command.

23.5.4.3.2 This action cannot be undone.

23.5.4.4 To add a new Problem, click the "Add Functional Area" link in the Treatment Plan box.

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23.5.4.5 To add a new Goal, click the "Add Goal" link in the box associated with the desired Problem record (labeled as "Needs" and "Functional Areas" on this screen).

23.5.4.6 To add a new Objective, click the "Add Objective" link in the box associated with the desired Goal.

23.5.4.7 To add a new Intervention, click the "Add Intervention" link in the box associated with the desired Objective.

23.5.5 If the plan has been signed off, all data fields will be in a read-only state.

23.5.6 Click Save to apply any changes.

23.5.7 Click Finish to return to the Activity List.

23.6 Sign off completed treatment plans and create new versions of existing treatment plans.

23.6.1 Navigate to Client List > Activity List > Treatment > TX Plan.

23.6.2 The Treatment Plan List screen will display.

23.6.3 Click the "Review" link in the Actions column of the desired plan record.

23.6.4 The Treatment Plan Profile screen will display.

23.6.5 If the plan is complete and currently in progress, or if the plan is no longer valid and will be replaced, it can be signed off.

23.6.5.1 A complete treatment plan has been reviewed and approved by the client and by all necessary staff members and collateral contacts.

23.6.5.2 In the Administrative Actions box, click the "Sign Off" link.

23.6.5.2.1 OWITS will confirm the sign-off action, making the plan the active treatment plan.

23.6.5.2.2 This action cannot be undone.

23.6.6 The Administrative Actions box will display three new links:

23.6.6.1 "Create New Version" – Copies data from the current treatment plan into a new version of the same plan (see 23.6.8).

23.6.6.2 "Create an Inactive Draft" – Copies data from the current treatment plan to create a new treatment plan (see 23.6.7).

23.6.6.3 "Perform Review" – Opens the TX Review module (see 23.6.9).

23.6.7 To create a new treatment plan based on data from the current treatment plan, click the "Create an Inactive Draft" link in the Administrative Actions box.

23.6.7.1 A draft treatment plan will be created.

23.6.7.1.1 All data from the current treatment plan will copy to the draft treatment plan.

23.6.7.1.2 The Plan Number (23.4.1.3) and Plan Version (23.4.1.4) fields will not change.

23.6.7.2 Modify data in the data fields as needed (see 23.4.1.1 through 23.4.32).

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23.6.7.3 Click Save to apply the changes, creating a draft treatment plan with a status of "Inactive – Draft."

23.6.7.3.1 This serves as a possible replacement for the current treatment plan, but it is not currently in progress.

23.6.7.3.2 The draft plan may be kept in its draft state indefinitely.

23.6.7.4 To replace the current treatment plan with this draft treatment plan, navigate to the draft plan's profile screen and click the "Make Draft Version Active" link in the Administrative Actions box.

23.6.7.4.1 OWITS will confirm the replacement.

23.6.7.4.2 The current treatment plan will be marked "Inactive" and will be kept only as a historical record.

23.6.7.4.3 The draft treatment plan will become the current treatment plan.

23.6.7.4.4 The Plan Version value (23.4.1.4) will increase by one, indicating that this is a revised plan.

23.6.7.4.5 This action cannot be undone.

23.6.7.5 When ready, sign off the new treatment plan (see 23.6.5).

23.6.8 To create a replacement treatment plan and skip the draft steps, click the "Create New Version" link in the Administrative Actions box.

23.6.8.1 This action immediately replaces the current treatment plan.

23.6.8.1.1 OWITS will confirm the replacement.

23.6.8.1.2 The current treatment plan will be marked "Inactive" and will be kept only as a historical record.

23.6.8.1.3 The Plan Version value (23.4.1.4) will increase by one, indicating that this is a revised plan.

23.6.8.1.4 Any existing drafts will be deleted.

23.6.8.1.5 This action cannot be undone.

23.6.8.2 Modify data in the data fields as needed (see 23.4.1.1 through 23.4.32).

23.6.8.2.1 All data from the current treatment plan will copy to the new treatment plan.

23.6.8.2.2 The Plan Start Date (23.4.1.12), Plan End Date (23.4.1.13), and Plan Period (23.4.1.10) fields will automatically populate but can be edited as needed.

23.6.8.3 When ready, sign off the new treatment plan (see 23.6.5).

23.6.9 To conduct a review of the current treatment plan and the client's progress through it, click the "Perform Review" link in the Administrative Actions box.

23.6.9.1 The Treatment Review module will open to its Profile screen.

23.6.9.2 See 24.0 for details on conducting and recording treatment reviews.

23.6.10 Return to the Treatment Plan List screen using the Navigation View links.

23.7 Generate reports of treatment plans.

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23.7.1 Navigate to Client List > Activity List > Treatment > TX Plan.

23.7.2 The Treatment Plan List screen will display.

23.7.3 Click the "Review" link in the Actions column of the desired plan record.

23.7.4 On any of the first five screens of the treatment plan, click the "Generate Report" link at the top of the screen.

23.7.4.1 A pop-up browser window will open.

23.7.4.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

23.7.4.2 The pop-up window will display a formatted report (as a PDF) of the data entered into the treatment plan, including:

23.7.4.2.1 Signature lines (with credentials) for all staff members assigned to the client's treatment team where "Yes" is selected in the Review Member field (14.7.2.4) of the Treatment Team screen.

23.7.4.2.2 A signature line for the client.

23.7.4.2.3 A list of diagnoses associated with this treatment episode.

23.7.4.2.4 A comprehensive list of the client's problems, goals, objectives, and interventions associated with this treatment plan (see 23.4.8.1).

23.7.4.2.5 A list of medications associated with this treatment episode.

23.7.4.3 This PDF can be saved or printed.

23.7.4.3.1 Use the Adobe PDF print and save icons (not the Internet Explorer print or save functions) to print or save the PDF.

23.7.4.3.2 CAUTION: The more problems, goals, objectives, and interventions have been added to the treatment plan, the more paper will be required to print it.

23.7.4.4 Close the pop-up window when finished.

23.8 Return to the Activity List or other modules using the Navigation View links.

24.0 Treatment Review

24.1 Use of the Treatment Review module is recommended for most agencies also using the Treatment Plan module (23.0).

24.2 This module is used to conduct and record reviews of the client's current treatment plan and his or her progress through it.

24.2.1 The client must have at least one treatment plan record for a treatment review record to be created.

24.2.2 Treatment reviews are conducted only on signed off treatment plans.

24.2.3 A treatment plan must exist with the plan status of "Active – Signed Off" (23.4.1.11.3) for a treatment review record to be created.

24.3 This module contains an ASAM screen intended for providers to complete during treatment to document the client's progress and problems that still need to be addressed.

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24.3.1 The initial ASAM is in the Admission series (17.3.17).

24.3.2 The concluding ASAM is in the Discharge series (see OWITS Reference Manual, Volume 9: Client Discharge).

24.4 Navigate to Client List > Activity List > Treatment > TX Review.

24.4.1 The Treatment Review List screen will display.

24.5 To conduct a treatment review, click the "Add New Treatment Review Record" link in the Treatment Review List heading.

24.5.1 The treatment review Profile screen will display.

24.5.1.1 This screen can also be accessed from the "Perform Review" link in the Administrative Actions box of the Treatment Plan Profile screen (23.4.1.16.4).

24.5.2 The treatment review Profile screen consists of the following fields:

24.5.2.1 *Client Name*

24.5.2.1.1 This read-only field displays the name of the client.

24.5.2.2 *DOB*

24.5.2.2.1 This read-only field displays the client's date of birth.

24.5.2.3 *Review Period*

24.5.2.3.1 In the first of these two fields ("From"), enter the earliest date of documents and records that will be reviewed as part of this treatment review, regardless of whether all of those documents and records are in OWITS.

24.5.2.3.2 In the second of these two fields ("to"), enter the latest date of documents and records that will be reviewed as part of this treatment review, regardless of whether all of those documents and records are in OWITS.

24.5.2.4 *Date of Review*

24.5.2.4.1 Enter the date on which the treatment review was or will be conducted.

24.5.2.4.2 This date can be in the future.

24.5.2.5 *Review Status*

24.5.2.5.1 This read-only field displays the current state of the treatment review.

24.5.2.5.2 "Cancelled" indicates that the review record was created, that it may or may not have been completed, that it was not approved, and that no changes were applied to the associated treatment plan.

24.5.2.5.3 "Pending" indicates that the review record has been created, that it may or may not be complete, that it has not been approved or signed off, but that is still active and that changes made during the review may be later applied to the associated treatment plan.

24.5.2.5.3.1 No new treatment reviews can be created if any treatment reviews have this status.

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24.5.2.5.4 "Completed (No Change)" indicates that the review record has been created, completed, approved, and signed off, and that no changes were made to the associated treatment plan.

24.5.2.5.5 "Completed (Changes Applied)" indicates that the review record has been created, completed, approved, and signed off, and that changes made to the problems, goals, objectives, and interventions of the plan have been applied to the associated treatment plan.

24.5.2.6 *Documents Reviewed (include dates of documents)*

24.5.2.6.1 List or describe any documents or records that were reviewed as part of this treatment review.

24.5.2.6.2 Include documents and records stored both in and out of OWITS.

24.5.2.7 *Assessments Conducted During This Review Period*

24.5.2.7.1 List or describe any assessments conducted as part of this treatment review.

24.5.2.7.2 Include assessments stored both in and out of OWITS.

24.5.2.7.3 Do not include in this field assessments that were completed prior to the treatment review.

24.5.3 When all of the required fields are filled (and others if applicable), click the right arrow to advance to the ASAM screen.

24.5.3.1 The ASAM screen consists of data entry fields to assist users in completing and recording assessments that evaluate the client based on the six ASAM dimensions.

24.5.3.2 The ASAM screen in the Treatment Review module should be used for updates to the initial ASAM assessment or follow-up ASAM assessments performed for the client.

24.5.3.2.1 The Admission module includes a screen for the primary ASAM results (17.3.17).

24.5.3.2.2 The Discharge module includes a screen for the concluding ASAM screens results (26.6.2).

24.5.3.3 OWITS does not contain an ASAM assessment.

24.5.3.4 Provider agencies are encouraged to use the ASAM assessment tools that best fit their business needs and enter the results into OWITS using this and other ASAM screens.

24.5.3.5 The ASAM is generally only performed for substance abuse clients.

24.5.3.5.1 Mental health providers may use the ASAM screens if desired.

24.5.3.6 See Appendix E – ASAM Levels of Care for a brief description of each of the ASAM levels of care.

24.5.3.7 A printable report of this screen, including the full text entered into the text boxes, can be generated as needed.

24.5.3.7.1 Click the Printable View icon at the top of the screen.

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24.5.3.7.2 A pop-up window will open containing exactly the same fields and content as currently displayed in the main OWITS window.

24.5.3.7.3 Use the Internet Explorer print functions to print this screen.

24.5.3.7.4 When printed, the "As Indicated By" text boxes (24.5.4.4) will expand to include all text that has been entered into them.

24.5.4 The ASAM screen consists of the following fields:

24.5.4.1 *Dimension*

24.5.4.1.1 This column lists the six dimensions of the ASAM criteria, including:

24.5.4.1.2 *Dimension 1 – Acute Intoxication and/or Withdrawal Potential*

24.5.4.1.3 *Dimension 2 – Biomedical Conditions and Complications*

24.5.4.1.4 *Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications*

24.5.4.1.5 *Dimension 4 – Readiness to Change*

24.5.4.1.6 *Dimension 5 – Relapse, Continued Use, or Continued Problem Potential*

24.5.4.1.7 *Dimension 6 – Recovery / Living Arrangement*

24.5.4.2 *Level of Risk*

24.5.4.2.1 These fields are not applicable to OWITS.

24.5.4.2.2 Users may select options in them or leave them blank as appropriate.

24.5.4.3 *Level of Care*

24.5.4.3.1 In this drop-down menu, select an option for each of the six categories listed under the "Dimension" heading.

24.5.4.3.2 "Level of Care" refers to the intensity of the clinical attention, treatment, or services that best fit the client's needs as they relate to the each dimension.

24.5.4.3.3 In the Treatment Review module, this selection should refer to the client's follow-up ASAM evaluation(s) in the current episode.

24.5.4.4 *As Indicated By*

24.5.4.4.1 In this text box dimension, enter a summary, narrative, or other explanation that details the clinical process, evaluation, or evidence that led to the determination of the selected level of care for each dimension listed under the "Dimension" heading.

24.5.4.4.2 In the Treatment Review module, this selection should refer to the client's follow-up ASAM evaluation(s) in the current episode.

24.5.4.5 *Recommended Level of Care*

24.5.4.5.1 Select the option that indicates the level of care most appropriate for the client's overall individual needs.

24.5.4.5.2 The option selected in this field applies to overall treatment, not a single dimension.

24.5.4.5.3 The option selected in this field may differ from the level of care available to the client or provided for the client by the agency.

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24.5.4.6 *Recommended Environment*

24.5.4.6.1 Select the option that best describes the treatment environment in which the client would likely have the best chances for successful recovery.

24.5.4.7 *Actual Level of Care*

24.5.4.7.1 Select the option that indicates the level of care that will be provided to the client by the agency.

24.5.4.7.2 The option selected in this field applies to overall treatment, not a single dimension.

24.5.4.7.3 The option selected in this field may differ from the level of care that would be the least restrictive, most safe, or otherwise ideal level of care for the client's individual needs.

24.5.4.8 *Actual Environment*

24.5.4.8.1 Select the option that best describes the setting in which the client will actually receive treatment.

24.5.4.9 *Clinical Override*

24.5.4.9.1 If the actual level of care (24.5.4.7) or actual environment (24.5.4.8) differs from the recommended level of care (24.5.4.5) or recommended environment (24.5.4.6), select an option in this field that identifies a reason for the difference.

24.5.4.9.2 This is generally used when the client or a clinician determines that the recommended treatment cannot or should not be the actual treatment provided.

24.5.4.9.3 If applicable, use the Comments field below (24.5.4.10) to explain the clinical override.

24.5.4.10 *Comments*

24.5.4.10.1 Enter any additional information related to the ASAM assessment and results.

24.5.4.10.2 Ideally, information entered into this text box should play a part in facilitating treatment planning and recovery goals.

24.5.5 When the necessary data has been entered into these fields, click the right arrow to advance to the Comments screen, which consists of the following fields:

24.5.5.1 *Was the client involved in the review process*

24.5.5.1.1 Indicate whether the client participated in the review of his or her treatment.

24.5.5.2 *New Functional Areas identified to be added to treatment plan*

24.5.5.2.1 Indicate whether new problems have been identified which should be added to the current treatment plan (24.5.7.2.6).

24.5.5.2.2 Any additional problems must be added as part of a draft plan (23.6.7) or a replacement plan (23.6.8).

24.5.5.3 *I will know I have achieved my recovery goal when (discharge criteria):*

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24.5.5.3.1 Indicate the progress the client should make or has made toward being eligible for transfer to a different agency or facility or eligible for discharge from treatment.

24.5.5.3.2 Use the client's own words whenever possible.

24.5.5.3.3 This field will automatically populate with text entered into the Transfer/Discharge Criteria field (23.4.3.4) of the treatment plan currently being reviewed.

24.5.5.4 *My strengths, resources, abilities and interests are:*

24.5.5.4.1 List the client's behavioral, personality, and situational attributes that have helped or hindered his or her completion of the treatment plan.

24.5.5.4.2 Use the client's own words whenever possible.

24.5.5.4.3 This field will automatically populate with the text entered into the Strengths/Resources/Abilities/Interests/Barriers to Success field (23.4.3.3) of the treatment plan currently being reviewed.

24.5.5.5 *My progress toward my recovery goal is:*

24.5.5.5.1 Indicate the progress the client has made toward his or her recovery goal(s), especially as related to those goals indicated in the treatment plan.

24.5.5.5.2 Use the client's own words whenever possible.

24.5.5.6 *I feel / my family feels this way about my treatment, planning, services and progress:*

24.5.5.6.1 Enter the client's personal statements or impressions regarding the treatment and/or services that he or she is receiving as well as the treatment plan and planning process.

24.5.5.6.2 Include relevant from the client's family or other concerned individuals.

24.5.5.6.3 Use the client's own words whenever possible.

24.5.5.7 *Clinician Comments / Changes to Diagnosis*

24.5.5.7.1 Enter any additional information from the clinician(s) responsible for reviewing the client's treatment.

24.5.5.8 *Additional Treatment Needs*

24.5.5.8.1 Indicate any additional treatment that the client does or may required to reach his or her goals.

24.5.5.8.2 Include treatment that is not part of the current treatment plan.

24.5.5.9 *Was plan reviewed for least restrictive setting*

24.5.5.9.1 Indicate whether the plan was evaluated to determine whether the client is currently receiving the most appropriate and lowest level of care.

24.5.5.10 *Was plan reviewed to make sure that services recommended are appropriate to client's strengths and need*

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24.5.5.10.1 Indicate whether the plan was evaluated to determine whether interventions, services, or other activities are appropriately addressing identified problem areas.

24.5.6 When all of the required fields have been filled (and others if applicable), click the right arrow to advance to the Review Team screen.

24.5.6.1 This screen allows the creation of a team of clinicians, facility staff, and collateral contacts who are participating or will participate in the treatment review and who will approve the results of the review.

24.5.6.1.1 The Available Treatment Team Members table lists the agency staff members and the client's collateral contacts who have been assigned as the client's treatment team during the current episode in the current facility.

24.5.6.1.2 Only the names of treatment team members who have "Yes" selected in the Review Member field (14.7.2.4) of the Treatment Team screen will be available in this table.

24.5.6.2 Select the treatment team members who will form the review team.

24.5.6.2.1 Place a check mark in the white box next to the name of the person who will be added to the review team.

24.5.6.2.1.1 Placing a check mark in the white box in the header row of this table will place a check mark in all of the boxes below it.

24.5.6.2.1.2 Removing a check mark from the white box in the header row of this table will remove all check marks below it.

24.5.6.3 When all of the desired names have been selected, click the "Add to Review Team" link in the Available Treatment Team Members heading.

24.5.6.4 The selected names will be moved to the Treatment Review Team table.

24.5.6.4.1 To remove a name from the Treatment Review Team, click the "Delete" link in the Actions column for the desired person.

24.5.6.4.2 The team member's name will be removed from the Treatment Review Team table.

24.5.6.4.3 The team member's name will be re-added to the Available Treatment Team Members table.

24.5.6.4.4 The team member's name can be moved back to the Treatment Review Team table if needed (see 24.5.6.2).

24.5.6.5 The staff members and collateral contacts who are part of the review team will be required to sign off the treatment review (24.6) in order to complete the review process.

24.5.6.6 The names of each of the review team members will appear on the report generated by the Treatment Review (24.8).

24.5.7 When the treatment review team is complete, click the right arrow to advance to the Plan Outline screen.

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24.5.7.1 The Treatment Review screen will display, which is similar to the Plan Outline screen in the TX Plan module (23.4.31).

24.5.7.1.1 The plan outline is a display of the treatment plan and all of the layered problems, goals, objectives, and interventions associated with it.

24.5.7.1.2 Click the "Printable View" icon at the top of the screen to open a pop-up window with a printer-friendly version of the plan outline.

24.5.7.1.3 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

24.5.7.1.4 Close the pop-up window when finished.

24.5.7.2 If it is determined necessary as part of the treatment review, aspects of the treatment plan can be modified from this screen.

24.5.7.2.1 Click the "Comment/Modify Plan" link in the Outline Actions box near the top of the screen.

24.5.7.2.2 OWITS will confirm the action.

24.5.7.2.3 To add a comment to any of the problems (labeled as "Needs" in this screen), goals, objectives, or interventions, click the "Comments" link next to the desired problem, goal, objective, or intervention number.

24.5.7.2.3.1 A "Review Comment" screen will display.

24.5.7.2.3.2 Enter desired comments in the large text box.

24.5.7.2.3.3 When finished, click Finish to return to the Plan Outline screen.

24.5.7.2.3.4 The comment text will be added to the plan outline and highlighted in yellow.

24.5.7.2.4 To change any of the problems (labeled as "Needs" in this screen), goals, objectives, or interventions, click the "Modify" link next to the desired problem, goal, objective, or intervention number.

24.5.7.2.4.1 OWITS will redirect to the TX Plan screen associated with the selected problem (23.4.11), goal (23.4.14), objective (23.4.17), or intervention (23.4.20).

24.5.7.2.4.2 Modify the data fields as needed.

24.5.7.2.4.3 Click Finish to apply the changes and return to the Plan Outline changes.

24.5.7.2.4.4 The header of the changed item will appear in red text.

24.5.7.2.5 To remove any of the problems (labeled as "Needs" in this screen), goals, objectives, or interventions, click the "Delete" link next to the desired problem, goal, objective, or intervention number.

24.5.7.2.5.1 OWITS will confirm the delete command.

24.5.7.2.5.2 The selected item will be deleted from the treatment plan.

24.5.7.2.5.3 This action cannot be undone.

24.5.7.2.5.4 The item will not be removed from the Plan Outline screen, but the header of the removed item will appear in dark blue text with a ~~strikethrough line~~.

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24.5.7.2.6 To add a problem record (identified as a "Functional Area"), click the "Add Functional Area" link in the box labeled Treatment Plan.

24.5.7.2.6.1 OWITS will redirect to the Problems/Goals screen of the TX Plan module (23.4.11).

24.5.7.2.6.2 Complete the data fields as appropriate.

24.5.7.2.6.3 Add goals, objectives, and interventions as appropriate.

24.5.7.2.6.4 Click Finish to return to the Plan Outline screen.

24.5.7.2.6.5 The header of the added item will appear in green text.

24.5.7.2.7 To add a goal, objective, or intervention, click the "Add" link next to the problem, goal, or objective number with which the new item will be associated.

24.5.7.2.7.1 OWITS will redirect to the Problems/Goals screen of the TX Plan module (23.4.11).

24.5.7.2.7.2 Complete the data fields as appropriate.

24.5.7.2.7.3 Click Finish to return to the Plan Outline screen.

24.5.7.2.7.4 The header of the added item will appear in green text.

24.5.7.3 When all of the desired changes have been made, click Finish to return to the Treatment Review List.

24.6 Review, approve, and sign-off completed treatment plan reviews.

24.6.1 Any user with access to the treatment review record can approve and sign off the review.

24.6.1.1 Whenever possible, the members of the client's treatment review team (24.5.6.2) should sign into OWITS, access the treatment review record, and sign off the treatment review themselves.

24.6.1.2 Due to system limitations, treatment review team members cannot sign off the same treatment review at the same time.

24.6.2 Click the "Review" link in the Actions column of the Treatment Review List table of the desired treatment review record.

24.6.3 Using the arrows or the Navigation View links, navigate to the Review Team screen (24.5.6).

24.6.3.1 The Treatment Review Team table will display the names of the treatment review team members.

24.6.3.2 The "Approved" column will display "No" until the associated team member has signed off.

24.6.3.3 The "Approved By" and "Approved Date" column will be blank until the associated team member has signed off.

24.6.4 If the review team member has reviewed and approved the treatment review record, click the "Sign-off" link in the "Sign-off" column for the desired team member.

24.6.4.1 The "Approved" column will display "Yes" after the associated team member has signed off.

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24.6.4.2 The "Approved By" column will display the name of the OWITS user who clicked the "Sign-off" link.

24.6.4.3 The "Approved Date" column will display the date on which the OWITS user clicked the "Sign-off" link.

24.6.5 When all of the treatment review team members have signed off, or when users have signed off the treatment review on behalf of all the treatment review team members, click Finish to return to the Treatment Review List screen.

24.6.5.1 The treatment review is not considered complete until all of the treatment review team members have signed off.

24.7 Apply changes made during the treatment plan review to the associated treatment plan.

24.7.1 Whenever possible, treatment reviews should be approved and signed off (24.6) by the treatment review team (24.5.6.2) prior to applying changes to the treatment plan.

24.7.2 Click the "Review" link in the Actions column of the Treatment Review List table of the desired treatment review record.

24.7.3 The treatment review's Profile screen includes an Actions box with three links:

24.7.3.1 "Cancel Review"

24.7.3.1.1 This link is available any time after the treatment review record has been saved.

24.7.3.1.2 If the treatment review has not been completed and will not be completed or has been rejected by the members of the treatment review team, click the "Cancel Review" link.

24.7.3.1.3 All fields in the treatment review record will change to a read-only state.

24.7.3.1.4 "Cancelled" will display in the Review Status field and on the Treatment Review List screen.

24.7.3.1.5 Click Finish to return to the Treatment Review List screen.

24.7.3.1.6 A new treatment review record can now be created as needed (24.5).

24.7.3.2 "Complete, No changes to TX Plan"

24.7.3.2.1 This link is only available if no changes have been applied to the Plan Outline screen (24.5.7) and the treatment review record has been saved.

24.7.3.2.2 If the Plan Outline screen has not been changed, and if the treatment review has been completed and approved by the members of the treatment review team, click the "Complete, No changes to TX Plan" link.

24.7.3.2.3 OWITS will confirm the command.

24.7.3.2.4 All fields in the treatment review record will change to a read-only state.

24.7.3.2.5 No changes will be made to the treatment plan.

24.7.3.2.6 Click Finish to return to the Treatment Review List screen.

24.7.3.3 "Apply Changes"

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24.7.3.3.1 This link is only available after any changes have been made on the Plan Outline screen (24.5.7) and the treatment review record has been saved.

24.7.3.3.2 If the Plan Outline screen has been changed in any way, and if the treatment review has been completed and approved by the members of the treatment review team, click the "Apply Changes" link.

24.7.3.3.2.1 Only changes on the Plan Outline screen are included.

24.7.3.3.2.2 Changes made to other data fields that are connected to the treatment plan will not be applied.

24.7.3.3.3 OWITS will confirm the command.

24.7.3.3.4 The changes will be applied to the treatment plan associated with the treatment review.

24.7.3.3.4.1 The current treatment plan will not be deleted.

24.7.3.3.4.2 The changes will be applied as a new version of the existing plan.

24.7.3.3.4.3 The value in the Plan Version field (23.4.1.4) will increase by one.

24.7.3.3.4.4 When ready, sign off the new version of the treatment plan as created through this treatment review process (see 23.6.5).

24.7.3.3.5 Any draft treatment plans created from the treatment plan associated with the treatment review will be deleted.

24.7.3.3.6 All fields in the treatment review record will change to a read-only state.

24.7.3.3.7 These actions cannot be undone.

24.7.3.3.8 Click Finish to return to the Treatment Review List screen.

24.8 Generate reports of treatment reviews.

24.8.1 Click the "Review" link in the Actions column of the Treatment Review List table for the desired review record.

24.8.2 On any of the five screens of the treatment review, click the "Generate Report" link at the top of the screen.

24.8.2.1 A pop-up browser window will open.

24.8.2.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

24.8.2.2 The pop-up window will display a formatted report (as a PDF) of the data entered into the treatment review, including:

24.8.2.2.1 All updated fields from the treatment review screens.

24.8.2.2.2 The ASAM assessment results.

24.8.2.2.3 The names of the members of the Treatment Review Team (24.5.6.2) as well as whether each has approved the review (and when, if applicable).

24.8.2.2.4 A comprehensive list of the client's problems, goals, objectives, and interventions from the treatment plan associated with this review (see 23.4.8.1).

24.8.2.3 This PDF can be saved or printed.

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24.8.2.3.1 Use the Adobe PDF print and save icons (not the Internet Explorer print or save functions) to print or save the PDF.

24.8.2.3.2 CAUTION: The more problems, goals, objectives, and interventions have been added to the treatment plan, the more paper will be required to print it.

24.8.2.4 Close the pop-up window when finished.

24.8.3 Click Finish to return to the Treatment Review List screen.

24.9 Return to the Activity List or other modules using the Navigation View links.

25.0 Medications

25.1 Use of the Medications module is optional.

25.2 The Medications module, which is located within the Treatment module, allows facilities to track the medications taken by or prescribed for the client during treatment.

25.2.1 Because OWITS is not a medical electronic health record, this section is minimal and should be used for reference purposes only.

25.2.2 This module is facility and episode specific, and data entered here will not be copied to other facilities or episodes.

25.2.3 This module should not be used to record individual instances of medication administration.

25.2.4 Medications recorded in this module are associated with the current episode of treatment and will appear on the printed Treatment Plan report (23.7.4.2).

25.2.5 A report is available for users to obtain comprehensive lists of the medications recorded in this module for all agency clients (see OWITS Reference Manual, Volume 10: Running Reports).

25.3 In the Navigation View, navigate to Client List > Activity List > Treatment > Medications.

25.3.1 The Medications screen will display.

25.3.2 The Medications table lists all medications entered for this client in the current facility and during the selected episode.

25.3.3 The Current Medications box lists all medications (with their related dosage and frequency) that have been entered for this client in the current facility and during the selected episode and that have not been discontinued.

25.4 Add new records of historical, current, or new medications as needed.

25.4.1 Click the "Add New Medication" link in the blue line in the center of the screen.

25.4.2 The following fields will become available:

25.4.2.1 *Medication*

25.4.2.1.1 In the first of these two fields, select the categorical description that best describes the medication to be recorded.

25.4.2.1.1.1 Example: Select "Antidepressant Medications" for medications such as Effexor, Paxil, Prozac, etc.

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25.4.2.1.1.2 Example: Select "Heroin Treatment Medications" for medications such as Buprenorphine, Methadone, Naltrexone, etc.

25.4.2.1.1.3 Select "General Medical Condition" if none of the categorical descriptions fit the medication to be recorded.

25.4.2.1.2 In the second of these two fields, select the specific name of the medication.

25.4.2.1.2.1 The contents of this second Medication field are determined by the categorical description selected in the first Medication field.

25.4.2.1.2.2 Select "Other" if the desired medication is not available in this second Medication field.

25.4.2.1.3 Selecting "Other" in the second Medication field will cause a small text box to appear.

25.4.2.1.3.1 In the new "Please Specify" field, enter the name of the medication that is not found in the second Medication field.

25.4.2.1.3.2 If a medication does not appear in the second Medication field but is frequently entered into this "Please Specify" field, it can be added by request (submit requests using the OWITS Support Ticket module or by sending an email to owits.support@state.or.us).

25.4.2.2 *Authorized Prescriber*

25.4.2.2.1 Enter the name of the physician or other health care professional who prescribed the medication to the client.

25.4.2.2.2 Enter "Not Applicable" if recording a non-prescribed over-the-counter medication.

25.4.2.3 *Discontinued by Physician*

25.4.2.3.1 If applicable, enter the name of the physician or other health care professional who instructed the client to stop taking the medication (whether he or she has actually stopped or not).

25.4.2.3.2 Enter "Self" if the client voluntarily discontinued the use of a non-prescribed over-the-counter medication.

25.4.2.4 *Reason*

25.4.2.4.1 If the medication has been discontinued (by a physician or other health care professional if it is a prescribed medication or by the client if it is a non-prescribed over-the-counter medication), select the option that best describes the reason for the discontinuation of the medication.

25.4.2.5 *Dose*

25.4.2.5.1 Enter the amount of the medication is administered to the client at a time.

25.4.2.5.2 Include self-administration.

25.4.2.5.3 Example: 100 mg

25.4.2.5.4 Example: 30 cc

25.4.2.5.5 Example: 2 tablets

25.4.2.6 *Frequency*

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25.4.2.6.1 Enter a brief description of how often the medication is administered to the client

25.4.2.6.2 Include self-administration.

25.4.2.6.3 Example: 2x daily

25.4.2.6.4 Example: With meals

25.4.2.6.5 Example: Bedtime

25.4.2.7 *Date Prescribed*

25.4.2.7.1 If the medication was prescribed, enter the date on which a physician or other health care professional issued the prescription for the medication.

25.4.2.7.2 If the medication is a non-prescribed over-the-counter medication, enter the date on which client started using it on a regular basis.

25.4.2.8 *Date Discontinued*

25.4.2.8.1 If any option is selected in the Reason field (25.4.2.4), this field will become required.

25.4.2.8.2 Enter the date that the client was instructed to discontinue the medication if it was prescribed by a physician or other health care professional or the date that the client voluntarily discontinued use if it was a non-prescribed over-the-counter medication.

25.4.2.8.3 To avoid confusion when reviewing the printed Treatment Plan report (23.7.4.2), ensure that this field is completed for all discontinued medications.

25.4.2.9 *Notes (including identification and documentation of drug reactions and instructions for use)*

25.4.2.9.1 To avoid potential confusion, specify whether the medication is part of the client's treatment and/or treatment plan.

25.4.2.9.2 Enter any additional information or details about the medication, the client's need for the medication, the prescription, the pharmacy and/or supplier, potential reactions, administration instructions (including or in addition to dosage instructions), etc.

25.4.3 When all the required fields (and others as appropriate) are filled, click Save to apply the medication to the client's record.

25.5 Review and modify existing medications as needed.

25.5.1 In the Actions column of the Medications table near the top of the screen, click the "Review" link for the desired medication.

25.5.2 The medication detail fields in the bottom section of the screen will populate with the data entered previously.

25.5.3 Modify and add to these fields as needed.

25.5.4 Click Save to apply the changes to the client's medication record.

25.6 Print prescription forms as needed.

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25.6.1 This prescription form may not be sufficient for the client to obtain the prescribed medications.

25.6.2 Agencies must individually determine if and how the prescription form function of this module will be used.

25.6.3 In the Actions column of the Medications table near the top of the screen, click the "Print" link for the desired medication.

25.6.3.1 A pop-up browser window will open.

25.6.3.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

25.6.3.2 The pop-up window will contain a prescription form (as a PDF), including:

25.6.3.2.1 The client's demographic information as entered in the Client Profile.

25.6.3.2.2 The medication name, dosage, frequency, prescribed date, and notes, as well as the name of the authorized prescriber as entered in the Medication section fields.

25.6.3.2.3 Signature lines and other prescription information.

25.6.3.3 This PDF can be saved or printed.

25.6.3.3.1 Use the Adobe PDF print and save icons (not the Internet Explorer print or save functions) to print or save the PDF.

25.6.3.4 Close the pop-up window when finished.

25.7 Click Finish to return to the Activity List.

26.0 Discharge

26.1 Use of the Discharge module may be required, depending on the reporting method selected by the agency or facility (see 1.5.1.1.1).

26.2 Due to their complexity, steps for creating and modifying Disenroll and Discharge records are detailed in OWITS Reference Manual, Volume 9: Client Discharge.

26.3 The Client Profile (see OWITS Reference Manual, Volume 4: Client Profile), Intake (7.0), and Admission (17.0) records must be completed before a Discharge record can be created.

26.4 The Program Enroll records (18.0) must also be completed with values in the End Date (18.4.2.6) and Termination Reason fields (18.4.2.7) for all programs in which the client participated in the selected facility.

26.4.1 The TEDS/NOMS Disenrollment data (26.5.2) must also be completed for TEDS-reported programs.

26.4.2 Clients cannot be enrolled in more programs in the current episode after a Discharge record has been completed.

26.4.2.1 If a client must be enrolled in additional programs after a Discharge record has been completed, the Discharge must be deleted, or a new Intake record must be created.

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26.5 To view a Disenrollment, locate the desired program enrollment in the Activity List and click the Review link in the Actions column.

26.5.1 The Program Enrollment Profile will display.

26.5.1.1 If the client has been disenrolled from the program, the End Date and Termination Reason fields will be filled.

26.5.2 In the Actions bar, click "Complete TEDS/NOMS Disenroll Status" link.

26.5.2.1 The Disenroll Status screen will display.

26.5.2.2 Click Cancel to return to a list of Program Enrollment records.

26.5.3 Click Cancel or Finish to return to the Activity List.

26.6 To view a Discharge record, use the Navigation View to navigate to Activity List > Discharge.

26.6.1 The Discharge Profile will display.

26.6.2 Use the links in the Navigation View under Discharge (Profile, Legal, Status, Substance Abuse, Tobacco, Tx Summary, and Diagnosis) or the blue arrows to navigate to the various pages of the discharge record.

26.6.3 Click Cancel to return to the Activity List.

27.0 Recovery Plan

27.1 Use of the Recovery Plan module is optional.

27.2 This module allows for creating, reviewing, and utilizing a plan for the client's recovery from addiction or mental health problems.

27.2.1 Recovery plans are generally designed collaboratively by the client and a clinician and focus primarily on the steps that the client will take after completing treatment to address ongoing recovery needs.

27.2.2 OWITS also allows for the creation and use of treatment plans (23.0), which differ from recovery plans in that they focus primarily on the steps that the clinician(s) and clinic staff will take to assist the client during treatment.

27.3 Please note that this manual is only intended to instruct OWITS users regarding the recording and utilization of recovery plan records.

27.3.1 This manual does not provide clinical instructions for how to create and/or use recovery plans to serve clients.

27.3.2 Users are expected to follow guidelines established by their agency regarding the content and application of recovery plans.

27.4 Navigate to Client List > Activity List > Recovery Plan

27.4.1 The Recovery Plan List screen will display.

27.4.2 An Intake (7.0) record must be completed before a recovery plan can be created.

27.4.3 To avoid errors when adding recovery team members (27.5.2.4), an Admission record (17.0) should also be created.

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27.5 To create a new recovery plan, click the "Add New Recovery Plan Record" link in the Recovery Plan List heading.

27.5.1 The Recovery Plan Profile screen will display, consisting of the following fields:

27.5.1.1 *Created By*

27.5.1.1.1 This read-only field will automatically populate with the name of the user who created this record.

27.5.1.2 *Created Date*

27.5.1.2.1 This read-only field will automatically populate with the date on which this record was created and saved.

27.5.1.3 *Updated By*

27.5.1.3.1 This read-only field will automatically populate with the name of the user who most recently modified this record.

27.5.1.4 *Last Updated Date*

27.5.1.4.1 This read-only field will automatically populate with the date on which this record was most recently modified.

27.5.1.5 *Plan Name*

27.5.1.5.1 Enter a name for the recovery plan.

27.5.1.5.2 Plan names should at least suggest the contents or goals of the plan.

27.5.1.5.3 Plan names cannot exceed 256 characters, including spaces.

27.5.1.5.4 Agencies are individually responsible for determining the format and specificity of recovery plan names.

27.5.1.6 *Plan Period (Days)*

27.5.1.6.1 Enter the number of days the plan is expected to be effective.

27.5.1.6.2 If a date has been entered into the Plan End Date field, when the recovery plan is saved, this field will automatically populate with the number of days between the Plan Start Date (27.5.1.8) and the Plan End Date (27.5.1.9).

27.5.1.7 *Plan Status*

27.5.1.7.1 This read-only field will automatically populate with values that describe whether the recovery has been prepared, completed, signed, or superseded.

27.5.1.7.2 "Active – Not Signed Off" indicates that the plan has been created but that it has not yet been approved by the client and/or by clinicians.

27.5.1.7.3 "Active – Signed Off" indicates that the plan has been approved by the client, by clinicians, and by others involved with the client's treatment.

27.5.1.7.4 "Inactive – Old Version" indicates a recovery plan record that has been replaced.

27.5.1.8 *Plan Start Date*

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27.5.1.8.1 Enter the date on which the client will begin taking or following any of the steps outlined in the recovery plan.

27.5.1.8.2 This date may be in the future.

27.5.1.9 *Plan End Date*

27.5.1.9.1 Enter the date on which the plan is expected to conclude, expire, or otherwise come to an end.

27.5.1.9.2 If a number has been entered into the Plan Period field, when the recovery plan is saved, this field will automatically populate with the date that is the number of Plan Period days (27.5.1.6) from the Plan Start Date (27.5.1.8).

27.5.1.10 *Next Review Date*

27.5.1.10.1 Enter the date on which an agency staff member is expected to review the recovery plan and the client's progress.

27.5.1.11 *Client Participated in Recovery Plan Development*

27.5.1.11.1 Indicate whether the client took part in the planning and development of this recovery plan.

27.5.1.12 *Administrative Actions*

27.5.1.12.1 This box contains links that can affect the recovery plan record.

27.5.1.12.2 The "Create New Version" link can later be used to duplicate most of the data in the current recovery plan into a new recovery plan record that can be modified and saved as if new (27.8.7).

27.5.1.12.3 The "Sign Off" link can later be used to complete a saved recovery plan (27.8.5).

27.5.1.12.4 The "Perform Review" link can later be used to initiate a recovery plan review and create a review record accordingly (27.8.8).

27.5.1.13 *Check Up History*

27.5.1.13.1 This table lists the details of the risk assessments that have been conducted in association with this recovery plan (see 27.6).

27.5.2 When all of the required fields have been filled (and others as appropriate), click the right arrow to advance to the Overview screen, which consists of the following fields and tables:

27.5.2.1 *High Risk Situations*

27.5.2.1.1 Indicate up to four of the client's top high risk situations

27.5.2.1.2 Attempting to select more than four options will produce an error message.

27.5.2.2 *Recovery Activities*

27.5.2.2.1 Indicate up to four ways the client spends time with people who do not have an alcohol or drug problem

27.5.2.2.2 Attempting to select more than four options will produce an error message.

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27.5.2.3 *Days to Next Check up*

27.5.2.3.1 This field can be used by care coordinators to identify when the next check up will or should take place.

27.5.2.3.2 This field is not currently configured for automatic use in OWITS.

27.5.2.3.3 This field may be left blank.

27.5.2.4 *Continuing Care Team*

27.5.2.4.1 This table displays the names of staff members and collateral contacts who have been assigned as the client's recovery team during the current episode in the current facility.

27.5.2.4.2 Only the names of treatment team members who have been selected as a Recovery Team Member (see 14.7.2.7) will appear in this table.

27.5.2.4.3 To add to or modify the continuing care team, click the "Add New Member" link in the Continuing Care Team heading.

27.5.2.4.3.1 OWITS will redirect to the Treatment Team screen in the Admission record associated with the current episode (17.3.23).

27.5.2.4.3.2 Add or modify treatment team members as needed, following the instructions detailed in 14.0.

27.5.2.4.3.3 Ensure that "Yes" is selected in the Recovery Team Member field.

27.5.2.4.3.4 Click Finish to return to the Continuing Care Overview screen.

27.5.2.4.3.5 Using the Navigation View links to exist the Treatment Team screen when accessed from the Continuing Care Overview screen will cancel any unsaved progress.

27.5.2.5 *Current Collateral Contacts*

27.5.2.5.1 This table displays the names of the client's current collateral contacts.

27.5.2.5.2 To add or modify collateral contacts, click the "Add New Contact" link.

27.5.2.5.2.1 The Collateral Contacts screen will display.

27.5.2.5.2.2 Add collateral contacts as needed (see OWITS Reference Manual, Volume 4: Client Profile).

27.5.2.5.2.3 Click Finish to return to the Continuing Care Overview screen.

27.5.2.5.2.4 Using the Navigation View links to exit the Collateral Contacts screen when accessed from the Continuing Care Overview screen will cancel any unsaved progress.

27.5.3 When data has been entered and care team or collateral contact names have been added as appropriate, click the right arrow to advance to the Life Domains/Goals screen.

27.5.3.1 The Recovery Plan Summary table lists any life domains (27.5.6) that have been entered for this recovery plan.

27.5.4 Functions can be initiated from this screen that will add records of life domains, goals, objectives, and action steps to the recovery plan record.

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27.5.4.1 Life Domain – An aspect of the client's life in which he or she would like to make improvements.

27.5.4.2 Goal – An ideal situation or state of being based on the life domain, often identified by the client, that is related to his or her life, recovery, etc., and that is reasonably achievable during treatment.

27.5.4.3 Objective – A small and measurable step or series of steps based on the goal, typically developed with the client, that are designed to help the client achieve the goal he or she has set.

27.5.4.4 Action Step – A specific action taken by the client by, with or without help from a clinician or other concerned individual(s), in an effort to achieve an objective and/or goal or to otherwise bring about change.

27.5.4.5 Action steps are nested in the objectives, which are nested in the goals, which are nested in the life domains (see Appendix F – Example of Treatment and Recovery Plan Hierarchies).

27.5.5 To add to this table, click the "Add New Life Domain" link in the Recovery Plan Summary heading.

27.5.6 The Life Domain/Strengths and Challenges Profile screen will display, which consists of the following fields:

27.5.6.1 *Life Domain #*

27.5.6.1.1 This read-only field will automatically populate with a number according to the total of life domain records added to this recovery plan.

27.5.6.1.2 The first life domain in this recovery plan will be 1, the second life domain will be 2, the third life domain will be 3, and so on.

27.5.6.2 *Date*

27.5.6.2.1 Enter the date on which the strengths and challenges recorded in this life domain profile were identified.

27.5.6.3 *Life Domain*

27.5.6.3.1 Select the option that best describes the categorical description of the strengths and challenges that will be recorded.

27.5.6.4 *My resources, strengths, and skills are*

27.5.6.4.1 Enter a description of the client's resources, strengths, and skills.

27.5.6.4.2 These should relate in some way to the life domain selected in the field above (27.5.6.3).

27.5.6.4.3 Use the client's own words, if possible.

27.5.6.5 *My barriers and challenges are*

27.5.6.5.1 Enter a description of the client's challenges and barriers to success.

27.5.6.5.2 These should relate in some way to the life domain selected in the field above (27.5.6.3).

27.5.6.5.3 Use the client's own words, if possible.

27.5.7 When all the required fields have been filled (and others appropriate), click Save.

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27.5.7.1 If no goals, objectives, or action steps are to be added with this strengths/challenges record, skip to step 27.5.20.

27.5.7.2 Additional information can be added to the strengths/challenges records as needed until the recovery plan has been signed off (27.8.5).

27.5.8 To enter a goal connected to the life domain record that is currently displayed, click the "Add Goal" link in the Goal List heading.

27.5.9 The Goal Profile screen will display, which consists of the following fields:

27.5.9.1 *Life Domain #*

27.5.9.1.1 This read-only field will automatically populate with the value that appears in the Life Domain # afield on the Life Domains/Strengths and Challenges Profile screen (27.5.6.1).

27.5.9.2 *Life Domain*

27.5.9.2.1 This read-only field will automatically populate with the name of category selected in the Life Domain field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.3).

27.5.9.3 *Strengths/Skills*

27.5.9.3.1 This read-only field will automatically populate with the text entered into the resources, strengths, and skills field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.4).

27.5.9.4 *Barriers and Challenges*

27.5.9.4.1 This read-only field will automatically populate with the text entered into the barriers and challenges field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.5).

27.5.9.5 *Goal Status*

27.5.9.5.1 Select the option that best describes what the client is doing or is going to do with this goal.

27.5.9.6 *My goal in this area is*

27.5.9.6.1 Enter a description of the client's goal.

27.5.9.6.2 These should relate in some way to the life domain selected on the previous screen (27.5.6.3).

27.5.9.6.3 Use the client's own words, if possible.

27.5.9.7 *I will know I have achieved this goal when*

27.5.9.7.1 Enter a description of how the client expects to identify his or her progress toward achieving the goal as described in the field above (27.5.9.6).

27.5.9.7.2 These should relate in some way to the life domain selected on the previous screen (27.5.6.3).

27.5.9.7.3 Use the client's own words, if possible.

27.5.9.8 *Projected Achievement Date*

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27.5.9.8.1 Enter the date on which the client or the clinician can reasonably expect the goal to be completed.

27.5.10 When all the required fields have been filled (and others as appropriate), click Save.

27.5.10.1 If no objectives or action steps are to be added with this goal, skip to step 27.5.19.

27.5.10.2 Additional information can be added to the goal records as needed until the recovery plan has been signed off (27.8.5).

27.5.11 To enter an objective connected to the goal that is currently displayed, click the "Add Objective" link in the Objective List heading.

27.5.12 The Objectives screen will display, which consists of the following fields:

27.5.12.1 *Life Domain #*

27.5.12.1.1 This read-only field will automatically populate with the value that appears in the Life Domain # field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.1).

27.5.12.2 *Date Assessed*

27.5.12.2.1 This read-only field will automatically populate with the date entered into the Date field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.2).

27.5.12.3 *Life Domain*

27.5.12.3.1 This read-only field will automatically populate with the name of category selected in the Life Domain field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.3).

27.5.12.4 *Strengths/Skills*

27.5.12.4.1 This read-only field will automatically populate with the text entered into the resources, strengths, and skills field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.4).

27.5.12.5 *Barriers and Challenges*

27.5.12.5.1 This read-only field will automatically populate with the text entered into the barriers and challenges field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.5).

27.5.12.6 *Goal*

27.5.12.6.1 This read-only field will automatically populate with the text entered into the goal field on the Goal Profile screen (27.5.9.6).

27.5.12.7 *Objective #*

27.5.12.7.1 This read-only field will automatically populate with a number according to the total number of objective records added to this goal in this life domain and recovery plan.

27.5.12.7.2 The first objective in this goal will be 1, the second objective will be 2, the third will be 3, and so on.

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27.5.12.7.3 Objectives created for other goals and/or other life domains will begin again with 1.

27.5.12.8 *Create Date*

27.5.12.8.1 This read-only field will automatically populate with the date on which this objective was created and saved.

27.5.12.9 *I will achieve my goal by (objective)*

27.5.12.9.1 Enter a description of the client's objectives associated with the goal to which it is correlated.

27.5.12.9.2 Use the client's own words, if possible.

27.5.12.10 *Objective Status*

27.5.12.10.1 Select the option that best describes how the client is progressing with this objective.

27.5.12.11 *Expected Achieve Date*

27.5.12.11.1 Enter the date on which the client or the clinician can reasonably expect the objective to be reached.

27.5.12.12 *Resolution Date*

27.5.12.12.1 If the objective has been reached or otherwise concluded, enter the completion date.

27.5.13 When all the required fields have been filled (and others as appropriate), click Save.

27.5.13.1 If no action steps are to be added with this objective, skip to step 27.5.18.

27.5.13.2 Additional information can be added to the objective records as needed until the recovery plan has been signed off (27.8.5).

27.5.14 To enter an action step connected to the objective that is currently displayed, click the "Add Action Step" link in the Action Steps heading.

27.5.15 The Action Steps screen will display, which consists of the following fields:

27.5.15.1 *Life Domain #*

27.5.15.1.1 This read-only field will automatically populate with the value that appears in the Life Domain # field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.1).

27.5.15.2 *Life Domain*

27.5.15.2.1 This read-only field will automatically populate with the name of category selected in the Life Domain field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.3).

27.5.15.3 *Strengths/Skills*

27.5.15.3.1 This read-only field will automatically populate with the text entered into the resources, strengths, and skills field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.4).

27.5.15.4 *Barriers and Challenges*

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27.5.15.4.1 This read-only field will automatically populate with the text entered into the barriers and challenges field on the Life Domains/Strengths and Challenges Profile screen (27.5.6.5).

27.5.15.5 *Goal*

27.5.15.5.1 This read-only field will automatically populate with the text entered into the goal field on the Goal Profile screen (27.5.9.6).

27.5.15.6 *Objective #*

27.5.15.6.1 This read-only field will automatically populate with the value that appears in the Objective # field on the Objectives screen (27.5.12.7).

27.5.15.7 *Objective*

27.5.15.7.1 This read-only field will automatically populate with the text entered into the objective field on the Objectives screen (27.5.12.9).

27.5.15.8 *Objective Create Date*

27.5.15.8.1 This read-only field will automatically populate with the date that appears in the Create Date field on the Objectives screen (27.5.12.8).

27.5.15.9 *Objective Status*

27.5.15.9.1 This read-only field will automatically populate with the option selected in the Objective Status field on the Objectives screen (27.5.12.10).

27.5.15.10 *Action Step #*

27.5.15.10.1 This read-only field will automatically populate with a number according to the total number of action steps added to this objective of this goal in this life domain and recovery plan.

27.5.15.10.2 The first action step of this objective will be 1, the second action step will be 2, the third will be 3, and so on.

27.5.15.10.3 Action steps created for other objectives and/or goals and/or life domains will begin again with 1.

27.5.15.10.4 Action steps do not necessarily need to be entered sequentially, though doing so may make it easier for the client to follow them.

27.5.15.11 *To achieve my goal, I will participate in the following activities*

27.5.15.11.1 Enter a description of the specific action the client will take to progress toward completion of the associated objective.

27.5.15.11.2 Use the client's own words, if possible.

27.5.15.12 *Create Date*

27.5.15.12.1 This read-only field will automatically populate with the date on which this action step was created and saved.

27.5.15.13 *Action Step Status*

27.5.15.13.1 Select the option that best describes whether the client has completed this action step.

27.5.16 When all of the required fields have been filled (and others as appropriate), click Save.

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27.5.16.1 If needed, repeat steps 27.5.14 through 27.5.16 to add more action steps to the objective.

27.5.17 Click Finish to return to the Objectives screen.

27.5.17.1 If needed, add more objectives.

27.5.17.2 Repeat steps 27.5.11 through 27.5.13 to add more objectives to the goal.

27.5.18 Click Finish to return to the Goal Profile screen.

27.5.18.1 If needed, add more goals.

27.5.18.2 Repeat steps 27.5.8 through 27.5.10 to add more goals to the life domain.

27.5.19 Click Finish to return to the Life Domain / Strengths and Challenges Profile screen.

27.5.19.1 If needed, add more life domains.

27.5.19.2 Repeat steps 27.5.5 through 27.5.7 to add more life domains.

27.5.20 Click Finish to return to the Recovery Plan Summary (Life Domains/Goals) screen.

27.5.20.1 Life Domains, Goals, Objectives, and Action Steps can be deleted from the Plan Outline screen in the Recovery Plan module or in the Recovery Plan Rvw module (28.0).

27.5.21 Click the right arrow to advance to the Plan Outline screen.

27.5.21.1 The plan outline is a display of the recovery plan and all of the layered life domains, goals, objectives, and action steps associated with it.

27.5.21.2 For instructions on modifying the plan and its contents from this screen, see 27.7.4.1 through 27.7.4.7.

27.5.21.3 Click the "Printable View" icon at the top of the screen to open a pop-up window with a printer-friendly version of the plan outline.

27.5.21.3.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

27.5.21.3.2 Close the pop-up window when finished.

27.5.22 Click Finish to return to the Recovery Plan Profile screen.

27.5.23 Click Finish to return to the Recovery Plan List.

27.6 To add check-up and risk assessment records, click the "Review" link in the Actions column of the Recovery Plan List table for the desired recovery plan record.

27.6.1 Click the "Add New Check Up" link in the Check Up History heading of the Recovery Plan Profile screen.

27.6.2 The Check Up Profile screen will display.

27.6.2.1 CAUTION: Use the Cancel or Finish button at the bottom of the screen to exit the Check Up Profile; using the Navigation View links may result in lost data or error messages.

27.6.3 The first section of the Check Up screen, labeled "Check Up Profile," consists of the following data fields:

27.6.3.1 *Date*

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27.6.3.1.1 This field will automatically populate with the current date.

27.6.3.1.2 If the risk assessment was conducted on a date other than the current date, change this field.

27.6.3.1.3 The date can be in the future.

27.6.3.2 *Staff*

27.6.3.2.1 Use this field to identify the name of the staff member who conducted the check up or risk assessment.

27.6.3.2.2 Type the first few letters of the staff member's *last name* and click the magnifying glass to the right of the field.

27.6.3.2.3 OWITS will search the agency records for staff members whose last names match the letters entered.

27.6.3.2.3.1 If one matching staff member record is found, the name will automatically populate.

27.6.3.2.3.2 If multiple matching staff members are found, use the resultant drop-down menu to select the correct name.

27.6.3.3 *Result*

27.6.3.3.1 Select the option that best describes the outcome of this check up or risk assessment.

27.6.3.4 *Start Time*

27.6.3.4.1 This field will automatically populate with the current time (as identified by the server located in the Eastern time zone).

27.6.3.4.2 If the risk assessment was conducted at a time other than the time displayed, change this field.

27.6.3.4.3 This time can be in the future.

27.6.4 The Check Up Profile section also contains the following assessment questions, which should be answered by a narrative or short answer in the available text box unless otherwise specified:

27.6.4.1 *How have you been doing with your recovery?*

27.6.4.2 *Recovery Sustained?*

27.6.4.3 *What has helped you sustain your recovery?*

27.6.4.3.1 This text box will only be available if "Yes" is selected in the Recovery Sustained field above (27.6.4.2).

27.6.4.4 *Have there been specific things (stressors or triggers) that have been making it difficult to sustain your recovery?*

27.6.4.4.1 This text box will only be available if "Yes" is selected in the Recovery Sustained field above (27.6.4.2).

27.6.4.5 *When did you relapse?*

27.6.4.5.1 Enter the date on which the client relapsed into substance abuse or into his or her problematic state of mental health.

27.6.4.5.2 If the client has not relapsed, leave this field blank.

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27.6.4.6 *What triggered the relapse?*

27.6.4.7 *What have you been using?*

27.6.4.8 *How often have you used?*

27.6.4.9 *How much have you been using?*

27.6.4.10 *What has worked well for you in the past when you have relapsed? What might you do this time to get back into recovery?*

27.6.4.11 *Can I help you access treatment or other recovery support services?*

27.6.4.11.1 Select "Yes" or "No" based on the client's response to the question.

27.6.4.12 *Specify Date and Time for Appointment*

27.6.4.12.1 In the Date field, enter a future date for the client's next appointment.

27.6.4.12.2 In the Time field, enter the time for which the client's next appointment is scheduled.

27.6.4.12.2.1 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

27.6.4.12.2.2 Example: 08:30 AM

27.6.4.12.2.3 Example: 03:25 PM

27.6.4.12.2.4 Example: 1630

27.6.5 The second section of the Check Up screen, labeled "Risk Assessment," includes ten assessment questions.

27.6.5.1 Each question includes the following three fields:

27.6.5.1.1 *Response*

27.6.5.1.1.1 Select the option that best fits the client's answer to the question asked.

27.6.5.1.2 *Last Response*

27.6.5.1.2.1 This read-only field will automatically populate with the option selected for this question in the most recent check up or risk assessment recorded in the current recovery plan.

27.6.5.1.2.2 If no check up or risk assessment has been conducted in the current episode, this field will be blank.

27.6.5.1.3 *Comment*

27.6.5.1.3.1 Enter a detailed description of the client's response in this text box.

27.6.5.1.3.2 Use the client's own words, if possible.

27.6.5.2 The risk assessment section includes the following questions:

27.6.5.2.1 *Mood: In the past week, how many times would you say your mood has changed?*

27.6.5.2.2 *Suicidality/Homicidality: Have you had any thoughts of hurting yourself or someone else?*

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27.6.5.2.3 *Medication Adherence: Have you had any changes in prescribed medication?*

27.6.5.2.4 *Medication Adherence: If currently taking medication, have you taken medication as prescribed this week?*

27.6.5.2.5 *Concern: How concerned are you right now about your ability to stay clean and sober until our next phone call?*

27.6.5.2.6 *Time Alone: How much time are you spending alone or with strangers? Comment Questions: Are you happy with the amount of time you spend alone? How have you been spending your free time (outside of work/other obligations)?*

27.6.5.2.7 *High Risk Situations: Have you been in any of these situations in the past week?*

27.6.5.2.8 *Craving: How many times have you experienced cravings, dreams, thoughts or desires to drink or use drugs?*

27.6.5.2.9 *Craving: If experienced, how strong?*

27.6.5.2.10 *Craving: What did you do when you had a craving?*

27.6.5.3 The risk assessment section also includes one self-populating data field:

27.6.5.3.1 *High Risk Situations*

27.6.5.3.1.1 This read-only field will automatically populate with the options selected in the High Risk Situations field on the Recovery Plan Overview screen (27.5.2.1).

27.6.6 The third section of the Check Up screen, labeled "Protective Factor," includes seven assessment questions.

27.6.6.1 Each question includes the following three fields:

27.6.6.1.1 *Response*

27.6.6.1.1.1 Select the option that best fits the client's answer to the question asked.

27.6.6.1.2 *Last Response*

27.6.6.1.2.1 This read-only field will automatically populate with the option selected for this question in the most recent check up or risk assessment recorded in the current recovery plan.

27.6.6.1.2.2 If no check up or risk assessment has been conducted in the current episode, this field will be blank.

27.6.6.1.3 *Comment*

27.6.6.1.3.1 Enter a detailed description of the client's response in this text box.

27.6.6.1.3.2 Use the client's own words, if possible.

27.6.6.2 The protective factor section includes the following questions:

27.6.6.2.1 *Living Environment: Are you currently living in a safe environment that supports your recovery?*

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27.6.6.2.2 *Recovery Activities: How many times have you participated in a recovery activity other than an AA/NA meeting with people who are sober or who have no alcohol/drug problem?*

27.6.6.2.3 *Meetings: How many AA/NA meeting have you attended this past week?*

27.6.6.2.4 *Meetings (2): Did you participate actively at any of these meetings?*

27.6.6.2.5 *Sponsor: How many times did you talk with your sponsor outside of meetings this past week?*

27.6.6.2.6 *Treatment Involvement: Are you involved in any other kind of services (medical, psychiatric, etc.)?*

27.6.6.2.7 *Progress Toward Goals: Have you been making any progress toward your goals?*

27.6.6.3 The protective factor section also includes three self-populating data fields:

27.6.6.3.1 *The four activities you chose were:*

27.6.6.3.1.1 This read-only field will automatically populate with the options selected in the Recovery Activities field on the Recovery Plan Overview screen (27.5.2.2).

27.6.6.3.1.2 This field is associated with the second question of this section (27.6.6.2.2).

27.6.6.3.2 *Risk Factor Total*

27.6.6.3.2.1 This read-only field will automatically populate with a score based on the options selected in the Response fields in the Risk Assessment section.

27.6.6.3.2.2 Clicking the Save button or the "Calculate Score" link (27.6.7) will update the value in this field.

27.6.6.3.3 *Protective Factor Total*

27.6.6.3.3.1 This read-only field will automatically populate with a score based on the options selected in the Response fields in the Protective Factor section.

27.6.6.3.3.2 Clicking the Save button or the "Calculate Score" link (27.6.7) will update the value in this field.

27.6.6.3.4 *Overall Risk Total*

27.6.6.3.4.1 This read-only field will subtract the Risk Factor Total (27.6.6.3.2) from the Protective Factor Total (27.6.6.3.3) and calculate an overall risk score.

27.6.6.3.4.2 A negative score indicates that the client is likely having trouble with his or her recovery.

27.6.6.3.4.3 A positive score indicates that the client is likely doing well with his or her recovery.

27.6.6.3.4.4 Clinicians should not rely exclusively on this score to evaluate the client's recovery progress.

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27.6.6.3.4.5 Clicking the Save button or the "Calculate Score" link (27.6.7) will update the value in this field.

27.6.7 When the Check Up Profile, Risk Assessment, and Protective Factor sections have been completed, click the "Calculate Score" link at the bottom of the Protective Factor section.

27.6.7.1 The Risk Factor Total (27.6.6.3.2), Protective Factor Total (27.6.6.3.3), and Overall Risk Total (27.6.6.3.4) fields will update and populate with their respective scores.

27.6.7.2 The Review Risk Level field (27.6.8.2) will also populate.

27.6.8 The fourth section of the Check Up screen, labeled "Check Up Case Management," includes the following fields:

27.6.8.1 *Possible Stresses*

27.6.8.1.1 Complete this field in response to the question "Do you have needs that are a major source of stress in any other part of your life?"

27.6.8.1.2 Select the options that best describe stressors in the client's life that are or could be contributing to his or her difficulties or challenges with recovery.

27.6.8.1.3 The available options in this option transfer box include the stressors identified on the Holmes and Rahe Stress Scale.

27.6.8.2 *Review Risk Level*

27.6.8.2.1 This read-only field will automatically populate with the questions in the Risk Assessment section for which a response was selected that indicates a problem or potential problem.

27.6.8.2.2 The areas identified in this field may warrant additional attention or action on the part of the client and/or clinician.

27.6.8.3 *Review Progress since last contact*

27.6.8.3.1 Describe any recovery progress the client has made since the most recent contact.

27.6.8.3.2 Contact is not restricted to check ups or risk assessment may include any client contact with the clinician and/or treatment agency.

27.6.8.4 *Problem solve issues raised by risk assessment*

27.6.8.4.1 Describe the problems or potential problems identified by this risk assessment.

27.6.8.4.2 Identify potential solutions for these problems and whether these solutions will be enacted by the client, clinician, or both.

27.6.8.5 *Anticipate upcoming high-risk situations*

27.6.8.5.1 If possible, identify any upcoming events or changes in the client's life or situation that may place him or her in a situation that might pose a threat to his or her recovery efforts.

27.6.8.6 *Set goals for coming week*

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27.6.8.6.1 Describe goals that the client will work toward over the next week.

27.6.8.6.2 Use the client's own words, if possible.

27.6.8.7 *Offer referrals to outside services*

27.6.8.7.1 If the client is referred for other services, describe them in this field.

27.6.8.8 *Schedule next contact*

27.6.8.8.1 In the Date field, enter a future date for the client's next contact with the treatment agency, which may or may not include another check up or risk assessment.

27.6.8.8.2 In the Time field, enter the time for which the client's next contact is scheduled.

27.6.8.8.2.1 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

27.6.8.8.2.2 Example: 08:30 AM

27.6.8.8.2.3 Example: 03:25 PM

27.6.8.8.2.4 Example: 1630

27.6.8.8.3 These fields may or may not be the same as the appointment fields in the Check Up Profile section (27.6.4.12).

27.6.8.9 *End Time*

27.6.8.9.1 This field will automatically populate with the time (as identified by the server located in the Eastern time zone) at which the risk assessment was first saved.

27.6.8.9.2 If the risk assessment was completed at a time other than the time displayed, change this field.

27.6.8.9.3 This time can be in the future.

27.6.8.9.3.1 Time must be in the HH:MM format (including AM or PM) or in military format (which will be automatically converted to "standard" time).

27.6.8.9.3.2 Example: 08:30 AM

27.6.8.9.3.3 Example: 03:25 PM

27.6.8.9.3.4 Example: 1630

27.6.9 If necessary, create encounter records from the risk assessment.

27.6.9.1 Click the "Add New Encounter" link at the bottom of the Check Up Case Management section of the risk assessment.

27.6.9.2 The Encounter screen will display.

27.6.9.3 Some of the fields on the Encounter screen will automatically populate with data entered into the related fields in the risk assessment, including:

27.6.9.3.1 *Note Type*

27.6.9.3.2 *Start Date*

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27.6.9.3.3 *Start Time*

27.6.9.3.4 *End Time*

27.6.9.3.5 *Duration*

27.6.9.4 Some of the fields on the Encounter screen will automatically populate with data entered into other OWITS modules in this episode, including:

27.6.9.4.1 *Service Location*

27.6.9.4.2 *Diagnoses*

27.6.9.5 Complete the remaining data fields as appropriate.

27.6.9.5.1 Add notes as needed.

27.6.9.5.2 Sign notes as needed.

27.6.9.5.3 See 20.0 for detailed instructions regarding creating and saving encounters.

27.6.9.6 Click Finish to return to the Check Up Profile section of the risk assessment.

27.6.10 Click Finish to record the risk assessment and return to the Recovery Plan Profile screen.

27.6.11 Click Finish to return to the Recovery Plan List.

27.7 Review and modify existing recovery plans as needed.

27.7.1 Navigate to Client List > Activity List > Recovery Plan.

27.7.2 The Recovery Plan List screen will display.

27.7.3 Click the "Review" link in the Actions column of the desired plan record.

27.7.4 If the plan has not been signed off (27.8.5), modify existing data fields as needed.

27.7.4.1 The Plan Outline screen (27.5.21) offers easy access to most aspects of the recovery plan for editing.

27.7.4.2 To view an existing Life Domain, Goal, Objective, or Action Step, click the "Review" link next to the desired item.

27.7.4.3 To remove an existing Goal, Objective, or Action Step, click the "Delete" link next to the desired item.

27.7.4.3.1 OWITS will confirm the delete command.

27.7.4.3.2 This action cannot be undone.

27.7.4.4 To add a new Life Domain, click the "Add Life Domain" link in the Recovery Plan box.

27.7.4.5 To add a new Goal, click the "Add Goal" link in the box associated with the desired Life Domain record.

27.7.4.6 To add a new Objective, click the "Add Objective" link in the box associated with the desired Goal record.

27.7.4.7 To add a new Action Step, click the "Add Action Step" link in the box associated with the desired Objective record.

27.7.5 If the plan has been signed off, all data fields will be in a read-only state.

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27.7.6 Click Save to apply any changes.

27.7.7 Click Finish to return to the Recovery Plan List.

27.8 Sign off completed recovery plans and create new versions of existing recovery plans.

27.8.1 Navigate to Client List > Activity List > Recovery Plan.

27.8.2 The Recovery Plan List screen will display.

27.8.3 Click the "Review" link in the Actions column of the desired plan record.

27.8.4 The Recovery Plan Profile screen will display.

27.8.5 If the plan is complete and currently in progress, or if the plan is no longer valid and will be replaced, it can be signed off.

27.8.5.1 A complete recovery plan has been reviewed and approved by the client and by all necessary staff members and collateral contacts.

27.8.5.2 In the Administrative Actions box, click the "Sign Off" link.

27.8.5.2.1 OWITS will confirm the sign-off action, making the plan the active recovery plan.

27.8.5.2.2 This action cannot be undone.

27.8.5.2.3 Data fields on the Recovery Plan Profile screen (27.5.1) and the Life Domains / Goals screens (27.5.4) will enter a read-only state.

27.8.5.2.4 This action cannot be undone.

27.8.5.2.5 Check Up risk assessments (27.6.1) can be added after the recovery plan has been signed off.

27.8.6 The Administrative Actions box will display three new links:

27.8.6.1 "Create New Version" – Copies data from the current recovery plan into a new version of the same plan (27.8.7).

27.8.6.2 "Perform Review" – Opens the Recovery Plan Rvw module (27.8.8).

27.8.7 To create a replacement recovery plan, click the "Create New Version" link in the Administrative Actions box.

27.8.7.1 This action immediately replaces the current recovery plan.

27.8.7.1.1 OWITS will confirm the replacement.

27.8.7.1.2 The current recovery plan will be marked "Inactive" and will be kept only as a historical record.

27.8.7.1.3 This action cannot be undone.

27.8.7.2 Modify data in the data fields as needed (see 27.5.1.1 through 27.5.22).

27.8.7.2.1 All data from the current recovery plan will copy to the new recovery plan, including check up risk assessments.

27.8.7.2.2 Most of the fields on the Recovery Plan Profile screen (27.5.1) will automatically populate but can be edited as needed.

27.8.7.3 When ready, sign off the new recovery plan (27.8.5).

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27.8.8 To conduct a review of the current recovery plan and the client's progress through it, click the "Perform Review" link in the Administrative Actions box.

27.8.8.1 The Recovery Plan Rvw module will open to its Profile screen.

27.8.8.2 See 28.0 for details on conducting and recording recovery plan reviews.

27.8.9 Return to the Recovery Plan List screen using the Navigation View links.

27.9 Generate reports of recovery plans.

27.9.1 Navigate to Client List > Activity List > Recovery Plan.

27.9.2 The Recovery Plan List screen will display.

27.9.3 Click the "Review" link in the Actions column of the desired plan record.

27.9.4 On the first screen of the recovery plan (Profile), click the "Generate Report" link at the top of the screen.

27.9.4.1 A pop-up browser window will open.

27.9.4.1.1 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

27.9.4.2 The pop-up window will display a formatted report (as a PDF) of the data entered into the recovery plan, including:

27.9.4.2.1 A signature line for the client.

27.9.4.2.2 An overview of high risk situations and recovery activities.

27.9.4.2.3 A list of recovery team members.

27.9.4.2.4 A list of collateral contacts.

27.9.4.2.5 A comprehensive list of the client's life domains, goals, objectives, and action steps associated with this recovery plan (see 23.4.8.1).

27.9.4.3 This PDF can be saved or printed.

27.9.4.3.1 Use the Adobe PDF print and save icons (not the Internet Explorer print or save functions) to print or save the PDF.

27.9.4.3.2 CAUTION: The more life domains, goals, objectives, and action steps have been added to the recovery plan, the more paper will be required to print it.

27.9.4.4 Close the pop-up window when finished.

27.10 Return to the Activity List or other modules using the Navigation View links.

28.0 Recovery Plan Review

28.1 Use of the Recovery Plan Review module is optional.

28.2 This module is used to conduct and record reviews of the client's current recovery plan and his or her progress through it.

28.2.1 The client must have at least one recovery plan record for a recovery plan review record to be created.

28.2.2 Recovery plan reviews are conducted only on signed off recovery plans.

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28.2.3 A recovery plan must exist with the plan status of "Active – Signed Off" (27.5.1.7.3) for a recovery plan review record to be created.

28.3 Navigate to Client List > Activity List > Recovery Plan Rvw.

28.3.1 The Recovery Review List screen will display.

28.4 To conduct a treatment review, click the "Add New Recovery Review Record" link in the Recovery Review List heading.

28.4.1 The recovery plan review Profile screen will display.

28.4.1.1 This screen can also be accessed from the "Perform Review" link in the Administrative Actions box of the Recovery Plan Profile screen (27.5.1.12.4).

28.4.2 The recovery plan review Profile screen consists of the following fields and table:

28.4.2.1 *Client Name*

28.4.2.1.1 This read-only field displays the name of the client.

28.4.2.2 *DOB*

28.4.2.2.1 This read-only field displays the client's date of birth.

28.4.2.3 *Review Period*

28.4.2.3.1 In the first of these two fields ("From"), enter the earliest date of documents and records that will be reviewed as part of this recovery review, regardless of whether all of those documents and records are in OWITS.

28.4.2.3.1.1 This field will automatically populate with the current date, but it can be changed as needed.

28.4.2.3.2 In the second of these two fields ("to"), enter the latest date of documents and records that will be reviewed as part of this recovery review, regardless of whether all of those documents and records are in OWITS.

28.4.2.4 *Date of Review*

28.4.2.4.1 Enter the date on which the recovery review was or will be conducted.

28.4.2.4.2 This date can be in the future.

28.4.2.5 *Review Status*

28.4.2.5.1 This read-only field displays the current state of the recovery review.

28.4.2.5.2 "Cancelled" indicates that the review record was created, that it may or may not have been completed, that it was not approved, and that no changes were applied to the associated recovery plan.

28.4.2.5.3 "Pending" indicates that the review record has been created, that it may or may not be complete, that it has not been approved or signed off, but that is still active and that changes made during the review may be later applied to the associated treatment plan.

28.4.2.5.3.1 No new treatment reviews can be created if any treatment reviews have this status.

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28.4.2.5.4 "Completed (No Change)" indicates that the review record has been created, completed, approved, and signed off, and that no changes were made to the associated recovery plan.

28.4.2.5.5 "Completed (Changes Applied)" indicates that the review record has been created, completed, approved, and signed off, and that changes made to the problems, goals, objectives, and interventions of the plan have been applied to the associated recovery plan.

28.4.2.6 *Check Up History*

28.4.2.6.1 This table displays the check up risk assessments that were conducted and recorded with the associated recovery plan.

28.4.3 When all of the required fields are filled (and others if applicable), click the right arrow to advance to the Plan Outline screen.

28.4.3.1 The Recovery Review screen will display, which is similar to the Plan Outline screen in the Recovery Plan module (27.5.21).

28.4.3.1.1 The plan outline is a display of the recovery plan and all of the layered life domains, goals, objectives, and action steps associated with it.

28.4.3.1.2 Click the "Printable View" icon at the top of the screen to open a pop-up window with a printer-friendly version of the plan outline.

28.4.3.1.3 Pop-ups must be enabled for this feature to function (see OWITS Reference Manual, Volume 1: OWITS Basics).

28.4.3.1.4 Close the pop-up window when finished.

28.4.3.2 If it is determined necessary as part of the recovery review, aspects of the recovery plan can be modified from this screen.

28.4.3.2.1 Click the "Comment/Modify Plan" link in the Outline Actions box near the top of the screen.

28.4.3.2.2 OWITS will confirm the action.

28.4.3.2.3 To add a comment to any of the life domains, goals, objectives, or action steps, click the "Comments" link next to the desired life domain, goal, objective, or action step number.

28.4.3.2.3.1 A "Review Comment" screen will display.

28.4.3.2.3.2 Enter desired comments in the large text box.

28.4.3.2.3.3 When finished, click Finish to return to the Plan Outline screen.

28.4.3.2.3.4 The comment text will be added to the plan outline and highlighted in yellow.

28.4.3.2.4 To change any of the life domains, goals, objectives, or action steps, click the "Modify" link next to the desired life domain, goal, objective, or action step number.

28.4.3.2.4.1 OWITS will redirect to the Recovery Plan screen associated with the selected life domain (27.5.5), goal (27.5.8), objective (27.5.11), or action step (27.5.14).

28.4.3.2.4.2 Modify the data fields as needed.

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28.4.3.2.4.3 Click Finish to apply he changes and return to the Plan Outline changes.

28.4.3.2.4.4 The header of the changed item will appear in red text.

28.4.3.2.5 To remove any of the life domains, goals, objectives, or action steps, click the "Delete" link next to the desired life domain, goal, objective, or action step number.

28.4.3.2.5.1 OWITS will confirm the delete command.

28.4.3.2.5.2 The selected item will be deleted from the recovery plan.

28.4.3.2.5.3 This action cannot be undone.

28.4.3.2.5.4 The item will not be removed from the Plan Outline screen, but the header of the removed item will appear in dark blue text with a ~~strikethrough line~~.

28.4.3.2.6 To add a life domain record, click the "Add Life Domain" link in the box labeled Recovery Plan.

28.4.3.2.6.1 OWITS will redirect to the Life Domains/Goals screen of the Recovery Plan module (27.5.5).

28.4.3.2.6.2 Complete the data fields as appropriate.

28.4.3.2.6.3 Add goals, objectives, and action steps as appropriate.

28.4.3.2.6.4 Click Finish to return to the Plan Outline screen.

28.4.3.2.6.5 The header of the added item will appear in green text.

28.4.3.2.7 To add a goal, objective, or action step, click the "Add" link next to the life domain, goal, or objective number with which the new item will be associated.

28.4.3.2.7.1 OWITS will redirect to the Life Domains/Goals screen of the Recovery Plan module (27.5.5).

28.4.3.2.7.2 Complete the data fields as appropriate.

28.4.3.2.7.3 Click Finish to return to the Plan Outline screen.

28.4.3.2.7.4 The header of the added item will appear in green text.

28.4.3.3 When all of the desired changes have been made, click Finish to return to the Recovery Review List.

28.5 Apply changes made during the recovery plan review to the associated recovery plan.

28.5.1 Click the "Review" link in the Actions column of the Recovery Review List table of the desired recovery review record.

28.5.2 The recovery plan review's Profile screen includes an Actions box with three links:

28.5.2.1 "Cancel Review"

28.5.2.1.1 This link is available any time after the recovery review record has been saved.

28.5.2.1.2 If the recovery review has not been completed and will not be completed or has been rejected by the client and/or clinician(s), click the "Cancel Review" link.

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28.5.2.1.3 All fields in the recovery review record will change to a read-only state.

28.5.2.1.4 "Cancelled" will display in the Review Status field and on the Recovery Review List screen.

28.5.2.1.5 Click Finish to return to the Recovery Review List screen.

28.5.2.1.6 A new recovery review record can now be created as needed (28.4).

28.5.2.2 "Complete, No changes to Recovery Plan"

28.5.2.2.1 This link is only available if no changes have been applied to the Plan Outline screen (27.5.21) and the recovery review record has been saved.

28.5.2.2.2 If the Plan Outline screen has not been changed, and if the recovery review has been completed and approved by the client and/or clinician(s), click the "Complete, No changes to Recovery Plan" link.

28.5.2.2.3 OWITS will confirm the command.

28.5.2.2.4 All fields in the recovery review record will change to a read-only state.

28.5.2.2.5 No changes will be made to the recovery plan.

28.5.2.2.6 Click Finish to return to the Recovery Review List screen.

28.5.2.3 "Apply Changes"

28.5.2.3.1 This link is only available after any changes have been made on the Plan Outline screen (27.5.21) and the recovery review record has been saved.

28.5.2.3.2 If the Plan Outline screen has been changed in any way, and if the treatment review has been completed and approved by the client and clinician(s), click the "Apply Changes" link.

28.5.2.3.2.1 Only changes on the Plan Outline screen are included.

28.5.2.3.2.2 Changes made to other data fields that are connected to the recovery plan will not be applied.

28.5.2.3.3 OWITS will confirm the command.

28.5.2.3.4 The changes will be applied to the recovery plan associated with the recovery review.

28.5.2.3.4.1 The current recovery plan will not be deleted.

28.5.2.3.4.2 The changes will be applied as a new version of the existing plan.

28.5.2.3.4.3 When ready, sign off the new version of the recovery plan as created through this recovery review process (27.8.5).

28.5.2.3.5 All fields in the recovery review record will change to a read-only state.

28.5.2.3.6 These actions cannot be undone.

28.5.2.3.7 Click Finish to return to the Recovery Review List screen.

28.6 OWITS will not generate reports of recovery reviews.

28.7 Return to the Activity List or other modules using the Navigation View links.

29.0 Consent

29.1 Use of the Consent module is recommended for most agencies.

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29.2 This module is used to record a client's agreement to a release of information to another agency or facility.

29.2.1 The Consent module is for disclosure agreements and release of information agreements only.

29.2.2 The Consent module does not include records of a client's consent to treatment.

29.3 To share any of the client's activity records (Intake, Admission, Assessments, Encounters, etc.) with other facilities or with other agencies, a Consent record must be created.

29.3.1 The client's profile information is automatically available to all facilities within the agency.

29.3.2 Specific records may be shared and others withheld.

29.3.3 Time limitations may be placed on the whole disclosure or on individual records.

29.3.4 The Consent may be revoked at any time.

29.4 To refer a client from one agency to another, a Consent record must be created.

29.4.1 The agency to which the client is referred will only have access to the client's disclosed records at the referring agency until the expiration date of the disclosure agreement.

29.4.2 The agency to which the client is referred must create a Consent record to relay information about new client activity back to the referring agency.

29.5 For specific instructions on creating and managing consent records for the release of information, see OWITS Reference Manual, Volume 8: Consent and Referrals.

30.0 Referrals

30.1 Use of the Referrals module is recommended for most agencies.

30.2 This module is used to refer clients from one agency to another.

30.2.1 Referrals made from an OWITS agency to another OWITS agency will also include information about the client, typically including the Client Profile and some records from the Activity list, as specified by the Consent record (see 29.0).

30.2.2 Referrals made from an OWITS agency to an agency that does not use OWITS records will not automatically include client information but will be recorded.

30.3 Referrals may be used for concurrent treatment, transferring clients, or post-treatment follow-up purposes.

30.3.1 Example: A client is found to need methadone maintenance services, which are not provided by the agency that is treating the client for his or her panic disorder. The client could be referred to a methadone maintenance clinic while mental health and receive treatment at both agencies.

30.3.2 Example: A client has completed addiction treatment programs related to a DUII charge but requires additional therapy to overcome alcohol withdrawals. The client could be referred to a recovery clinic following the completion of the DUII program.

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30.4 A Consent record (29.0) must be created before the client can be referred from one agency to another.

30.5 Individual referral records are created within the client's activity list while incoming referrals are handled at the agency level.

30.6 For specific instructions on creating and managing referrals, see OWITS Reference Manual, Volume 8: Consent and Referrals.

31.0 Payments

31.1 Use of the Payments module is optional.

31.2 This module tracks payments from clients for services rendered within the current episode.

31.3 For details regarding the function and use of the Payments module, see OWITS Reference Manual, Volume 11: Billing.

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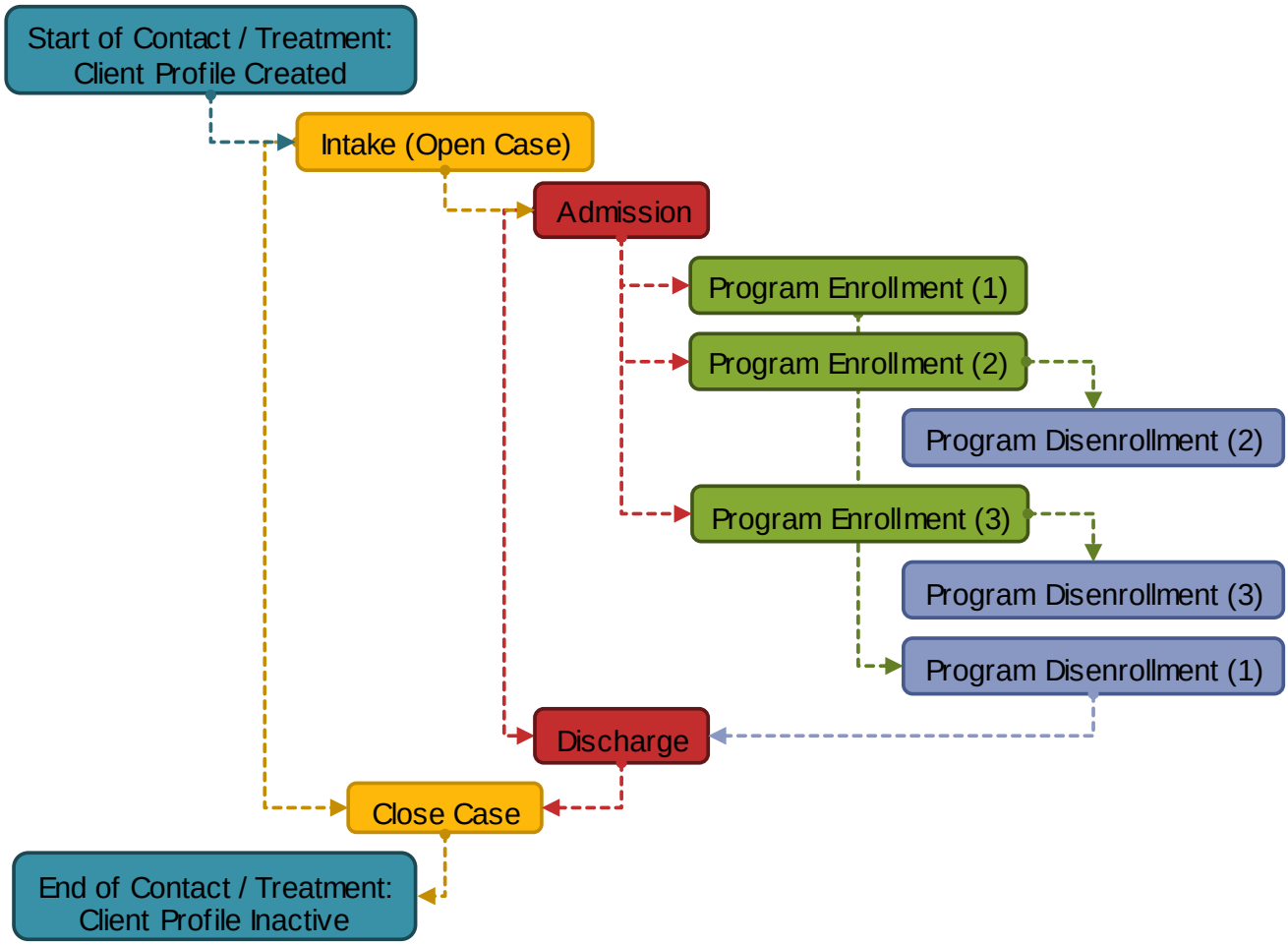
Appendix A – Activity List Module Hierarchy

This diagram illustrates the hierarchy of the primary modules used to record client treatment. A client may be enrolled in as many or as few programs as are necessary to complete treatment. Note that this is only an example and that actual treatment records will vary.



Appendix B – Activity List Modules: Required, Optional, or Recommended

Activity List Step	Necessity	Prerequisite(s)
Non-Episode Contact	Recommended	Client Profile
Intake	Required	Client Profile
Vital Signs	Optional	Intake
Lab/Radiology	Optional	Intake
Client Eligibility	Optional	Intake
Fee Determination	Optional	Intake
Drug Testing	Recommended	Intake
Wait List	Recommended	Intake
TX Team	Recommended	Intake
Screening	Recommended	Intake
Assessments	Recommended	Intake
Assessments > ASAM	Recommended	Intake, Admission, Program Enroll
Admission	Required	Intake
Program Enroll	Required	Intake, Admission
Problem List	Optional	Intake
Encounters	Required	Intake, Admission, Program Enroll
Immunization	Optional	Intake
Notes > Misc. Notes	Recommended	Intake
Treatment > TX Plan	Recommended	Intake, Admission, Program Enroll
Treatment > TX Review	Recommended	Intake, Admission, Program Enroll, TX Plan
Treatment > Medications	Optional	Intake
Discharge	Conditionally Required	Intake, Admission, Program Enroll, Program Disenroll
Recovery Plan	Optional	Intake
Recovery Plan Review	Optional	Intake, Recovery Plan
Consent	Recommended	Intake
Referrals	Recommended	Intake, Admission, Program Enroll
Payments	Optional	Intake

Appendix C – Example of CPMS Mental Health Enrollment Form

DHS
Oregon Department of Human Services
CPMS - OMHAS

CLIENT PROCESS MONITORING SYSTEM
White - Local Copy Yellow - State Copy

Mental Health
Basic or Residential Services
Enrollment Form

☐ Check box if correction
___/___/___ Date of Correction

Clinic Identification
3 CMHP
4 Provider

5 Opening Date
Month Day Year

6 Name (USE UPPER CASE BLOCK LETTERS)
Last First Birth Name

7 Case Number

8 Date of Birth
1 - Known
2 - Estimated
Month Day Year

9 Legal Status
100 - Voluntary
500 - Involuntary Civil
600 - Involuntary Criminal

10 Eligibility Code
Codes on back of form.

12 Gender
F = Female
M = Male

13 Education
Highest grade completed.

14 School/Training
Now enrolled in school or training?
1 = Yes 2 = No

15 Referral Source
Codes on back of form.

17 Estimated Gross Household Monthly Income
Enter income or
0001 = Refused
0002 = Unknown
9999 = More than $9,999

18 Residence Code
County or State code
Codes on back of form.

19 Race/Ethnicity
01 - White (Non-Hispanic)
02 - Black (Non-Hispanic)
03 - Native American
04 - Alaskan Native
05 - Asian
06 - Hispanic (Mexican)
07 - Hispanic (Puerto Rican)
08 - Hispanic (Cuban)
09 - Other Hispanic
10 - Southeast Asian
11 - Other Race
12 - Native Hawaiian/ Other Pacific Islander

21 Marital Status
1 - Never Married
2 - Married
3 - Widowed
4 - Divorced
5 - Separated
6 - Living as Married

22 Living Arrangement
01 - Private residence - alone
02 - Private residence - w/spouse or significant other
03 - Private residence - w/parent, relative, adult child(ren)
06 - Private residence - w/friend(s) or other unrelated person(s)
(More codes on back of form.)

23 Number of Dependents
Enter the total number of people in each age group that are dependent upon the income indicated in item #17 **(including the consumer)**
0 - 5 6 - 17 18 - 64 65+

24 Source of Income
Mark only one box. Enter a "1" next to the primary source.
Wages, Salary
Public Assistance
Other
None

25 Employment Status
1 - Full time (35 hours or more)
2 - Part time (17 - 34 hours)
3 - Irregular (less than 17 hours)
4 - Not employed (but has sought employment)
5 - Not employed (and has not sought employment)

29 Prime Number
Enter the Consumers' Medicaid Recipient Prime Number

33 Employability Factor
0 - Employable or working now
1 - Student
2 - Homemaker
3 - Retired
4 - Unable for physical or psychological reasons
5 - Incarcerated
6 - Seasonal worker
7 - Temporary layoff

92 Diagnostic Impression
01 - Not mentally ill/diagnosis deferred
02 - Delirium, Dementia, Amnesic and other Cognitive disorders
03 - Substance-related disorders
05 - Schizophrenia and other psychotic disorders
06 - Mood disorders
09 - Anxiety disorders
10 - Adjustment disorders
11 - Personality disorders
14 - Disorders usually diagnosed in infancy childhood or adolescence
16 - Eating disorders
19 - Dissociative disorders
17 - Other
18 - Unknown
Primary Secondary

75 Level of Functioning
Enter the Level of Function based on the Global Assessment of Functioning (GAF) Scale.
You may also use the Children's Global Assessment Scale (CGAS).
Range = 0 - 100
Did you use the CGAS?
Y - Yes
N - No

Form Number MHD-ADMS-0189
Revision Number 10/03

Appendix D – Example of CPMS Alcohol & Drug Enrollment Form

CLIENT PROCESS MONITORING SYSTEM

ALCOHOL & DRUG ENROLLMENT FORM

State of Oregon
CPMS AMH
Department of Human

Current User Id:

ADULT TREATMENT

	CLINIC IDENTIFICATION		5 OPENING DAT
	3 CMHP	4 PROVIDER	

6 NAME (USE UPPER CASE BLOCK LETTERS)					
LAST		FIRST		BIRTH NAME	

7 CASE NUMBER	8 DATE OF BIRTH	10 ELIGIBILITY CODE	11 Program Area:
			1-ALCOHOL 2-DRUG

116. Level of Care Assessed	12 SEX	106 PRENATAL	107 INTERPRETER	13 EDUCATION	14 SCHOOL/TRAINING	15 Referral Source(s)
Enter the Level of Care for which the client was assessed.	F=Female M=Male	Client Pregnant at Enrollment?	Will Interpreter services be needed for client?	Highest Grade Completed	Now Enrolled in School or Training?	Select First Appropriate Code(s) From Top of List.

17 ESTIMATED GROSS HOUSEHOLD MONTHLY INCOME	18 CLIENT PRIMARY RESIDENCE	115 Zip Code of Residence
ENTER ACTUAL INCOME 0000=NO INCOME 0001=REFUSED 9999=MORE THAN $9999/MONTH	COUNTY OR STATE CODE	Enter Zip code of Residence or enter 00001 - Transient

19 RACE/ETHNICITY	20 HEALTH INSURANCE	21 MARITAL STATUS	22 LIVING ARRANGEMENT
	Choose primary sourc		Enter First Appropriate Code

23 DEPENDENTS	24 SOURCE OF HOUSEHOLD INCOME	25 EMPLOYMENT STATUS	33 EMPLOYABILITY FACTOR	124 SELF HELP
ENTER THE TOTAL NUMBER OF PEOPLE IN EACH AGE GROUP THAT ARE DEPENDENT UPON THE INCOME INDICATED IN ITEM #17 (INCLUDING THE CLIENT) under 6 / 6 - 17 / 18 - 64 / 65+	Choose the Primary Source			Frequency of Self Help Attendance 30 Days Before Enrollment

31 TOTAL ARRESTS	32 DUII ARRESTS	122 RECENT ARRESTS	34 METHADONE	117 Level of Care at Admission
In past 5 years	In past 5 years	In the last 30 days before treatmen		Enter the Level of Care for which the client was admitted

PATTERNS OF ABUSE	PRIMARY SUBSTANCE	SECONDARY SUBSTANCE	TERTIARY SUBSTANCE
36 ADDICTION TYPE(S) Complete all blocks			
38 FREQUENCY OF USE OR DEGREE OF IMPAIRMENT			
39 MOST RECENT USUAL ROUTE OF ADMINISTRATION			
40 AGE AT FIRST USE (00 = Affected at Birth)			

Appendix E – ASAM Levels of Care

The following descriptions of levels of care were copied from the ASAM PPC-2R manual (ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition, Revised), published by the American Society of Addiction Medicine, Inc.

This information is provided in this manual as a quick reference only and should not be exclusively used when evaluating a client's placement or treatment needs.

Adult Placement Criteria

Level 0.5 – Early Intervention

Early intervention is an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address problems or risk factors that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use.

Level I – Outpatient Treatment

Level I encompasses organized outpatient treatment services, which may be delivered in a wide variety of settings. In Level I programs, addiction treatment staff, including addiction-credentialed physicians, provide professionally directed evaluation, treatment, and recovery services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours a week. The services follow a defined set of policies and procedures or clinical protocols.

Level I services are tailored to each patient's level of clinical severity and are designed to help the patient achieve changes in his or her alcohol- or other drug-using behaviors. Treatment thus must address major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs.

Level II.1 – Intensive Outpatient Treatment

Intensive outpatient programs (IOPs) generally provide nine or more hours of structured programming per week, consisting primarily of counseling and education about substance-related and mental health problems. The patient's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring. (Services provided outside the primary program must be tightly coordinated.)

Intensive outpatient treatment differs from partial hospitalization (Level II.5) programs in the intensity of clinical services that are directly available. Specifically, most intensive outpatient programs have less capacity to effectively treat patients who have substantial unstable medical and psychiatric problems than do partial hospitalization programs.

Level II.5 – Partial Hospitalization Programs

Partial hospitalization programs generally feature 20 or more hours of clinically intensive programming per week, as specified in the patient's treatment plan. Level II.5 partial hospitalization

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programs typically have direct access to psychiatric, medical, and laboratory services, and thus are better able than Level II.1 programs to meet needs identified in Dimensions 1, 2, and 3, which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.

Patients who meet Level III criteria in Dimensions 4, 5, or 6 and who otherwise would be placed in a Level III program may be considered for placement in a Level II.5 program if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs, such as a correctional facility or other licensed health care facility or a supervised living situation.

Level III.1 – Clinically Managed Low-Intensity Residential Services

Level III.1 programs offer at least five hours per week of low-intensity treatment of substance-related disorders (or as specified by state licensure requirements). Treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility, and reintegrating the individual into the worlds of work, education, and family life. The services provided may include individual, group, and family therapy; medication management and medication education. Mutual / self-help meetings are usually available on site.

Level III.3 – Clinically Managed Medium-Intensity Residential Services

Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity clinical services to support recovery from substance-related disorders.

For the typical resident in a Level III.3 program, the effects of the substance-related disorder on the individual's life are so significant, and the resulting level of impairment so great, that outpatient motivational and/or relapse prevention strategies are not feasible or effective.

Level III.5 – Clinically Managed High-Intensity Residential Services

Level III.5 programs are designed to treat persons who have significant social and psychological problems. Such programs are characterized by their reliance on the treatment community as a therapeutic agent. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect a global change in participants' lifestyles, attitudes, and values. This philosophy views substance-related problems as disorders of the whole person that are reflected in problems with conduct, attitudes, moods, values, and emotional management. The defining characteristics of these residents are found in their emotional, behavioral, and cognitive conditions (Dimension 3) and their living environments (Dimension 6).

Individuals who are appropriately placed in a Level III.5 program typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Their mental disorders may involve serious and persistent Axis I disorders (such as schizophrenia, bipolar disorders, and major depression) and Axis II disorders (such as borderline, narcissistic, and antisocial/personality disorders).

Level III.7 – Medically Monitored Intensive Inpatient Treatment

Level III.7 programs provide a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures,

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and clinical protocols. They are appropriate for patients whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.

Level IV – Medically Managed Intensive Inpatient Treatment

Level IV program services are delivered by an interdisciplinary staff of addiction-credentialed physicians and other appropriately credentialed treatment professionals. Such a program encompasses a planned regimen of 24-hour medically directed evaluation and treatment services, provided under a defined set of policies, procedures, and clinical protocols.

Treatment is provided 24 hours a day in a permanent facility with inpatient beds. The full resources of a general acute care or psychiatric hospital are available. Although treatment is specific to substance dependence disorders, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed.

Opioid Maintenance Therapy

Opioid maintenance therapy is an organized, usually ambulatory, addiction treatment service for opiate-addicted patients. It is delivered by addiction-trained personnel or addiction-credentialed clinicians who provide individual treatment, case management, and health education (including education about human immunodeficiency virus [HIV], tuberculosis [TB], and sexually transmitted diseases [STD]). The natures of the services provided (such as dose, level of care, length of service, or frequency of visits) is determined by the patient's clinical needs, but such services always include regularly scheduled psychosocial treatment sessions and daily or other scheduled medication visits within a structured program (for patients who are doing well enough to have take-home doses of methadone or who are taking LAAM).

Level I-D – Ambulatory Detoxification Without Extended On-Site Monitoring

Level I-D detoxification is an organized outpatient service, which may be delivered in an office setting, health care or addiction treatment facility, or in a patient's home, by trained clinicians who provide medically supervised evaluation, detoxification, and referral services according to a pre-determined schedule. Such services are provided in regularly scheduled sessions. Level I-D services should be delivered under a defined set of policies and procedures or medical protocols.

Level II-D – Ambulatory Detoxification With Extended On-Site Monitoring

Level II-D detoxification is an organized outpatient service, which may be delivered in an office setting or a health care or addiction treatment facility, by trained clinicians who provide medically supervised evaluation, detoxification, and referral services. Level II-D services are provided in regularly scheduled sessions. They are delivered under a defined set of policies and procedures or medical protocols. Outpatient services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's entry into ongoing treatment and recovery.

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Level III-D – Residential / Inpatient Detoxification

Clinically Managed Residential Detoxification (sometimes referred to as "social setting detoxification") is an organized service that may be delivered by appropriately trained staff who provide 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal. Clinically managed residential detoxification is characterized by its emphasis on peer and social support.

Medically Monitored Inpatient Detoxification is an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols.

Level IV-D – Medically Managed Intensive Inpatient Detoxification

Level IV-D detoxification is an organized service delivered by medical and nursing professionals that provides for 24-hour medically directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedure or medical protocols.

Adolescent Placement Criteria

Level 0.5 – Early Intervention

Early intervention is an organized service that may be delivered in a wide variety of settings. Early intervention services are designed to explore and address the adolescent's problems or risk factors that appear to be related to substance use and to assist the adolescent in recognizing the harmful consequences of substance use.

Level I – Outpatient Treatment

Level I encompasses organized outpatient treatment services, which may be delivered in a wide variety of settings. In Level I programs, addiction treatment staff, including addiction-credentialed physicians, provide professionally directed evaluation, treatment, and recovery services to adolescents who have substance-related disorders. Such services are provided in regularly scheduled sessions of (usually) fewer than six contact hours a week. The services follow a defined set of policies and procedures or clinical protocols.

Level I services are tailored to each patient's level of clinical severity and are designed to help the patient achieve changes in his or her alcohol- or other drug-using behaviors. Treatment thus must address major familial, attitudinal, behavioral, and cognitive issues that have the potential to undermine the goals of treatment or to impair the adolescent's ability to cope with major life tasks without the use of alcohol or other drugs. Treatment interventions and modalities are tailored to engage adolescents who are at varying levels of developmental maturity.

Level II.1 – Intensive Outpatient Treatment

Intensive outpatient programs (IOPs) generally provide at least six hours of structured programming per week, consisting primarily of counseling and education about alcohol and other drug problems. The precise number of hours of service delivered should be adjusted to meet each patient's

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needs. Six hours per week will be too few for many adolescents who meet the specifications for Level II.1—especially those who are early in their treatment or those who are stepping down from a more intensive level of care.

The adolescent's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the patient is stable and requires only maintenance monitoring.

Level II.5 – Partial Hospitalization Programs

Partial hospitalization programs generally feature 20 or more hours of clinically intensive programming per week, as well as daily or near-daily contact, as specified in the patient's treatment plan. Level II.5 partial hospitalization programs often have direct access to or close referral relationships with psychiatric, medical, and laboratory services, and thus are better able than Level II.1 programs to meet needs identified in Dimensions 1, 2, and 3, which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.

Partial hospitalization often occurs during school hours; such programs typically have access to educational services for their adolescent patients. Programs that do not provide educational services should coordinate with a school system in order to assess and meet their adolescent patients' educational needs.

Adolescents who meet Level III criteria in Dimensions 4, 5, or 6 and who otherwise might be placed in a Level III.1 or III.5 program may be considered for placement in a Level II.5 program if the patient resides in a facility that provides 24-hour support and structure and that limits access to alcohol and other drugs, such as a correctional facility or other licensed health care facility or a supervised living situation.

Level III.1 – Clinically Managed Low-Intensity Residential Services

Level III.1 programs are often provided in halfway houses and non-therapeutic group homes. Such a program offers at least five hours a week of low-intensity treatment of substance-related disorders (or the number of hours specified by state licensure requirements). Treatment is directed toward applying recovery skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery, and reintegrating the individual into the worlds of school, work, and family life. The services provided may include individual, group, and family therapy, educational and vocational counseling, and recreational activities. Mutual / self-help meetings are usually available on site or transportation is provided to meetings held off-site.

Level III.5 – Clinically Managed High-Intensity Residential Services

Level III.5 programs are designed to provide relatively extended, subacute treatments that aim to effect fundamental personal change for the adolescent who has significant social and psychological problems. The goals and modalities of treatment focus not only on the adolescent's substance use, but also on a holistic view of the adolescent that takes into account his or her behavior, emotions, attitudes, values, learning, family, culture, lifestyle, and overall health. Often, adolescents in Level III.5 programs are in need of *habilitative* rather than rehabilitative approaches, emphasizing the acquisition of new capacities rather than the restoration of lost ones.

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Level III.7 – Medically Monitored Intensive Inpatient Treatment

Level III.7 programs provide a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. They feature permanent facilities, including inpatient beds, and function under a defined set of policies, procedures, and clinical protocols. They are appropriate for adolescents whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.

Level IV – Medically Managed Intensive Inpatient Treatment

Level IV program services are delivered by an interdisciplinary staff of addiction-credentialed physicians and other appropriately credentialed treatment professionals. Such a program encompasses a planned regimen of 24-hour medically directed evaluation and treatment services, provided under a defined set of policies, procedures, and clinical protocols.

Treatment is provided 24 hours a day in a permanent facility with inpatient beds. The full resources of a general acute care or psychiatric hospital are available. Although treatment is specific to substance dependence disorders, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions and mental disorders that need to be addressed.

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Appendix F – Example of Treatment and Recovery Plan Hierarchies

This table illustrates the nesting of certain aspects of the Treatment Plan (23.0) and the Recovery Plan (27.0). Treatment Plans contain Problems, Goals, Objectives and Interventions. Recovery Plans contain Life Domains, Goals, Objectives, and Interventions. Wording used for this example was drawn from the Treatment Plan, but the same structure applies to Recovery Plan records. Note that this is only an example and that actual plans will vary.

Problem 1	Goal 1.1	Objective 1.1.1	Intervention 1.1.1.1
			Intervention 1.1.1.2
			Intervention 1.1.1.3
		Objective 1.1.2	Intervention 1.1.2.1
			Intervention 1.1.2.2
			Intervention 1.1.2.3
		Objective 1.1.3	Intervention 1.1.3.1
			Intervention 1.1.3.2
			Intervention 1.1.3.3
	Goal 1.2	Objective 1.2.1	Intervention 1.2.1.1
			Intervention 1.2.1.2
			Intervention 1.2.1.3
		Objective 1.2.2	Intervention 1.2.2.1
			Intervention 1.2.2.2
			Intervention 1.2.2.3
Problem 2	Goal 2.1	Objective 2.1.1	Intervention 2.1.1.1
Problem 3	Goal 3.1	Objective 3.1.1	Intervention 3.1.1.1
	Goal 3.2	Objective 3.2.1	(No Intervention)
		Objective 3.2.2	(No Intervention)
		Objective 3.2.3	Intervention 3.2.3.1
			Intervention 3.2.3.2
		Objective 3.2.4	Intervention 3.2.4.1
Problem 4	Goal 4.1	(No Objective)	(No Intervention)

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Appendix G – OWITS Reference Manual Volume Titles

- OWITS Reference Manual, Volume 1: OWITS Basics
- OWITS Reference Manual, Volume 2: Client Records Overview
- OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records
- OWITS Reference Manual, Volume 4: Client Profile
- *OWITS Reference Manual, Volume 5: Client Activity and Contact*
- OWITS Reference Manual, Volume 6: Screenings and Assessments
- OWITS Reference Manual, Volume 7: Groups and Group Notes
- OWITS Reference Manual, Volume 8: Consent and Referrals
- OWITS Reference Manual, Volume 9: Client Discharge
- OWITS Reference Manual, Volume 10: Running Reports
- OWITS Reference Manual, Volume 11: Billing
- OWITS Reference Manual, Volume 12: Troubleshooting
- OWITS Reference Manual, Volume 13: Tier 1 System Administration
- OWITS Reference Manual, Volume 14: Tier 2 System Administration
- OWITS Reference Manual, Volume 15: AMH Policies for OWITS Records and Users

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Appendix H – Navigation View Map

A map of the navigation pane links can be found here (OWITS Navigation Map).
Due to its size, printing this document is **not** recommended.

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Revision History

Revised By	Date	Description
Justin D. King	May 3, 2012	Reference manual created.
Justin D. King	June 25, 2012	Revision History table added.
Justin D. King	July 25, 2012	Removed "HIV Positive" field description from Intake due to the field being removed from OWITS.
Justin D. King	October 10, 2012	With the October release of OWITS, most date fields no longer automatically populate with the current date. This manual has been updated accordingly.
Justin D. King	January 4, 2013	Added ASAM information.
Justin D. King	January 23, 2013	Applied changes based on internal feedback. With the January release of OWITS, behavior of the Program Enrollment screen changed. This manual has been updated to reflect that change.
Justin D. King	February 4, 2013	Added an ASAM reference as an appendix.
Justin D. King	February 26, 2013	Added cross-references and February release updates.
Justin D. King	January 2, 2014	Added CPMS form examples and link to Navigation Map.

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