



OWITS Reference Manual

Volume 9

Client Discharge

Revision 1-0

Table of Contents

DESCRIPTION.....2

PURPOSE.....2

DEFINITIONS / ABBREVIATIONS3

1.0 TREATMENT CONTINUITY6

2.0 ORDER OF OPERATIONS7

3.0 INITIAL STEPS7

4.0 DISENROLLING CLIENTS FROM PROGRAMS8

5.0 DISCHARGING CLIENTS FROM TREATMENT12

6.0 CLOSING EPISODES23

7.0 RESUMING TREATMENT IN AN EXISTING EPISODE.....23

APPENDIX A – OWITS REFERENCE MANUAL VOLUME TITLES.....26

APPENDIX B – NAVIGATION VIEW MAP.....27

REVISION HISTORY28

Description

This manual details the processes required for recording a client’s completion or conclusion of treatment for agency records and for state reporting requirements.

Purpose

Referring to this manual will allow OWITS users to indicate that a client’s treatment has concluded or has resumed.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 3 of 28
	Client Discharge	Updated: January 2, 2014		

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.”
- 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.
- 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 provides users with information.
- Drop-Down Menu: A list of options in a data entry field that allows users to select only one item.
- DSM: Diagnostic and Statistical Manual – a reference compiled by the American Psychiatric Association designed to assist mental health professionals in the identification of a client’s mental health problems and related circumstances. In this manual, unless otherwise specified, “DMS” refers the DSM-IV.
- 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 drugs and the client’s successful discharge from treatment before reinstating his or her driver’s license or other legal privileges.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 4 of 28
	Client Discharge	Updated: January 2, 2014		

- **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*.
- **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.
- **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.
- **GAF:** Global Assessment of Functioning – A numerical scale used by mental health professionals to rate subjectively the social, occupational, and psychological functioning of adults.
- **Heading / Subheading:** The title of an OWITS module or of divisions and screens within OWITS modules. See also *Module*.
- **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.
- **MH:** Mental Health – an abbreviation commonly used within OWITS for mental health treatment, services, treatment domain, etc.
- **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.
- **Populate:** To fill a data entry field with data.
- **Pop-up:** A new browser window that opens to display additional information without disrupting the page currently open.
- **Roster:** A list of names.
- **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.
- **Treatment Domain:** A designation in OWITS client records that separates some client information based on the type of treatment or service administered.
- **TX:** An abbreviation for “treatment” often used in OWITS.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 5 of 28
	Client Discharge	Updated: January 2, 2014		

- User: A person who interacts with the OWITS system.
- Value: A specific data point for a given data type, such as one option in a drop-down menu.
- 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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	OWITS Reference Manual	Volume 9	Revision 1-0	Page 6 of 28
	Client Discharge	Updated: January 2, 2014		

1.0 Treatment Continuity

- 1.1** AMH and SAMHSA require treatment providers to indicate when clients have concluded treatment or are no longer receiving services, but agencies using OWITS have options regarding how that is reported.
- 1.1.1** For details regarding the Activity List modules listed below, see OWITS Reference Manual, Volume 5: Client Activity and Contact.
- 1.2** An agency may choose to report only Program Enrollment information.
- 1.2.1** An Intake record is created at the start of treatment.
- 1.2.2** An Admission record is created at the start of treatment.
- 1.2.3** The client is enrolled in programs as needed.
- 1.2.4** The client is disenrolled from programs as appropriate.
- 1.2.5** Only one Admission record is entered per treatment domain.
- 1.2.6** A Discharge record is not entered.
- 1.2.7** The client's treatment is considered complete (or otherwise concluded) when the client has no active program enrollments, and treatment is considered resumed (or started anew) when the client is enrolled in a program after a period of no active enrollments.
- 1.3** An agency may choose to report separate episodes.
- 1.3.1** An Intake record is created at the start of treatment.
- 1.3.2** An Admission record is created at the start of treatment.
- 1.3.3** The client is enrolled in programs as needed.
- 1.3.4** The client is disenrolled from programs as appropriate.
- 1.3.5** When the client has completed treatment, has received all necessary services, or has otherwise ceased receiving treatment or services, a Discharge record is entered.
- 1.3.6** A "Date Closed" date is added to the Intake record.
- 1.3.6.1** This date may be automatically applied ([5.4.1](#)).
- 1.3.7** If the client returns for additional treatment or services, a new episode is recorded, repeating [1.3.1](#) through [1.3.6](#) above.
- 1.3.7.1** The agency may also choose to re-open the most recent episode ([7.2](#)), delete the Discharge record ([7.3](#)), and continue treatment as if the client had not left.
- 1.4** In both cases, the Client Profile data is unaffected.
- 1.5** This reference manual describes how to complete disenrollments, how to create Discharge records, how to close and re-open cases, and how to handle the associated data.
- 1.6** Individual agencies may determine which of the above options to use when recording the conclusion of treatment.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 7 of 28
	Client Discharge	Updated: January 2, 2014		

1.7 Note: The terms “episode” and “case” refer to a period of treatment defined by a beginning date and an ending date and are used interchangeably in OWITS and throughout this manual.

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

2.0 Order of Operations

2.1 Disenrollment and Discharge data elements cannot be completed until data has been added to certain portions of the Activity List.

2.2 The client must be disenrolled from all programs ([4.0](#)) before a Discharge record can be entered ([5.0](#)).

2.3 All Activity lines on the client’s Activity List that display “In Progress” in the Status column should be completed.

2.3.1 “In Progress” indicates missing data or an incomplete record.

2.3.2 Clicking the “Details” link in the Status column will produce a pop-up window that lists the missing information (see OWITS Reference Manual, Volume 5: Client Activity and Contact).

2.4 If the Activity List includes an Admission record, a Discharge record must be entered before the episode can be closed.

2.5 A new episode cannot be created until the previous episode in the same treatment domain has been closed.

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.

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 It may be useful to 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.

3.4 Click the “Activity List” link in the Actions column for the desired client.

3.4.1 If the client has multiple open episodes, the Episode List screen will display.

3.4.1.1 Click the “Review” link in the Actions column for the desired treatment episode.

3.4.1.2 If the selected episode is recorded in a facility other than the context facility, use the My Settings > Change Facility function to select the correct facility and repeat steps [3.3](#) through [3.4.1.1](#).

3.5 Confirm that the necessary records have been entered ([2.4](#)) and that Activity List records are complete ([2.3](#)).

4.0 Disenrolling Clients from Programs

4.1 Navigate to Client List > Activity List > Program Enroll.

4.1.1 The Program Enrollment list will display.

4.1.2 Program enrollments that do not show a date in the End Date column are still open.

4.2 Click the “Review” link in the Actions column for the program from which the client is to be disenrolled.

4.2.1 The Program Enrollment Profile screen will display.

4.2.2 Non-TEDS-reported programs will include only eight fields.

4.2.3 TEDS reported programs will include two sections of data.

4.2.3.1 “Program Enrollment Profile” displays at the top with “TEDS/NOMS Status at Program Enrollment” below.

4.3 Enter the necessary disenrollment data.

4.3.1 Enrollment data can be updated if necessary.

4.3.2 The editable Program Enrollment fields for all programs include the following:

4.3.2.1 *Program Staff*

4.3.2.1.1 At enrollment, this field automatically populated with the name of the user who created the Program Enrollment record.

4.3.2.1.2 If the current value is inaccurate, change this field to the name of the person who collected the program enrollment data; otherwise, do not edit this field.

4.3.2.2 *Days on Wait List*

4.3.2.2.1 At enrollment, the number of days the client’s name was on a waiting list to participate in the selected program was entered.

4.3.2.2.2 Confirm that the value in this field is accurate.

4.3.2.2.3 This field is not required for non-TEDS reported programs.

4.3.2.3 *Start Date*

4.3.2.3.1 At enrollment, the date on which the client began the program was entered.

4.3.2.3.2 If the current value is inaccurate, enter the date on which the client began the program.

4.3.2.3.3 CAUTION: Changing the date in this field may cause the “Days on Wait List” field ([4.3.2.2](#)) to clear.

4.3.2.4 *End Date*

4.3.2.4.1 Enter the date on which the client’s participation in the program was concluded.

4.3.2.4.2 This date must be on or after the Start Date ([4.3.2.3](#)).

4.3.2.5 *Termination Reason*

4.3.2.5.1 Select the option that best describes the reason for the conclusion of the client’s participation in the program.

4.3.2.6 *Notes*

4.3.2.6.1 Enter any additional information about the client’s enrollment in or disenrollment from this program.

4.3.2.6.2 It may be useful to include whether the client qualified for special funding or other unique considerations.

4.3.3 The editable Program Enrollment fields for TEDS reported programs also include the following:

4.3.3.1 *Methadone Used as Part of TX*

4.3.3.1.1 If necessary, update the selection that indicates whether the client received Methadone or other opiate/opioid addiction treatment medications as part of this program.

4.3.3.2 *Employment Status*

4.3.3.2.1 If necessary, update the selection that indicates the client’s employment status at the time of enrollment.

4.3.3.2.2 This field does NOT refer to employment status at the time of disenrollment.

4.3.3.3 *Primary Income Src*

4.3.3.3.1 If necessary, update the selection that indicates what the client’s primary source of income was at the time of enrollment.

4.3.3.3.2 This field does NOT refer to income at the time of disenrollment.

4.3.3.4 *Expected Payment Src*

4.3.3.4.1 If necessary, update the selection that indicates how the treatment or services associated with this program were to be paid.

4.3.3.4.2 This field does NOT refer to payment at the time of disenrollment.

4.3.3.5 *Health Insurance*

4.3.3.5.1 If necessary, update the selection that best describes the client’s health insurance situation at the time of enrollment.

4.3.3.5.2 This field does NOT refer to insurance at the time of disenrollment.

4.3.3.6 *# of Times You Have Participated in a Self Help Group in the Last 30 Days*

4.3.3.6.1 If necessary, update the selection that indicates how often the client attended a self-help group in the 30 days prior to enrollment.

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

4.3.3.6.3 This value may be estimated.

4.3.3.6.4 This field does NOT refer to self-help group attendance at the time of disenrollment.

4.3.4 Click Save.

4.4 If disenrolling a client from a non-TEDS program:

4.4.1 Click Finish to return to the Program Enrollment screen.

4.4.2 Repeat steps [4.1](#) through [4.3.4](#) as needed to continue disenrolling the client from additional programs.

4.5 If disenrolling a client from a TEDS program:

4.5.1 The enrollment data below the “TEDS/NOMS Status at Program Enrollment” heading will become read-only.

4.5.2 Click the “Complete TEDS/NOMS Disenroll Status” link in the Actions box near the bottom of the screen.

4.5.2.1 If this link is black (unavailable), confirm that all the above required fields are complete and that there are no “In Progress” items on the client’s Activity List ([2.3](#)).

4.5.3 The TEDS/NOMS Status at Program Disenrollment screen will display, including the following fields:

4.5.3.1 *Disenrollment Type*

4.5.3.1.1 Select the option that best describes the reason for the conclusion of the client’s participation in the program.

4.5.3.2 *Last Face-to-Face Contact Date*

4.5.3.2.1 Enter the date of the last direct, in-person contact a clinician had with the client.

4.5.3.3 *Employment Status*

4.5.3.3.1 Select the option that best describes the client’s employment status at the time of disenrollment.

4.5.3.3.2 This field specifically refers to employment status at the time of disenrollment.

4.5.3.4 *Living Arrangement*

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 11 of 28
	Client Discharge	Updated: January 2, 2014		

4.5.3.4.1 Select the option that best describes the client’s housing situation at the time of enrollment.

4.5.3.4.2 This field specifically refers to living arrangement at the time of disenrollment.

4.5.3.5 *# of Arrests in Last 30 Days or Since Admission, Whichever is Less*

4.5.3.5.1 Enter the number of times the client has been arrested in the last 30 days or since being enrolled in this program.

4.5.3.5.2 If the client has been enrolled in the program for fewer than 30 days, count only the arrests that have occurred since the date of enrollment.

4.5.3.6 *# of Times You Have Participated in a Self Help Group in the Last 30 Days*

4.5.3.6.1 Select the option that best describes the client’s attendance (if any) in a self-help program in the past 30 days.

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

4.5.3.6.3 This value may be estimated.

4.5.3.6.4 This field specifically refers to self-help group attendance at the time of disenrollment.

4.5.3.7 *Primary Drug – Drug Type*

4.5.3.7.1 This field will automatically populate with the drug entered at Admission.

4.5.3.7.2 If the client’s most significant or most severe substance problem is different at the time of disenrollment, select that substance in this field.

4.5.3.8 *Secondary Drug – Drug Type*

4.5.3.8.1 This field will automatically populate with the drug entered at Admission.

4.5.3.8.2 If the client’s second most significant or second most severe substance problem is different at the time of disenrollment, select that substance in this field.

4.5.3.8.3 If the client has no Secondary Drug, select “None.”

4.5.3.9 *Tertiary Drug – Drug Type*

4.5.3.9.1 This field will automatically populate with the drug entered at Admission.

4.5.3.9.2 If the client’s third most significant or third most severe substance problem is different at the time of disenrollment, select that substance in this field.

4.5.3.9.3 If the client has no Tertiary Drug, select “None.”

4.5.3.10 *Primary Drug – Frequency of Use*

4.5.3.10.1 Select the option that best describes how often the client uses or abuses the substance as of the time of disenrollment.

4.5.3.11 *Secondary Drug – Frequency of Use*

4.5.3.11.1 Select the option that best describes how often the client uses or abuses the substance as of the time of disenrollment.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 12 of 28
	Client Discharge	Updated: January 2, 2014		

4.5.3.11.2 If the Secondary Drug is “None,” this field will automatically populate with “N/A.”

4.5.3.12 *Tertiary Drug – Frequency of Use*

4.5.3.12.1 Select the option that best describes how often the client uses or abuses the substance as of the time of disenrollment.

4.5.3.12.2 If the Tertiary Drug is “None,” this field will automatically populate with “N/A.”

4.5.4 When all the required fields have been completed, click Save.

4.5.5 The Administrative Actions box on this screen contains two links that can be used if desired.

4.5.5.1 Discharge Client: Clicking this link will open the Discharge module if the client has been disenrolled from all programs and if the Admission record is complete ([2.3](#)).

4.5.5.2 Transfer to Another Program: Clicking this link will open the Program Profile screen to enroll the client in another program (see OWITS Reference Manual, Volume 5: Client Activity and Contact) and continue treatment.

4.5.6 When finished, click Finish to the Program Enrollment list screen.

4.6 Repeat steps [4.1](#) through [4.3.4](#) as needed to continue disenrolling the client from additional programs.

4.7 A disenrollment record cannot be deleted, but the disenrollment can be undone ([7.4](#)).

5.0 Discharging Clients from Treatment

5.1 Navigate to Client List > Activity List > Discharge.

5.1.1 If there are no open enrollments or other errors that would prevent a discharge, the Discharge > Profile screen will display.

5.1.2 If there are open program enrollments or other errors, OWITS will redirect to the relevant screen or list and produce an error message.

5.2 Complete the required Discharge screens.

5.2.1 The Discharge series begins with the Discharge > Profile screen, which consists of the following fields:

5.2.1.1 *Discharged*

5.2.1.1.1 Enter the date on which the client concluded treatment or the date on which the facility determined to close the client’s treatment records.

5.2.1.2 *Date of Last Contact*

5.2.1.2.1 Enter the date of the last direct, in-person contact a clinician had with the client.

5.2.1.2.2 An informational message near the top of the screen will suggest a date that could be entered into this field based on the most recent treatment activity recorded in the context episode.

5.2.1.3 *Discharge Staff*

5.2.1.3.1 Select the name of the staff member completing the Discharge record or the name of the staff member who determined that the client should be discharged from treatment.

5.2.1.4 *Discharge Referral*

5.2.1.4.1 Select the option that best describes the organization to which the client will be referred for additional treatment or services.

5.2.1.5 *Reason*

5.2.1.5.1 Select the option that best describes the reason for the conclusion of the client's treatment.

5.2.1.6 *Disposition*

5.2.1.6.1 This field is not currently configured for use in Oregon.

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

5.2.1.7.1 Select the option that best describes the client's attendance (if any) in a self-help program in the 30 days prior to the discharge date ([5.2.1.1](#)).

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

5.2.1.7.3 This value may be estimated.

5.2.1.7.4 This field is specific to the Substance Abuse domain.

5.2.2 In the Substance Abuse domain, the Discharge > Profile screen also includes an ASAM section that compares the ASAM criteria in the Admission record (in the read-only fields labeled "At Intake") with the ASAM criteria at Discharge (in the editable fields labeled "At Discharge").

5.2.2.1 *Dimension*

5.2.2.1.1 This column lists the six dimensions of the ASAM criteria, including:

5.2.2.1.2 *Dimension 1 – Acute Intoxication and/or Withdrawal Potential*

5.2.2.1.3 *Dimension 2 – Biomedical Conditions and Complications*

5.2.2.1.4 *Dimension 3 – Emotional, Behavioral, or Cognitive Conditions and Complications*

5.2.2.1.5 *Dimension 4 – Readiness to Change*

5.2.2.1.6 *Dimension 5 – Relapse, Continued Use, or Continued Problem Potential*

5.2.2.1.7 *Dimension 6 – Recovery / Living Arrangement*

5.2.2.2 *Level of Care*

5.2.2.2.1 In the read-only field, review the level of care at Admission.

5.2.2.2.2 In the editable drop-down menu, select an option for each of the six categories listed under the "Dimension" heading.

5.2.2.2.3 "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.

5.2.2.2.4 In the Discharge series, this selection should refer to the client's final ASAM evaluation in the current episode.

5.2.2.3 *As Indicated By*

5.2.2.3.1 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.

5.2.2.3.2 In the Discharge series, this text should refer to the client’s final ASAM evaluation in the current episode.

5.2.3 When all the required fields (and others, if applicable) have been filled, *do not* click Save.

5.2.3.1 Clicking Save in the Discharge record prior to the TX Summary screen will produce preemptive error messages that indicate blank fields in screens that have not been viewed or accessed yet.

5.2.4 Click the Right Arrow to advance to the Legal screen (not currently present in the Mental Health domain), which contains the following fields:

5.2.4.1 *Legal Status*

5.2.4.1.1 Use this option transfer box to indicate whether the client is involved in any legal proceedings related to treatment.

5.2.4.1.2 Use this field to indicate whether the client received treatment or services related to a DUII diversion or conviction.

5.2.4.1.3 Select as many options as necessary to fully describe the client’s legal situation.

5.2.4.1.4 Select “None” or leave the Selected Legal Status box blank if the client is not currently involved in any legal proceedings.

5.2.4.2 *# of Arrests in Lifetime*

5.2.4.2.1 Enter the total number of times the client has been arrested.

5.2.4.2.2 Count all arrests regardless of the outcome (release, acquittal, conviction, etc.).

5.2.4.2.3 Enter 0 if the client has never been arrested.

5.2.4.2.4 This value may be estimated.

5.2.4.3 *# of Arrests in Last 30 Days or Since Admission, Whichever is Less*

5.2.4.3.1 Enter the number of times the client has been arrested in the last 30 days or since the date of admission.

5.2.4.3.2 If the client has been in the current treatment episode for fewer than 30 days, count only the arrests that have occurred since the date of admission.

5.2.4.4 *Total # of Arrests Since Admission*

5.2.4.4.1 This read-only field will calculate the total number of times the client has been arrested since the date of admission, based on the Admission record and Program Enrollment and Disenrollment records.

5.2.5 When all the required fields (and others, if applicable) have been filled, *do not* click Save.

5.2.6 Click the Right Arrow to advance to the Status screen, which contains two boxes:

5.2.6.1 In both the Substance Abuse and Mental Health domains, the “Status At Admission” box contains the following read-only fields, all of which populate from Admission:

5.2.6.1.1 *Relationship Status*

5.2.6.1.2 *Living Arrangement*

5.2.6.1.3 *Employment Status*

5.2.6.2 In the Substance Abuse domain, the “Status at Admission” box also contains the following read-only fields, all of which populate from Admission:

5.2.6.2.1 *Pregnant*

5.2.6.2.2 *County of Residence*

5.2.6.3 In the Mental Health domain, the “Status at Admission” box also contains the following read-only fields, all of which populate from Admission or from the most recent Mental Health Assessment (see OWITS Reference Manual, Volume 6: Screenings and Assessments).

5.2.6.3.1 *# Days in stable housing in last 90 days*

5.2.6.3.2 *Health Insurance*

5.2.6.3.3 *# of Months Employed*

5.2.6.3.4 *Currently enrolled in Vocational Rehabilitation*

5.2.6.3.5 *Gross Annual Household Income*

5.2.6.3.6 *# of Employers*

5.2.6.3.7 *# of Arrests up to 30 Days during treatment*

5.2.6.3.8 *# of Arrests in Last 12 Months*

5.2.6.3.9 *# Days incarcerated in last 12 months*

5.2.6.3.10 *School Attendance*

5.2.6.3.11 *Co-Occurring Health Problem*

5.2.6.3.12 *Client Type*

5.2.6.4 The “Status At Discharge” box contains editable versions of the same fields as the “Status at Admission” box, all of which should be completed to show the difference in the indicated factors of the client’s life between the date of admission and the date of discharge.

5.2.7 When all the required fields (and others, if applicable) have been filled, *do not* click Save.

5.2.8 Click the Right Arrow to advance to the Substance Abuse screen (not present in the Mental Health domain), which contains the following fields:

5.2.8.1 *Substance*

5.2.8.1.1 These fields will automatically populate from the Admission record.

5.2.8.1.2 If the client is still using or abusing substances, select the Primary Substance currently identified as the most significant problem for the client.

5.2.8.1.2.1 The Primary Substance must be the substance identified as the client's most significant problem.

5.2.8.1.2.2 The Secondary Substance and the Tertiary Substance, if applicable, must constitute a less severe problem for the client than the Primary Substance.

5.2.8.1.3 If the client is no longer using or abusing any substances, select "None" in the Primary, Secondary, and Tertiary fields.

5.2.8.1.4 Nicotine cannot be selected as a primary, secondary, or tertiary substance, regardless of its relative severity.

5.2.8.2 *Severity*

5.2.8.2.1 Select the option that best describes the degree to which the substance use or abuse affects the client.

5.2.8.2.2 If the related substance is None, this field will display N/A.

5.2.8.3 *Frequency*

5.2.8.3.1 Select the option that best describes how often the client uses or abuses the substance.

5.2.8.3.2 If the related substance is None, this field will display N/A.

5.2.8.4 *Method*

5.2.8.4.1 Select the option that best describes the route by which the client takes the substance into his or her body.

5.2.8.4.2 If multiple methods apply, select the method that is most frequently used.

5.2.8.4.3 If the related substance is None, this field will display N/A.

5.2.8.5 *Was Methadone Maintenance Part of TX*

5.2.8.5.1 Indicate whether the client received Methadone maintenance or other medications for opiate or opioid addiction during treatment.

5.2.8.6 *Discharge Status: Treatment*

5.2.8.6.1 Select the option that best describes the current status of the client's treatment.

5.2.8.7 *Post-Discharge Case Management*

5.2.8.7.1 Indicate whether the client will receive case management or continued non-treatment contact after discharge.

5.2.8.8 *# of Days*

5.2.8.8.1 If "Yes" was selected in the Post-Discharge Case Management Field above ([5.2.8.7](#)), enter the number of days that the case management or non-treatment contact is expected to continue.

5.2.8.8.2 This value may be estimated.

5.2.8.9 *Prognosis*

 OWITS	OWITS Reference Manual	Volume 9	Revision 1-0	Page 17 of 28
	Client Discharge	Updated: January 2, 2014		

- 5.2.8.9.1** Select the option that best describes the clinician’s opinion of the client’s potential for continued recovery.
- 5.2.8.10** *Was a family member involved*
- 5.2.8.10.1** Indicate whether a member of the client’s family was involved in the client’s treatment.
- 5.2.8.11** *Was Concerned Person Involved*
- 5.2.8.11.1** Indicate whether an unrelated individual (such as a close friend, a teacher, or a neighbor) was involved in the client’s treatment.
- 5.2.8.12** *Codependent/Collateral*
- 5.2.8.12.1** Select “Yes” if the client received services because of problems arising from his or her relationship with an alcohol or drug user *and* was admitted for service to a treatment facility *and* has his or her own client profile.
- 5.2.8.12.2** If the client does not meet the criteria above, select “No” or leave this field blank.
- 5.2.8.13** *Was MH Service Received*
- 5.2.8.13.1** Indicate whether mental health treatment or services were provided in addition to the substance abuse treatment.
- 5.2.8.14** *Psychiatric Follow-up*
- 5.2.8.14.1** If mental health services were, should have been, or should be provided to the client, indicate what step (if any) has been taken to fulfill this need.
- 5.2.9** When all the required fields (and others, if applicable) have been filled, *do not* click Save.
- 5.2.10** Click the Right Arrow to advance to the Tobacco screen, which contains the following fields:
- 5.2.10.1** *Have you ever used Tobacco/Nicotine products?*
- 5.2.10.1.1** Indicate whether the client has used tobacco.
- 5.2.10.1.2** Selecting “Yes” will make additional fields available.
- 5.2.10.2** *Smoker Status*
- 5.2.10.2.1** Select the option that best describes how often the client uses a tobacco product.
- 5.2.10.2.2** Include chewing tobacco or other forms of tobacco that are not smoked.
- 5.2.10.2.3** If “No” is selected above ([5.2.10.1](#)), this field will display “Never Smoked.”
- 5.2.10.3** *At what age did you first use tobacco/nicotine products?*
- 5.2.10.3.1** Select the option that best fits the age at which the client used any form of tobacco for the first time.
- 5.2.10.3.2** If “No” is selected above ([5.2.10.1](#)), this field will display “NA.”
- 5.2.10.4** *In the past 30 days, what tobacco/nicotine product did you use most frequently?*

- 5.2.10.4.1** Indicate the tobacco product used most often by the client during the 30 days prior to the admission date (see OWITS Reference Manual, Volume 5: Client Activity and Contact).
- 5.2.10.4.2** Select “None” if the client has not used tobacco in the 30 days prior to the admission date.
- 5.2.10.4.3** If “No” is selected above ([5.2.10.1](#)), this field will display “NA.”
- 5.2.10.4.4** This field is specific to the Substance Abuse domain.

5.2.10.5 *Other Please Describe*

- 5.2.10.5.1** 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 (see OWITS Reference Manual, Volume 5: Client Activity and Contact).
- 5.2.10.5.2** This field will only be available if “Other” is selected as the tobacco product ([5.2.10.4](#)).
- 5.2.10.5.3** This field is specific to the Substance Abuse domain.

5.2.10.6 *In the past 30 days, how often did you use tobacco/nicotine products?*

- 5.2.10.6.1** Select the option that best describes the daily frequency of the client’s use of any or all tobacco products.
- 5.2.10.6.2** If “None” or “No” is selected in the fields above, this field will display “NA.”

5.2.10.7 *In the past 30 days, how many cigarettes did you smoke per week?*

- 5.2.10.7.1** Enter the average number of cigarettes the client smoked each week during the 30-day period prior to the admission date.
- 5.2.10.7.2** Count cigarettes only.
- 5.2.10.7.3** This value may be estimated.
- 5.2.10.7.4** If “No” is selected above ([5.2.10.1](#)), this field will display 0.

5.2.11 When all the required fields (and others, if applicable) have been filled, *do not* click Save.

5.2.12 Click the Right Arrow to advance to the TX Summary screen, which contains the following fields tables:

5.2.12.1 *Presenting Problem (In Client’s Own Words):*

5.2.12.1.1 This read-only text display will automatically populate with the text entered into the matching field at Intake.

5.2.12.2 *Strengths, Abilities, Needs, and Preferences of Person Served – Client Statement Regarding Progress*

5.2.12.2.1 Enter any relevant details regarding the client’s treatment, prospects for future recovery, maintenance of learned skills, self-evaluation, etc.

5.2.12.3 *Program Enrollment*

5.2.12.3.1 This table will list all of the programs in which the client was enrolled during the context episode, the dates of the enrollment duration, the

facility, and any notes entered into the Notes field at Program Enrollment ([4.3.2.6](#)).

5.2.12.4 *Services Rendered*

5.2.12.4.1 This table will list the services that the client received during treatment as recorded in the Encounters module (see OWITS Reference Manual, Volume 5: Client Activity and Contact), including the service code and the total number of sessions.

5.2.12.5 *Recommendations*

5.2.12.5.1 Enter any desired clinician recommendations for further treatment for the client.

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

5.3 To update the client's diagnoses at the time of discharge, click the Discharge > Diagnosis link in the navigation pane (or skip to [5.4](#) to complete the Discharge record without updating the diagnoses).

5.3.1 A diagnosis is required in order to save the Discharge record, but the Discharge > Diagnosis screen will automatically populate with data from Admission, which will normally include a diagnosis.

5.3.2 Note that the contents of all diagnosis drop-down menus in this section are sorted alphabetically.

5.3.3 The Diagnosis screen consists of the following fields and sections:

5.3.3.1 *Primary*

5.3.3.1.1 Select the option that best describes the primary diagnosis of the client's problem.

5.3.3.2 *Secondary*

5.3.3.2.1 Select the option that best describes the secondary diagnosis of the client's problem.

5.3.3.3 *Tertiary*

5.3.3.3.1 Select the option that best describes the tertiary diagnosis of the client's problem.

5.3.3.4 *Axis I, Axis II, Axis III, and Axis IV*

5.3.3.4.1 Use these sections if specific diagnoses have been identified for the client on one or more of the four DSM axes.

5.3.3.4.2 Diagnoses will be required on all four axes even if only one has been identified.

5.3.3.4.3 Each axis includes options to specify that no diagnosis has been made for that axis.

5.3.3.5 Click the Edit Axis Evaluation link.

5.3.3.5.1 In the Axis field, select Axis I.

5.3.3.5.1.1 Selecting Axis I in this field will filter the Diagnosis field (below) to show only Axis I diagnoses.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 20 of 28
	Client Discharge	Updated: January 2, 2014		

- 5.3.3.5.2** In the Diagnosis field, select the option that matches the client’s Axis I diagnosis.
- 5.3.3.5.2.1** Near the top of the drop-down menu, select “Diagnosis or Condition Deferred on Axis I (DSM)” if the diagnosis for this axis will be added later.
- 5.3.3.5.2.2** Near the top 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.
- 5.3.3.5.3** In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.
- 5.3.3.5.3.1** 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.
- 5.3.3.5.4** Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client’s most significant problem.
- 5.3.3.5.5** Click the Add to Axis link in the gray bar labeled Axis I.
- 5.3.3.5.6** In the Axis field, select Axis II.
- 5.3.3.5.6.1** Selecting Axis II in this field will filter the Diagnosis field (below) to show only Axis II diagnoses.
- 5.3.3.5.7** In the Diagnosis field, select the option that matches the client’s Axis II diagnosis.
- 5.3.3.5.7.1** Near the top of the drop-down menu, select “Diagnosis or Condition Deferred on Axis II (DSM)” if the diagnosis for this axis will be added later.
- 5.3.3.5.7.2** Near the top 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.
- 5.3.3.5.8** In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.
- 5.3.3.5.8.1** 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.
- 5.3.3.5.9** Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client’s most significant problem.
- 5.3.3.5.10** Click the Add to Axis link in the gray bar labeled Axis II.
- 5.3.3.5.10.1** In the Axis field, select Axis III.
- 5.3.3.5.10.2** Selecting Axis III in this field will filter the Diagnosis field (below) to show only Axis III diagnoses.
- 5.3.3.5.11** In the Diagnosis field, select the option that matches the client’s Axis III diagnosis.

- 5.3.3.5.11.1** Near the top of the drop-down menu, select “Diagnosis or Condition Deferred on Axis III (DSM)” if the diagnosis for this axis will be added later.
- 5.3.3.5.11.2** Near the top 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.
- 5.3.3.5.12** In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.
- 5.3.3.5.12.1** 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.
- 5.3.3.5.13** Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client’s most significant problem.
- 5.3.3.5.14** Click the Add to Axis link in the gray bar labeled Axis III.
- 5.3.3.5.15** In the Axis field, select Axis IV.
- 5.3.3.5.15.1** Selecting Axis IV in this field will filter the Diagnosis field (below) to show only Axis IV diagnoses.
- 5.3.3.5.16** In the Diagnosis field, select the option that matches the client’s Axis IV diagnosis.
- 5.3.3.5.16.1** Near the top of the drop-down menu, select “Diagnosis or Condition Deferred on Axis IV (DSM)” if the diagnosis for this axis will be added later.
- 5.3.3.5.16.2** Near the top 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.
- 5.3.3.5.17** In the Specifier field, enter additional clinical details regarding the severity, remission, and prior history of the diagnosis as directed by the DSM-IV.
- 5.3.3.5.18** 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.
- 5.3.3.5.19** Use the Principal Diagnosis field, to indicate if the selected diagnosis is the client’s most significant problem.
- 5.3.3.5.20** Click the Add to Axis link in the gray bar labeled Axis IV.
- 5.3.3.5.21** Click Finish to return to the Diagnosis screen.
- 5.3.3.6** *Axis V*
- 5.3.3.6.1** Enter the client’s most recent GAF score.
- 5.3.3.6.2** This must be a number between 0 and 100.
- 5.3.3.7** *Highest GAF Score in Last Year*

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 23 of 28
	Client Discharge	Updated: January 2, 2014		

6.0 Closing Episodes

- 6.1** Completing a Discharge record offers the opportunity to have OWITS close the episode automatically ([5.4.1](#)), but episodes that are not closed at Discharge can be closed manually.
- 6.2** To manually close an episode, navigate to the Client List > Episode List screen for the desired client.
 - 6.2.1** The Episode List table will display.
 - 6.2.2** Cases with no date in the “Closed Date” column are still open, regardless of whether a Discharge has been recorded.
- 6.3** Click the “Review” link in the Actions column for the desired episode.
 - 6.3.1** The Client Activity List for the selected episode will display.
- 6.4** Confirm that the Activity List records are complete.
 - 6.4.1** The “Status” column should not list any activity records as “In Progress” ([2.3](#)).
 - 6.4.2** The client should be disenrolled from all programs ([4.0](#)).
 - 6.4.3** If an Admission record was created, a Discharge record must also be created ([5.0](#)).
- 6.5** Navigate to the Intake screen.
 - 6.5.1** Intake can be reached by clicking the Activity List > Intake link in the navigation pane.
 - 6.5.2** Intake can be reached by clicking the “Review” link in the Actions column for the “Intake Transaction” activity.
- 6.6** Enter a date into the “Date Closed” field.
 - 6.6.1** This date must be on or after the Discharge date ([5.2.1.1](#)).
 - 6.6.2** This date cannot be in the future.
- 6.7** Click the “Save & Close the Case” link.
 - 6.7.1** The Intake screen will be changed to a read-only state.
 - 6.7.2** Clicking the Save or Finish button instead of this link after adding a closure date will produce an error message.
- 6.8** Click Finish to return to the Activity List.
- 6.9** The episode is now closed and cannot be edited unless it is reopened ([7.2](#)).

7.0 Resuming Treatment in an Existing Episode

- 7.1** If a client returns for additional treatment or services after concluding treatment, additional treatment can be recorded without creating a new Intake, at the agency’s discretion.
 - 7.1.1** If the agency chooses the program-only recording method ([1.2](#)), the client need only be enrolled in a new program (see OWITS Reference Manual, Volume 5: Client Activity and Contact).
 - 7.1.2** If the agency chooses the multiple-episode recording method ([1.3](#)), a closed case can be reopened.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 24 of 28
	Client Discharge	Updated: January 2, 2014		

7.2 To resume treatment in a closed episode, reopen the case.

7.2.1 Navigate to the Client List > Episode List screen for the desired client.

7.2.1.1 The Episode List table will display.

7.2.1.2 Cases with a date in the “Closed Date” column are closed.

7.2.2 Click the “Review” link in the Actions column for the desired episode.

7.2.2.1 The Client Activity List for the selected episode will display.

7.2.3 Navigate to the Intake screen.

7.2.3.1 Intake can be reached by clicking the Activity List > Intake link in the navigation pane.

7.2.3.2 Intake can be reached by clicking the “Review” link in the Actions column for the “Intake Transaction” activity.

7.2.4 Click the “Re-Open Case” link next to the “Date Closed” field.

7.2.4.1 Only users with the “Case Reopen” role will be able to see and use this link (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

7.2.4.2 The closure date will be removed.

7.2.4.3 The Intake record will be changed to an editable state.

7.2.5 It is now possible to edit existing records and add some new records.

7.3 To enroll a previously discharged client in another program or to otherwise continue treatment, delete the existing Discharge record.

7.3.1 Navigate to the Activity List > Discharge > Profile screen.

7.3.1.1 The Discharge Profile will display.

7.3.1.2 If the context episode is closed, all fields will be in a read-only state, and the case must be reopened before the Discharge record can be deleted (see [7.2](#)).

7.3.2 If desired, capture Discharge data.

7.3.2.1 Click the Generate Report link at the top of the screen.

7.3.2.2 The Discharge data will display in a pop-up window (see [5.5.3](#)) from which it can be saved or printed for later use.

7.3.3 Click the “Delete Discharge” link in the Administrative Actions box near the bottom of the screen.

7.3.3.1 This link is only available to users with the Agency Administrator role (see OWITS Reference Manual, Volume 3: Agencies, Facilities, Programs, and Staff Records).

7.3.3.2 OWITS will confirm the delete command.

7.3.3.3 Click “Yes” to delete the Discharge record.

7.3.3.4 This action cannot be undone.

7.3.4 When the Discharge has been successfully deleted, the Activity List will display.

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 25 of 28
	Client Discharge	Updated: January 2, 2014		

- 7.3.5** Additional treatment records, including Program Enrollments, can be recorded for the client in the context episode.
- 7.4** To resume enrollment in program from which the client was previously disenrolled, remove the End Date.
- 7.4.1** Navigate to the Activity List > Program Enroll screen.
- 7.4.1.1** The Program Enrollment list will display.
- 7.4.1.2** Programs that have a date in the End Date field are programs from which the client has been disenrolled.
- 7.4.2** Click the “Review” link in the Actions column for the desired program enrollment.
- 7.4.2.1** The Program Enrollment Profile screen will display.
- 7.4.3** Remove the date from the End Date field.
- 7.4.3.1** Click outside the End Date field for the change to take effect.
- 7.4.4** The Termination reason field will clear and will change from yellow (required) to white (not required).
- 7.4.5** Click Save.
- 7.4.6** Click Finish to return to the Program Enrollment list screen.
- 7.4.7** The Program Enrollment is now active and can be used as a reference point in Encounters (see OWITS Reference Manual, Volume 5: Client Activity and Contact) and for Group Roster entries (see OWITS Reference Manual, Volume 7: Groups and Group Notes).

	OWITS Reference Manual	Volume 9	Revision 1-0	Page 26 of 28
	Client Discharge	Updated: January 2, 2014		

Appendix A – 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

Appendix B – 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.

DRAFT

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	November 27, 2013	Manual completed.
Justin D. King	January 2, 2014	Added link to Navigation Map.

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