DDAP Data System – PA WITS

End User Clinical Guide

Pennsylvania DDAP
Updated: June 2022

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Applies to:

PA WITS Version 22+

Pennsylvania DDAP

DDAP Data System – PA WITS

Intended Audience

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

System Requirements

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

Internet Browsers

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

- Microsoft Edge
- Google Chrome
- Mozilla Firefox
- Apple Safari

NOTE: When resetting PA-WITS account credentials, be sure to **remove any prior saved Passwords** from the browser settings. Failing to do so may cause the browser to substitute the older login info upon hitting **"Submit"** and the login attempt will fail.

Pop-up Blocker

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

Customer Resources

PA WITS Training Material Website: Contains links to user guides and other useful system information. https://www.ddap.pa.gov/Training/Pages/DataSystem_Training.aspx

PA WITS Support Structure: See Part 6 of this guide. Overview of the PA WITS problem reporting structure that describes the proper procedures to report various types of user issues.

PA WITS Help Desk: Email: RA-DAPAWITS@pa.gov
Phone: 717 736-7459 (M-F 8:00 am–4:00 pm)

PA WITS Production Site: https://pa.witsweb.org

PA WITS Support Structure

This section describes the various levels of the support available to users, and the types of issues each level is responsible for addressing.

Tier 1 Support: PA WITS Agency/Staff Administrator at SCA or Provider

- Champion PA WITS at your organization
- Create new staff accounts, reset passwords, lock/unlock accounts, change user account permissions
- Have a solid understanding of WITS screens, business rules, and processes; be able to help users with any usability issue that is covered in PA-WITS training manuals or other available user and system documentation

- Address user issues during normal operation hours
- Ensure users review and complete the on-demand self-service training at: (https://www.ddap.pa.gov/Training/Pages/DataSystem_Training.aspx). Please note: While the steps in these videos are still accurate for PA WITS functionality wise, the appearance of the screens will be different due to a recent user interface update.
- Escalate system errors or complex issues to **PA WITS Service Desk** (Tier 2 Support)

Tier 2 Support: DDAP, PA WITS Service Desk

- Available Monday-Friday, 8 AM – 4:00 PM (except on State Holidays) to answer calls or emails from the SCA or Provider's Tier 1 support designee.
- Email: RA-DAPAWITS@pa.gov
- Phone: 717-736-7459
- Work with SCA or Provider's Agency or Staff Administrator to see the issue through to resolution. If the problem cannot be resolved, DDAP will escalate the issue to Tier 3 support.

Tier 3 Support: FEi Systems

The **PA WITS Service Desk** will work with the vendor, Fei Systems, to address issues not resolved at the Tier 1 or 2 levels, and to address other system defects or availability issues.

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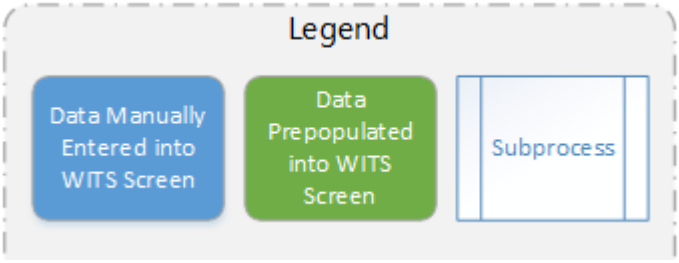
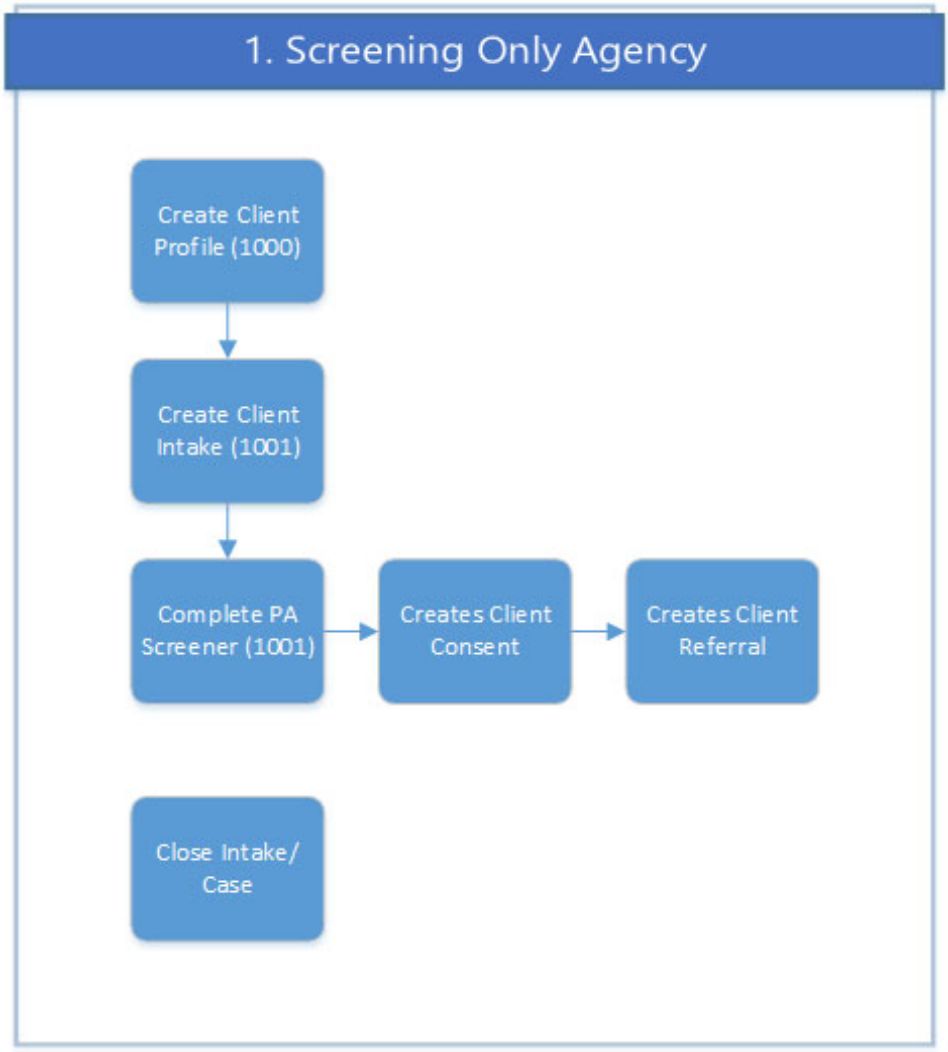
Part 1: Types of Agency Workflows

Workflow Diagrams

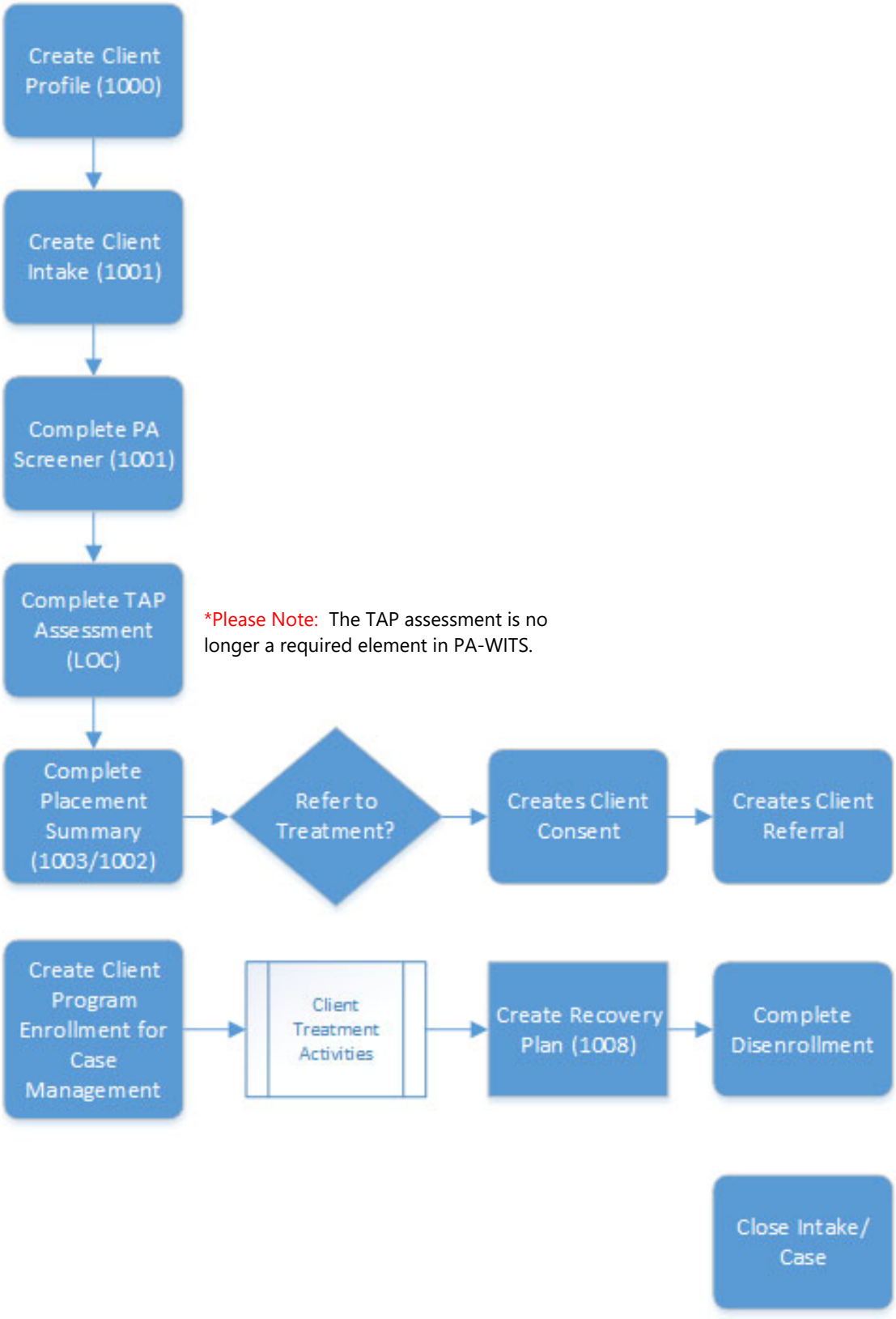
The following diagrams illustrate how the data being entered into PA WITS at a user's agency fits into the overall system's workflow. This guide identifies the workflow activities of five differing types of agencies.

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



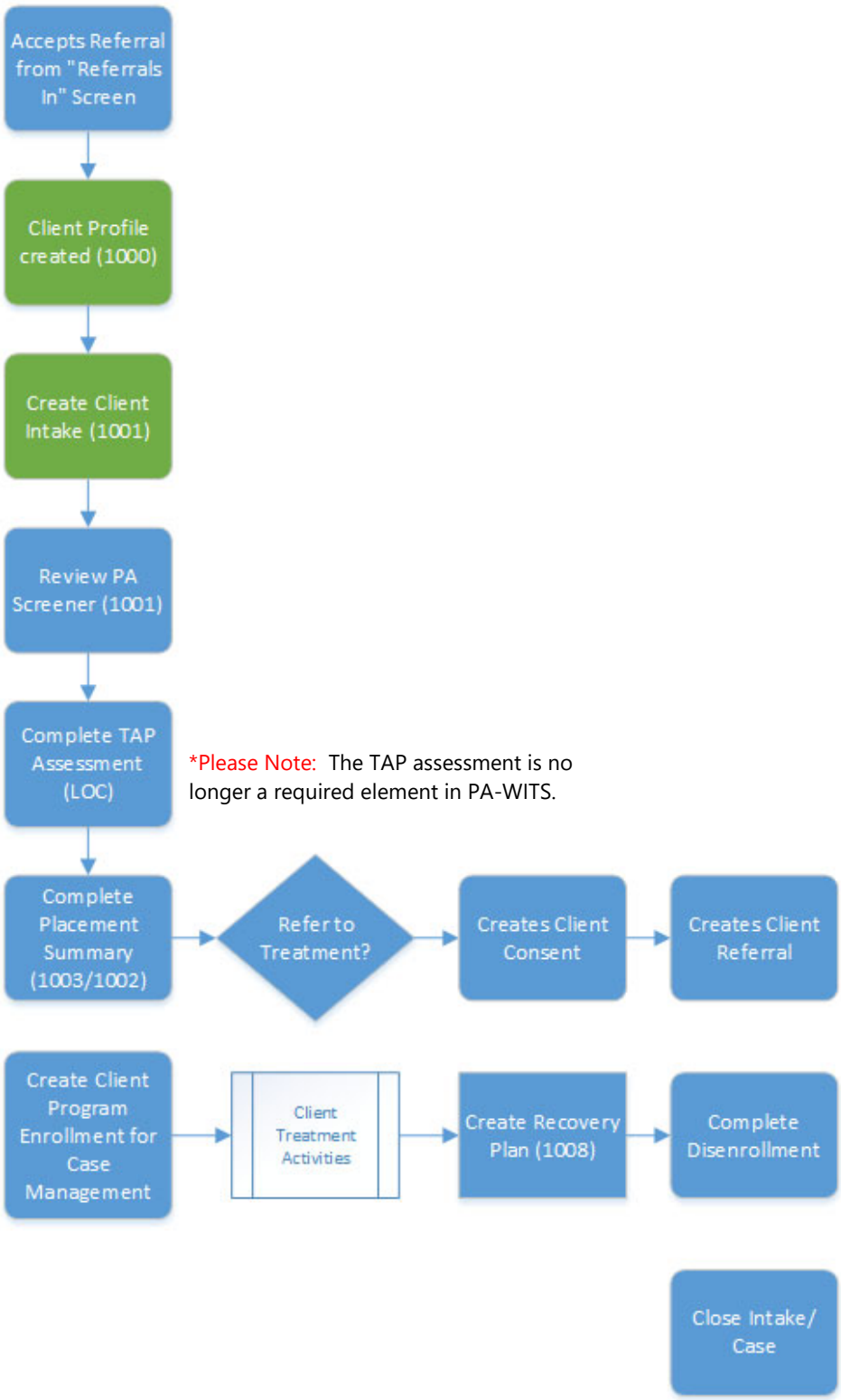


2. Screening Agency with Case Management

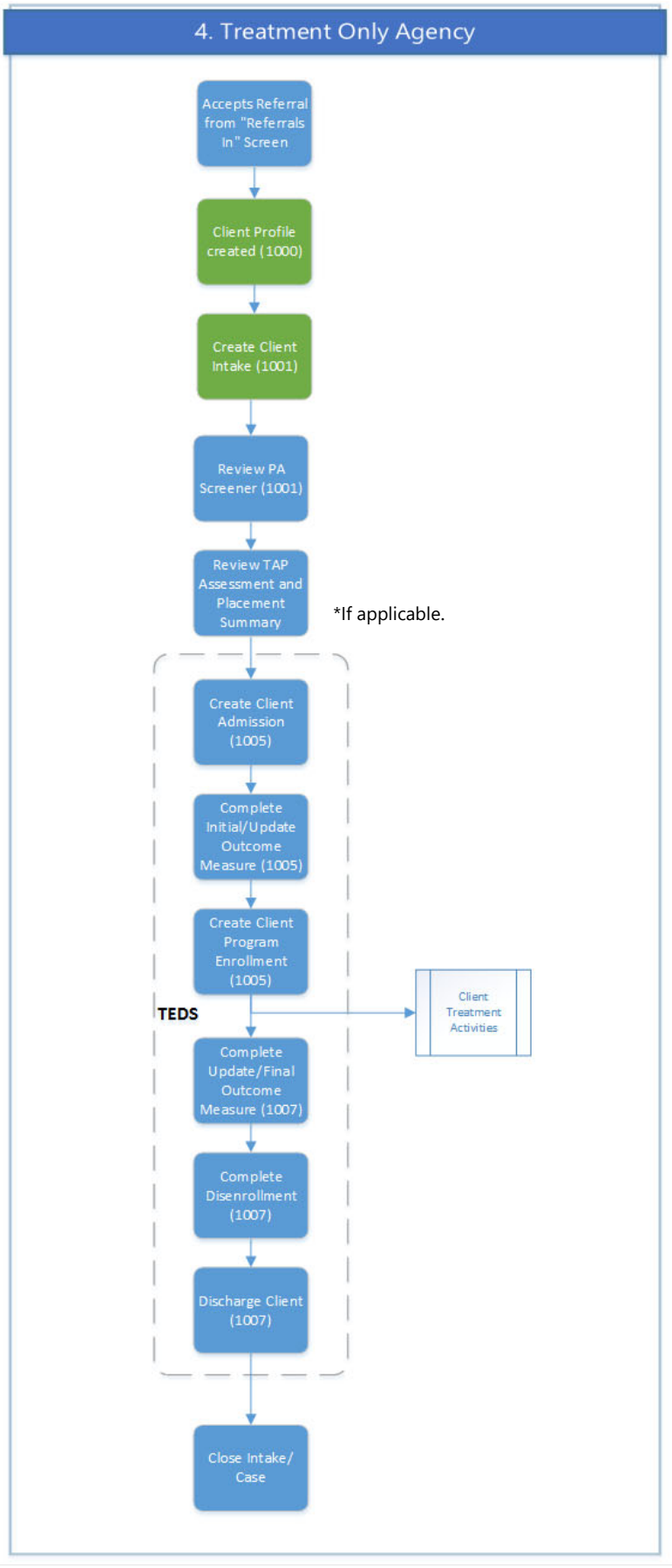


*Please Note: The TAP assessment is no longer a required element in PA-WITS.

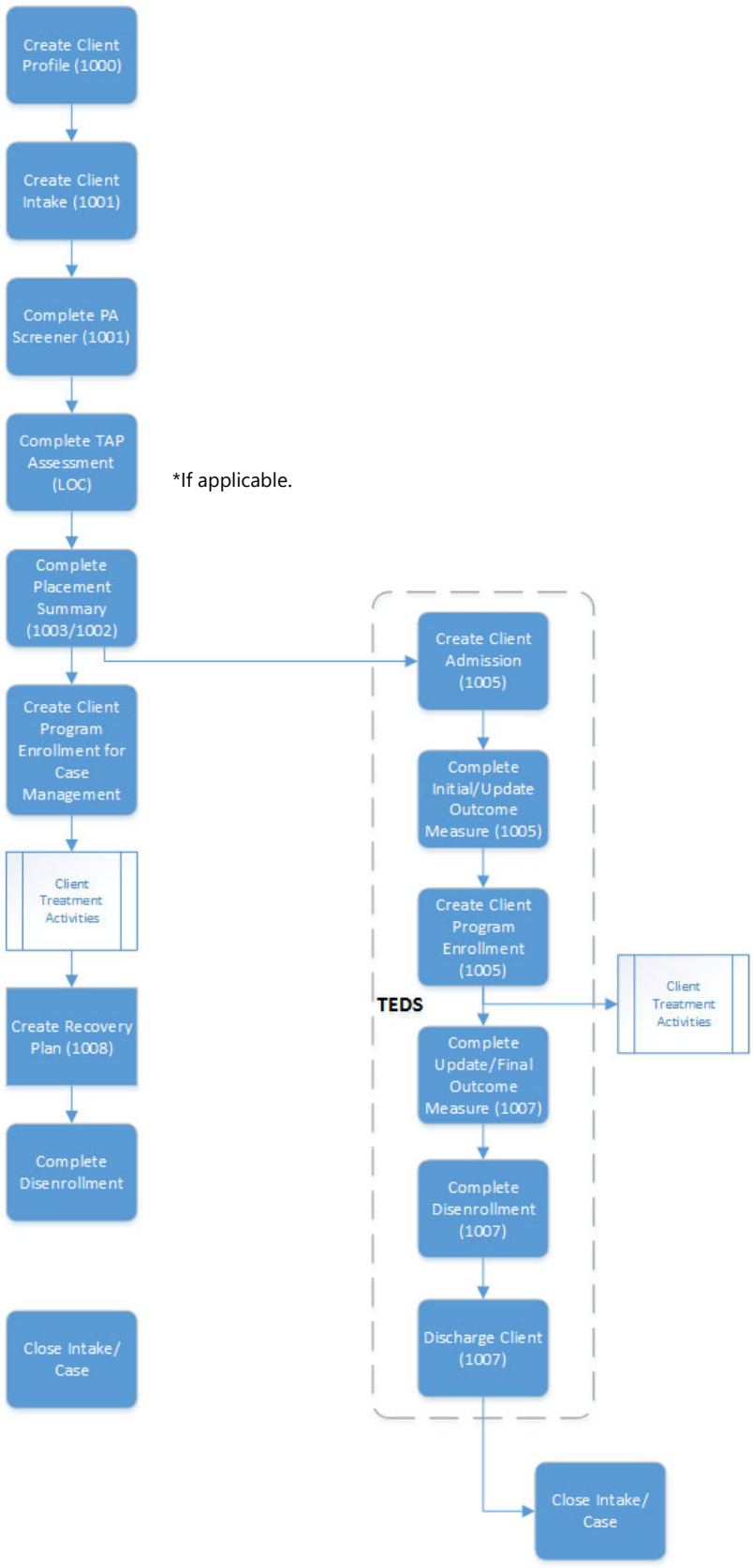
3. Case Management Only Agency



*Please Note: The TAP assessment is no longer a required element in PA-WITS.


4. Treatment Only Agency
Accepts Referral from "Referrals In" Screen
Client Profile created (1000)
Create Client Intake (1001)
Review PA Screener (1001)
Review TAP Assessment and Placement Summary
*If applicable.
Create Client Admission (1005)
Complete Initial/Update Outcome Measure (1005)
Create Client Program Enrollment (1005)
TEDS
Client Treatment Activities
Complete Update/Final Outcome Measure (1007)
Complete Disenrollment (1007)
Discharge Client (1007)
Close Intake/ Case

5. Full Functional Agency



Part 2: Client Setup

Search for a Client

Where: Client List > Client Search

Before creating a new client record, perform a search for your client to ensure the client does not have an existing profile in PA WITS.

1. To view clients within your agency, choose the desired facility from the **Facility** dropdown box and click on the **"Client List"** menu item. A blank **Client List** screen will appear.
2. Use the fields in the **Client Search** or **Advanced Search** section to narrow your results. i.e. Because Clients reside at the **Agency** level, leaving the **Facility** field blank will expand the search terms to include clients in all the Facilities within a given Agency.
3. After entering your search criteria, click **"Search"** to view the results.

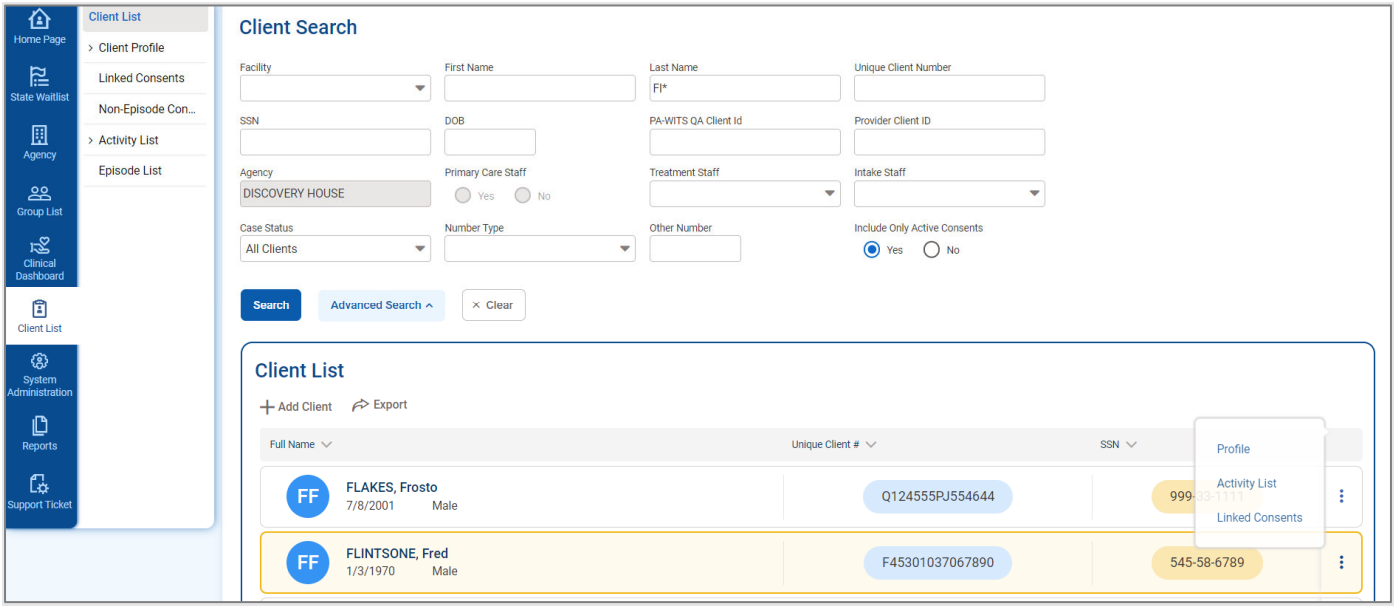


Figure 2-1: Client List screen, Action links

Look for your client in the **Client List**. If listed, hover over the ellipsis (three vertical dots) in the last column and select the desired action.

If your client is <u>not</u> displayed in the **Client List**, you can create a new client record by clicking on the **"+Add Client"** link.

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

Duplicate Client Check

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

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

If a possible duplicate client is identified based on the UCN, the following message will be displayed:

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

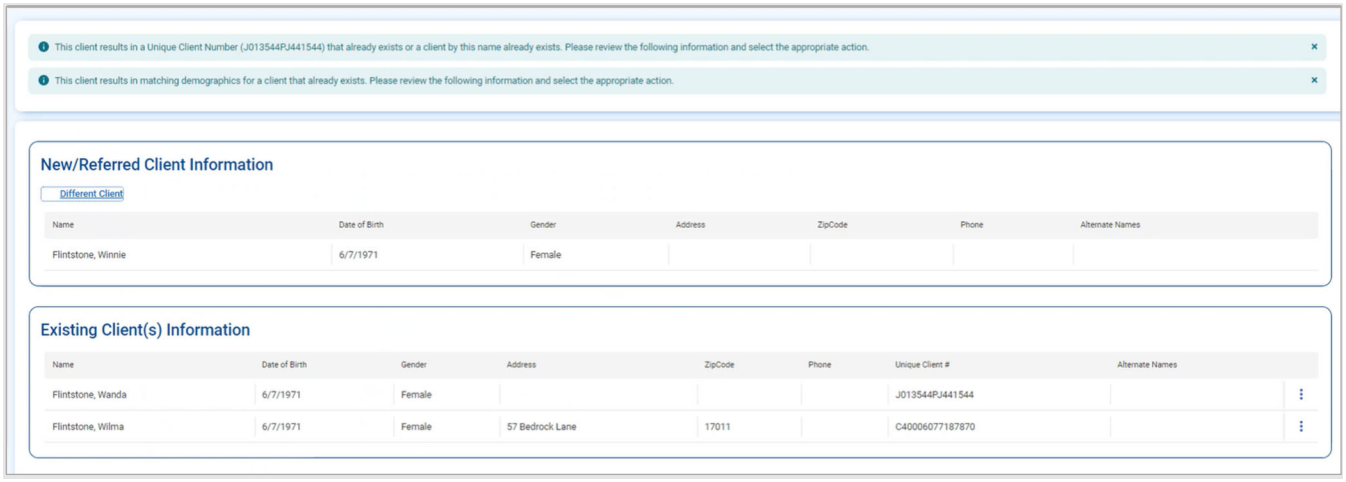
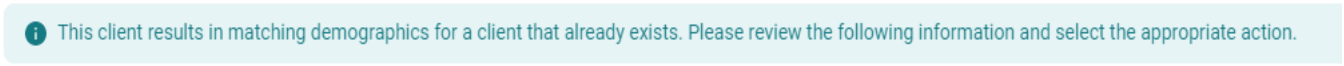


Figure 2-2: New/Referred Client Information with Existing Client Information

If a possible duplicate client is identified from any other criteria, the following message will be displayed:

"This client results in matching demographics for a client that already exists. Please review the following information and select the appropriate action."



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

If the referred client is different than the existing client, click **"Different Client"**.

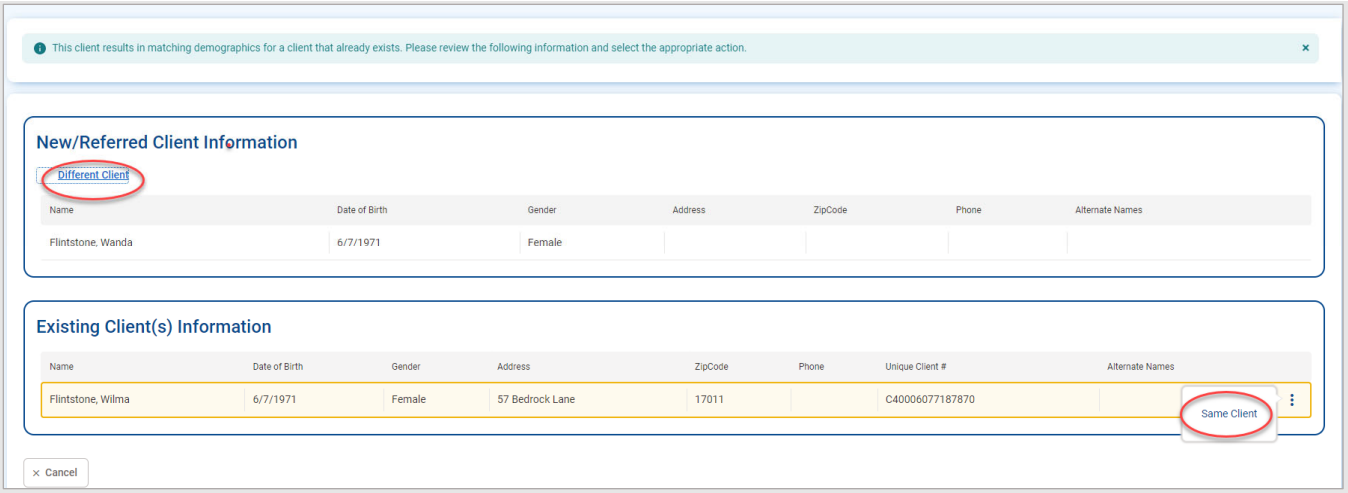


Figure 2-3: Existing Client Information, Same Client link

Client Search Tips

Client Names

You may use a client's actual **First** and/or **Last Name**, **Nickname** or an **Alternate Name** in the **First Name** / **Last Name** fields to perform a client search.

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

Example: To find clients whose last name begins with the letters "JON": Type **"Jon*"** in the **Last Name** field. To find last names that END with the letters "JON" type **"*jon".**

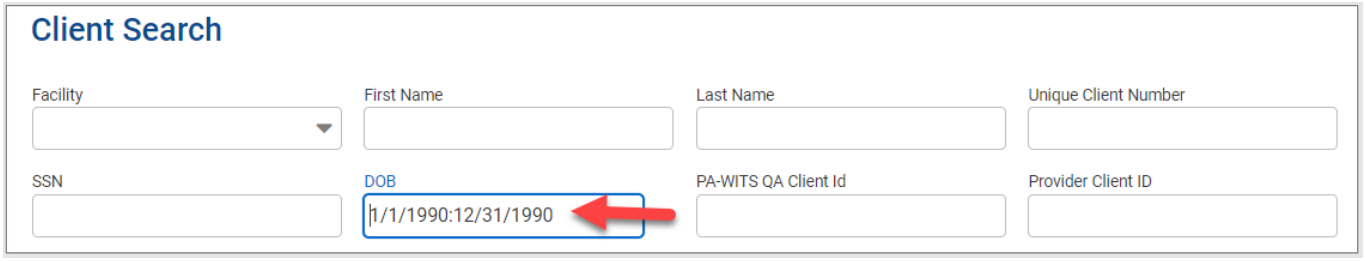
Client Social Security Numbers

Example: To search for a client whose **SSN** ends with 1123, type **"*1123"** in the **SSN** field. To search by the first digits in an **SSN#**, move the asterisk to after the desired numbers.

Client Birthday or Age

To search within a specific timeframe, separate the two dates in the range with a colon (:).

Example: To find clients born in the year 1990: Type **"1/1/1990:12/31/1990"** in the **DOB** field.



Search for clients born before or after a certain date using the **(>)** and **(<)** symbols.

Example: Entering **">12/30/1959"** will find all clients born **AFTER** 1959**.** Using (<) in front of the date will return all clients born **BEFORE** 12/31/1959.

Create Client Profile

Where: Client List > Client Profile

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

1. On the left navigation menu, click "**Client List**", an additional navigation panel with related elements will open.
2. In the main view window within the **Client List** area, click "**+Add Client**".

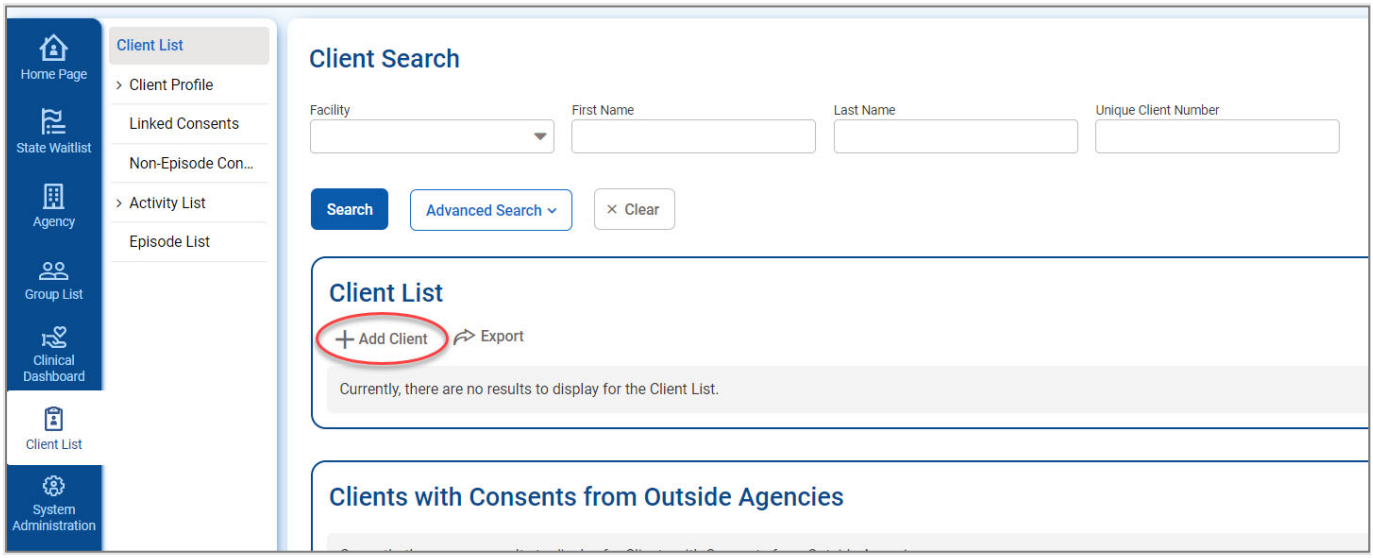


Figure 2-4: Client List screen, Add Client link

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

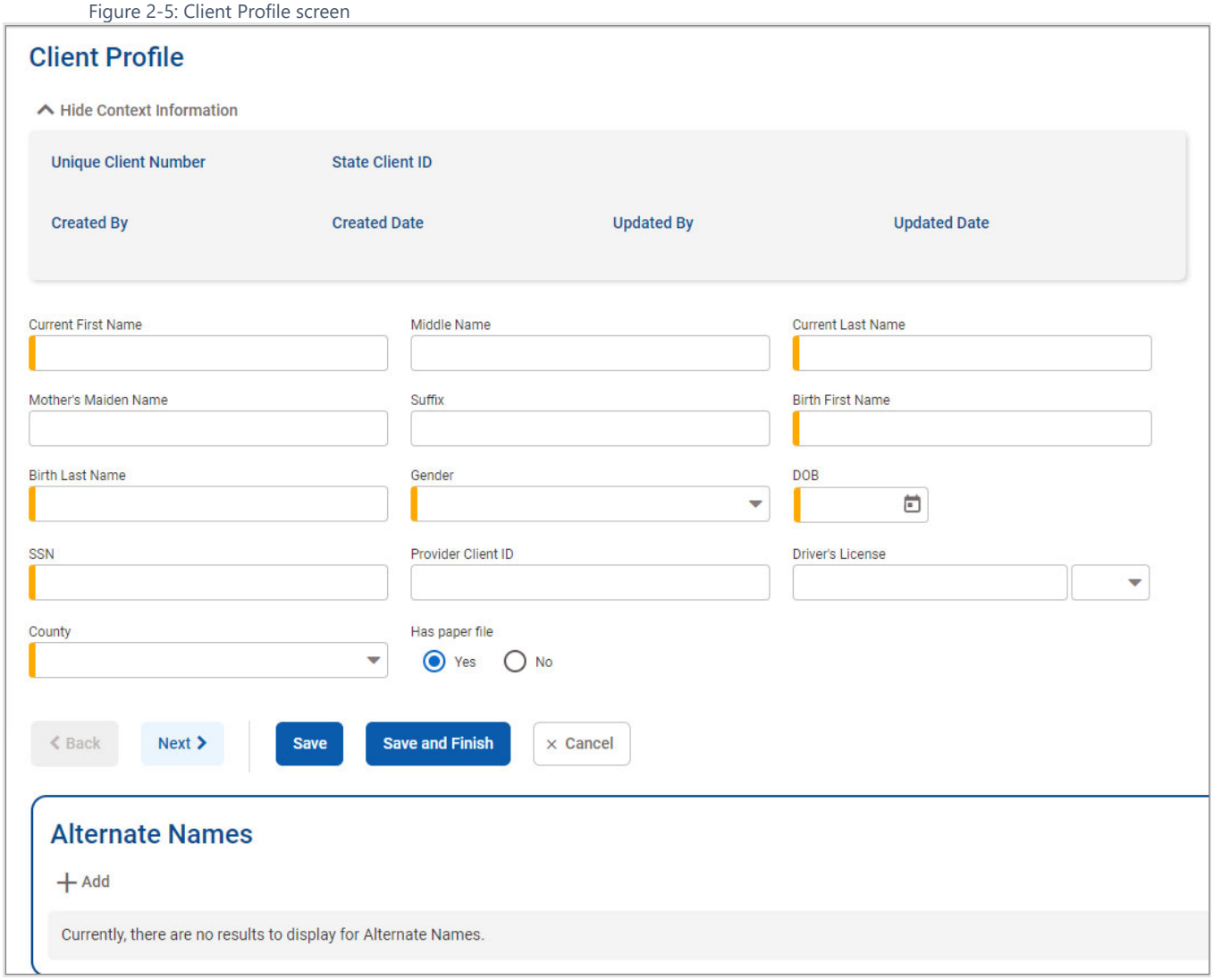
Table 2-1: Client Profile fields

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

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

Required fields are indicated by solid gold shading to the left of the field. **This is true in any area of PA WITS.**

Figure 2-5: Client Profile screen



4. Click "**Save**". This action will generate the **Unique Client Number (UCN)**.

Alternate Names

The client's nickname or street name may be entered here. A client's **Alternate Names** entries are searchable on the **Client List** screen.

5. On the **Alternate Names** screen, click "**Add Alternate Name"**, the bottom half of the screen now becomes editable.

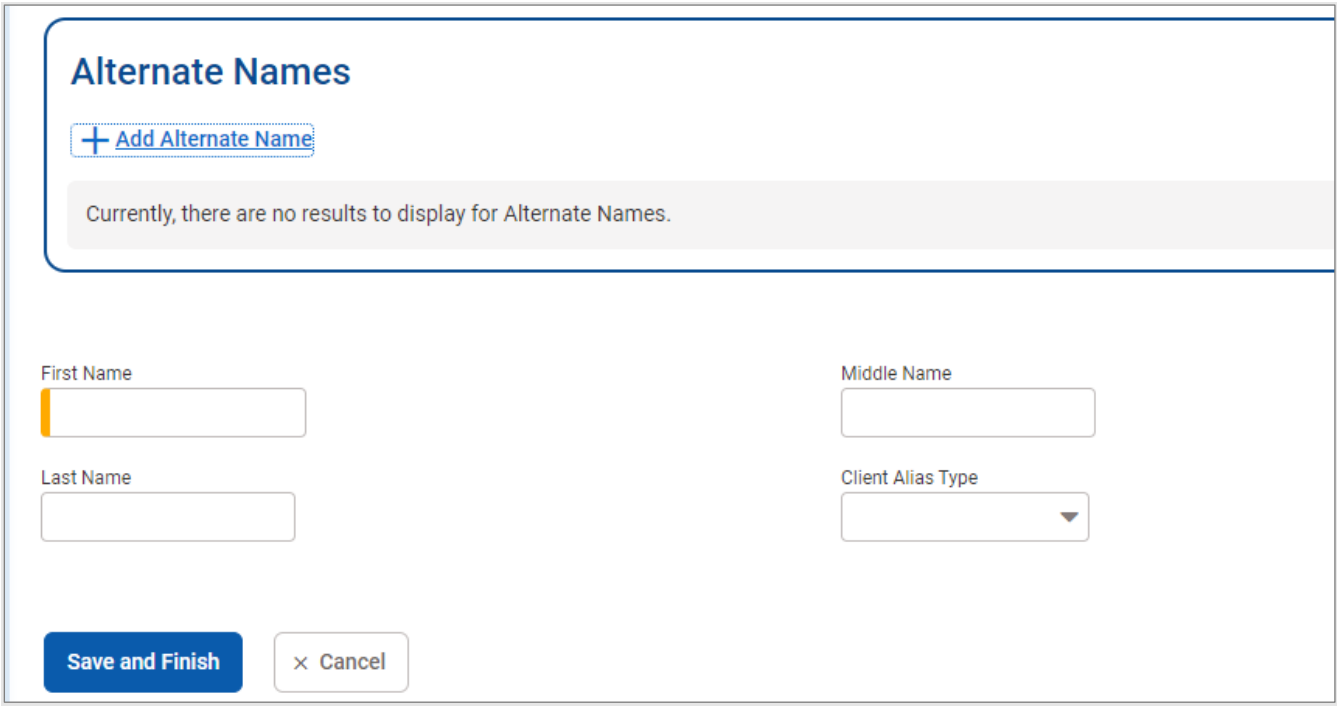


Figure 2-6: Alternate Names screen

6. Complete <u>at least</u> the **First Name** field.

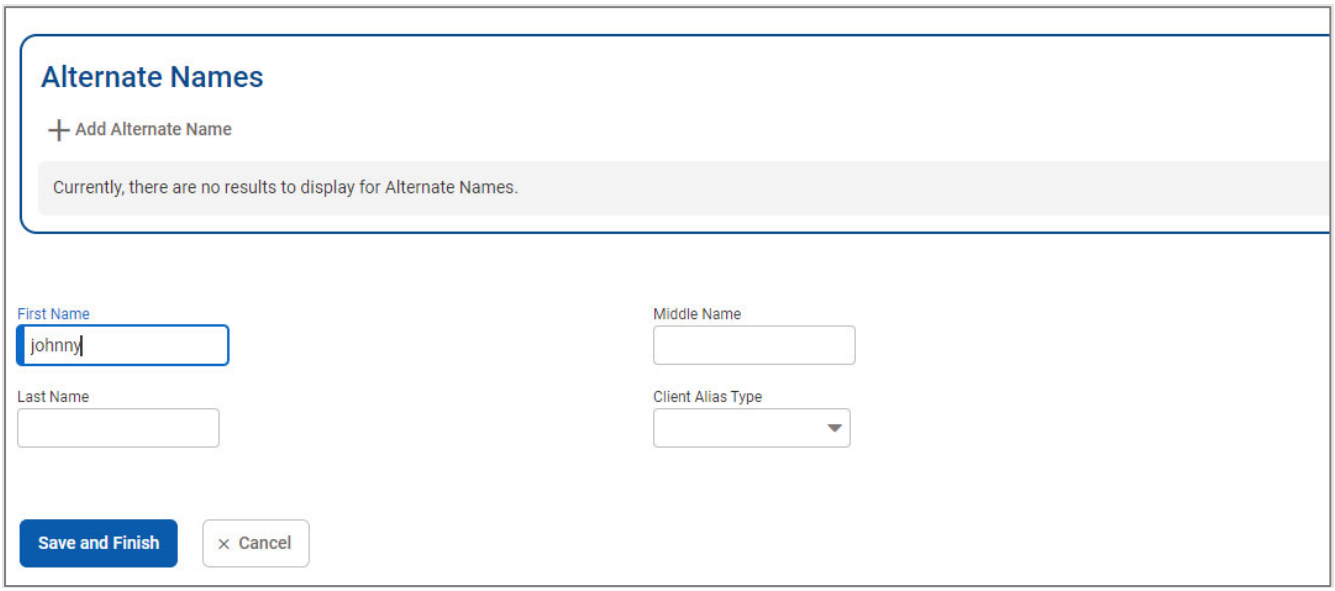


Figure 2-7: Add Alternate Name

7. Click "**Save and Finish"**. The name will now appear in the list at the top of the screen.
8. From the **Alternate Names** screen, click the "**Next>"** button to open the **Additional Information** screen.

Additional Information

5. On the **Additional Information** screen, complete at least the **Required** fields to satisfy TEDS reporting requirements that must be completed before creating an **Intake**.

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

Field	Description
Ethnicity	Select from the drop-down list.
Selected Races	Select one or more races. **NOTE:** the option **"Refused"** cannot be combined with another option.
Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?	Select from the drop-down list.

REMINDER:

A **solid gold shading** to the left of the field indicates the field is *"required"* and must be completed in order to save the record.

A **striped gold bar** indicates the field is required for a record to be considered complete by the system, but the record may be saved without filling them in initially.

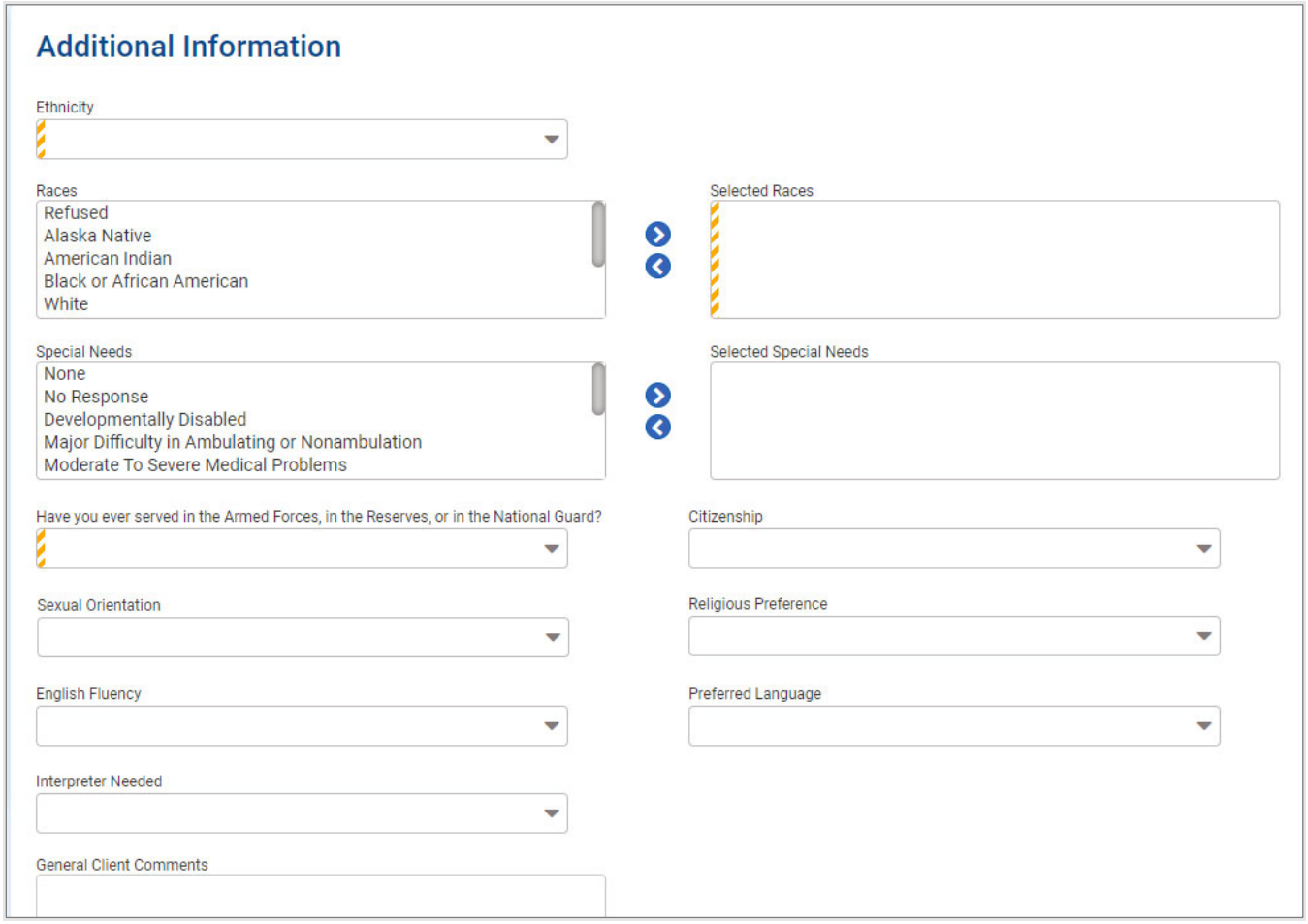


Figure 2-8: Additional Information screen

6. When complete, click **"Save",** then click the "**Next>"** button to open the **Contact Info** screen.

Contact Info

NOTE: In Pennsylvania, an address is required to complete a client's profile. Details on entering homeless clients are included.

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

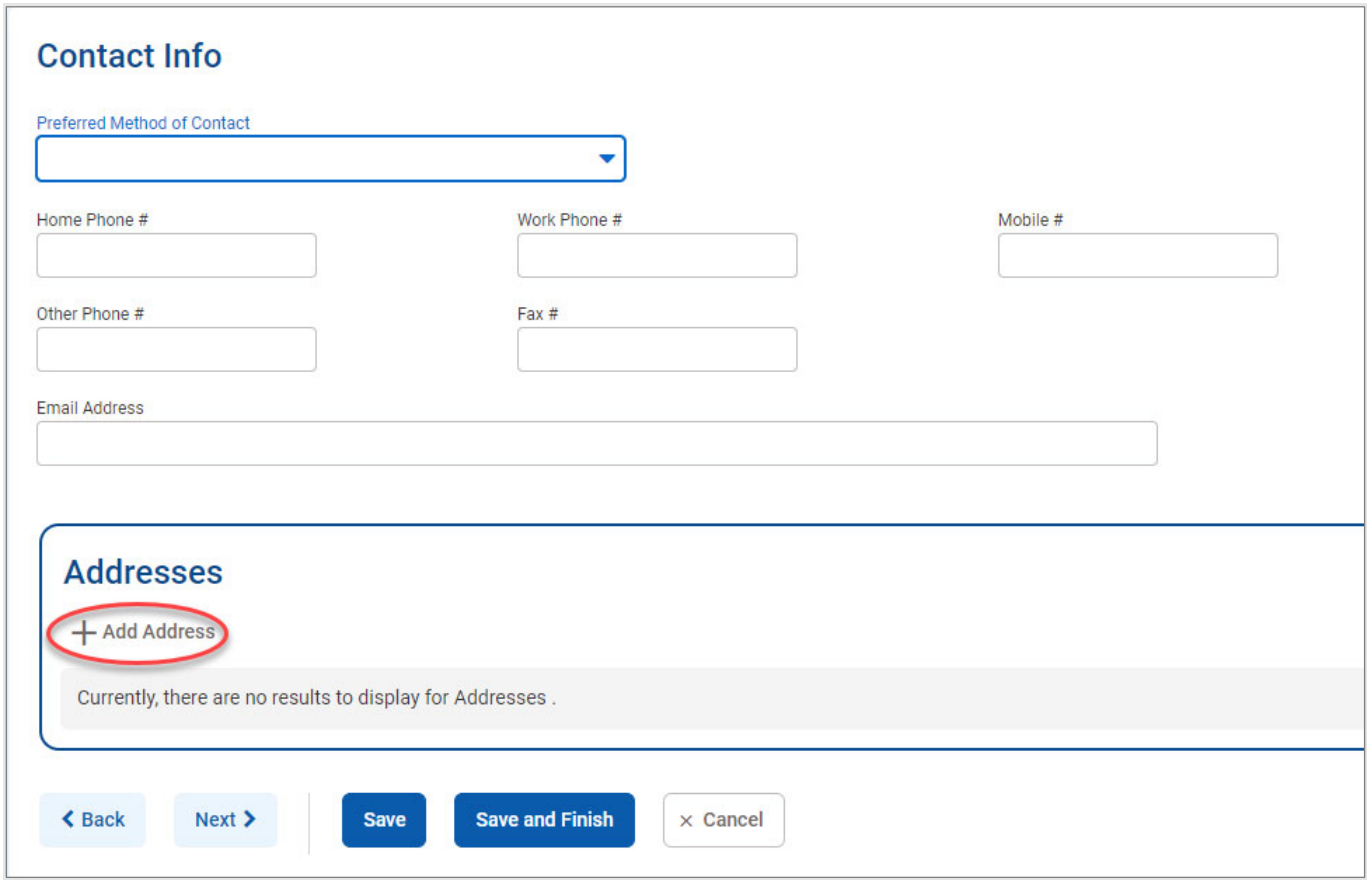


Figure 2-9: Contact Info screen

8. Enter the client's **Address Type** using the dropdown menu and fill in at least the **Address Line 1**, **City**, **State**, and **Zip Code** fields as required.

NOTE: If the client is **Homeless**, select the **Address Type** of "**Client Homeless".** The **City**, **State** and **Zip Code** fields will cease to be "required".

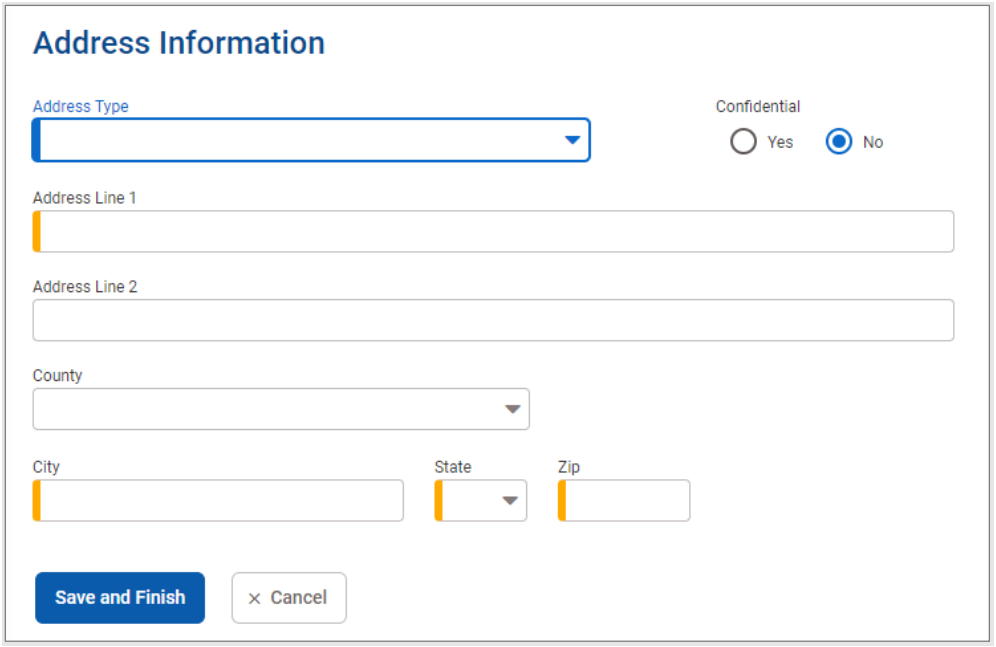


Figure 2-10: Address Information screen

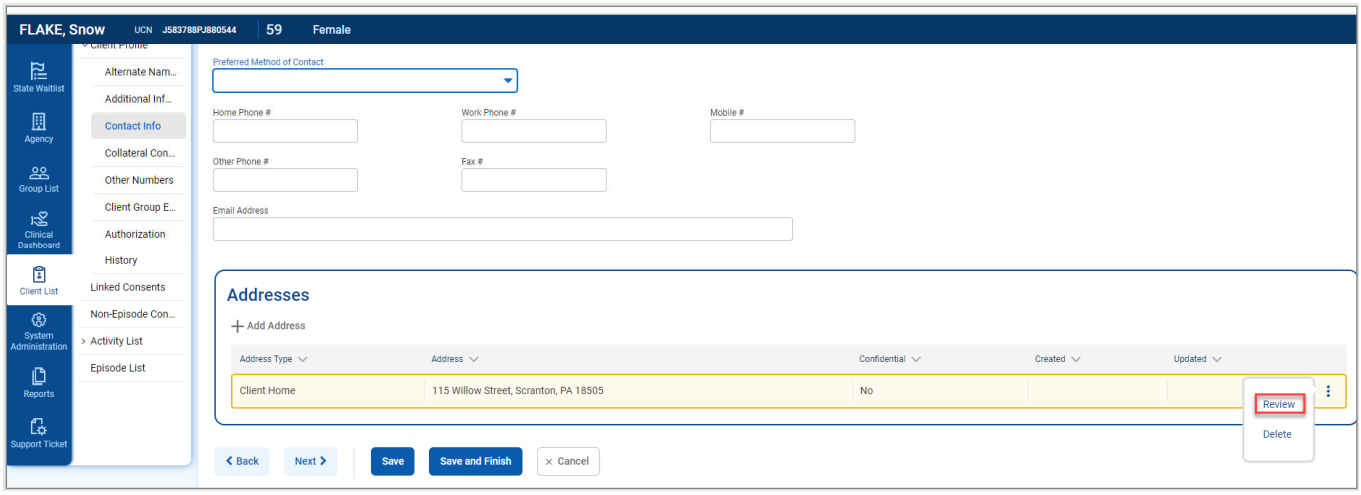
9. When complete, click "**Save and Finish".** **T**he client's address information will show in the **Contact Info** screen. Add an **Additional Address** if needed.
10. From the **Contact Info** screen, click the **"Next>"** button to open the **Collateral Contacts** screen.

NOTE: If a client has a new address, update the **Address Type** of the client's current address record to type **"Previous"**, and then add the new address.

Figure 2 9: Address Validation screen

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

NOTE: PA WITS uses the **USPS Address Standardization Web Tool** to validate client addresses. If USPS detects any errors, PA WITS will display the results from USPS. You can then decide to select the original address entered or the suggested address from USPS.



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

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

Collateral Contacts

Adding **Collateral Contacts** is *optional*, however, the extra information can prove invaluable in finding the client in the future when they are no longer actively receiving services.

On the **Collateral Contacts** screen, (note the fields below currently are grey), click the **"Add Contact"** link and choose the relevant **Contact Type**. Options include but are not limited to, various family members, health care providers, government offices and/or service agencies and various legal contacts.

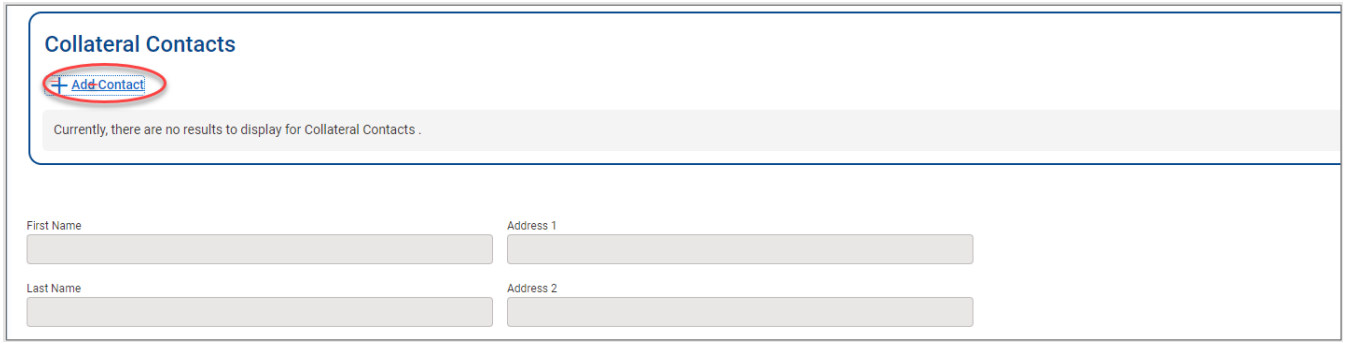
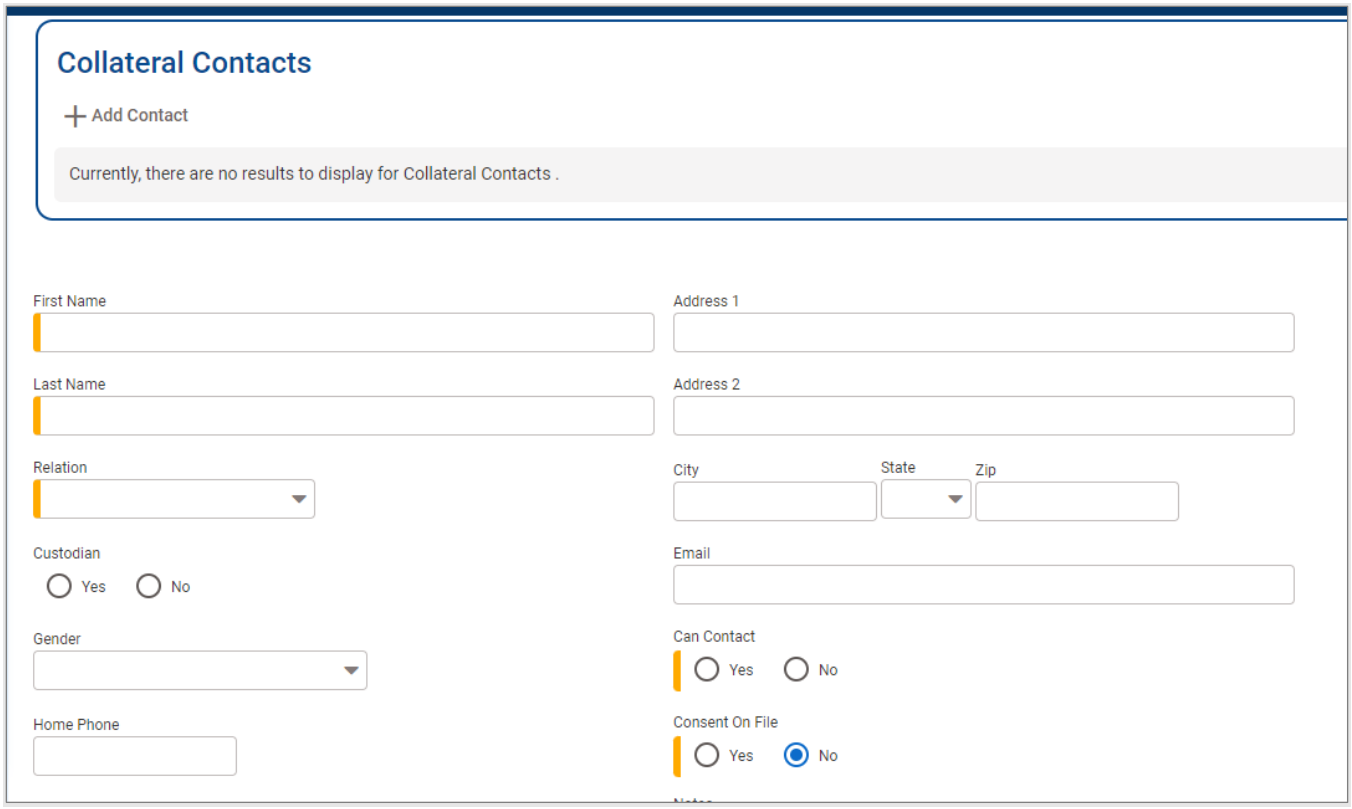


Table 2-3: Collateral Contacts Fields

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


Collateral Contacts
Add Contact
Currently, there are no results to display for Collateral Contacts .
First Name
Last Name
Relation
Custodian
Yes
No
Gender
Home Phone
Address 1
Address 2
City
State
Zip
Email
Can Contact
Yes
No
Consent On File
Yes
No

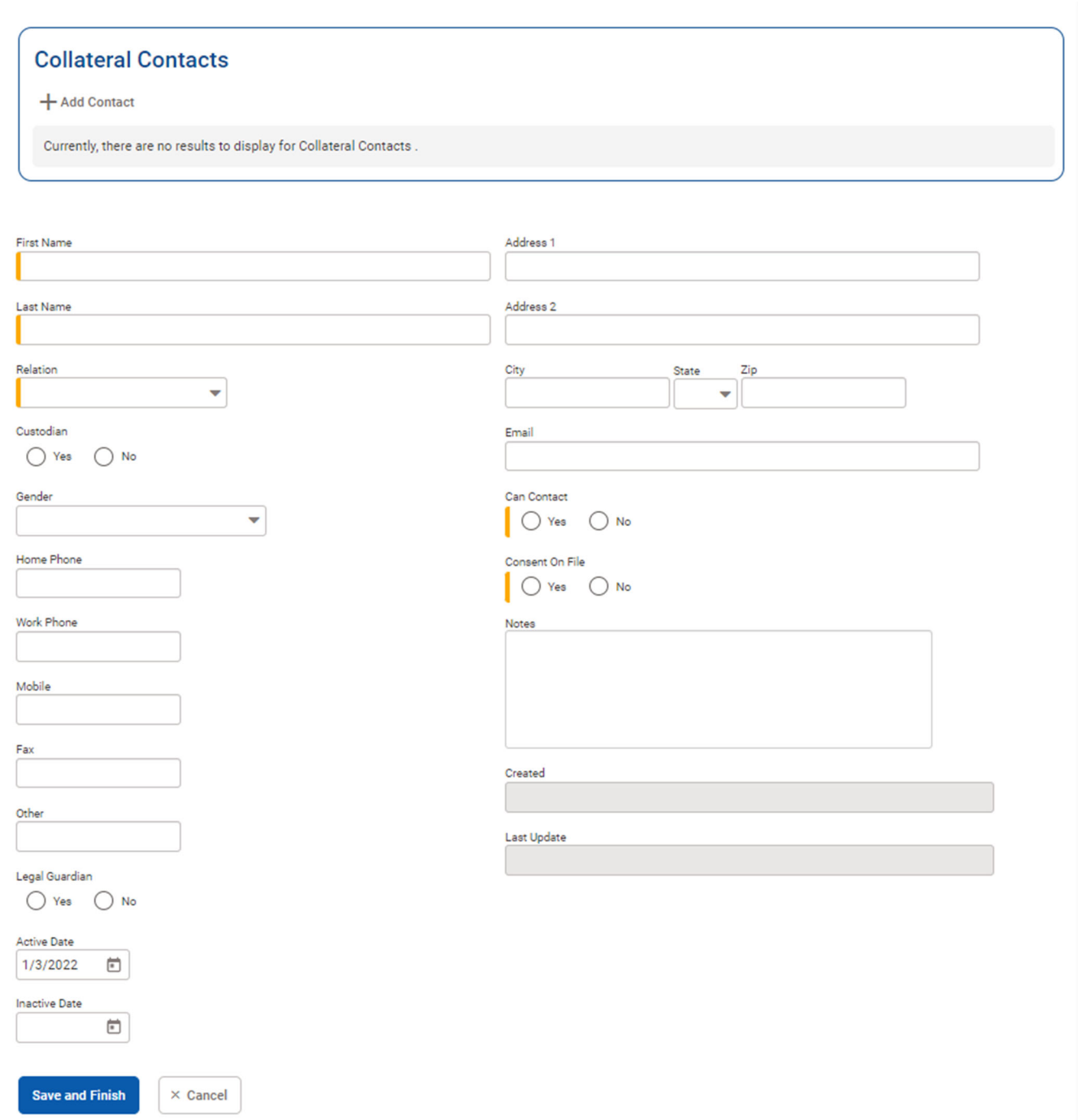


Figure 2-11: Add Collateral Contacts screen

11. When complete, click **"Save and Finish"**. The names will now be displayed in the table at the top of the screen.
12. From the **Collateral Contacts** screen, click the "**Next>"** button to open the **Other Numbers** screen.

Other Numbers

In this section, users can add additional identifying numbers for a client, such as a court case number.

13. On the **Other Numbers** screen, click the **"Add Other Number"** link. The bottom half of the screen now becomes editable.

    Fill in the required information.

NOTE: This section is OPTIONAL and does not need to be completed for the profile to be considered complete. However, once **Add Other Number** is chosen, the fields within it will become required.

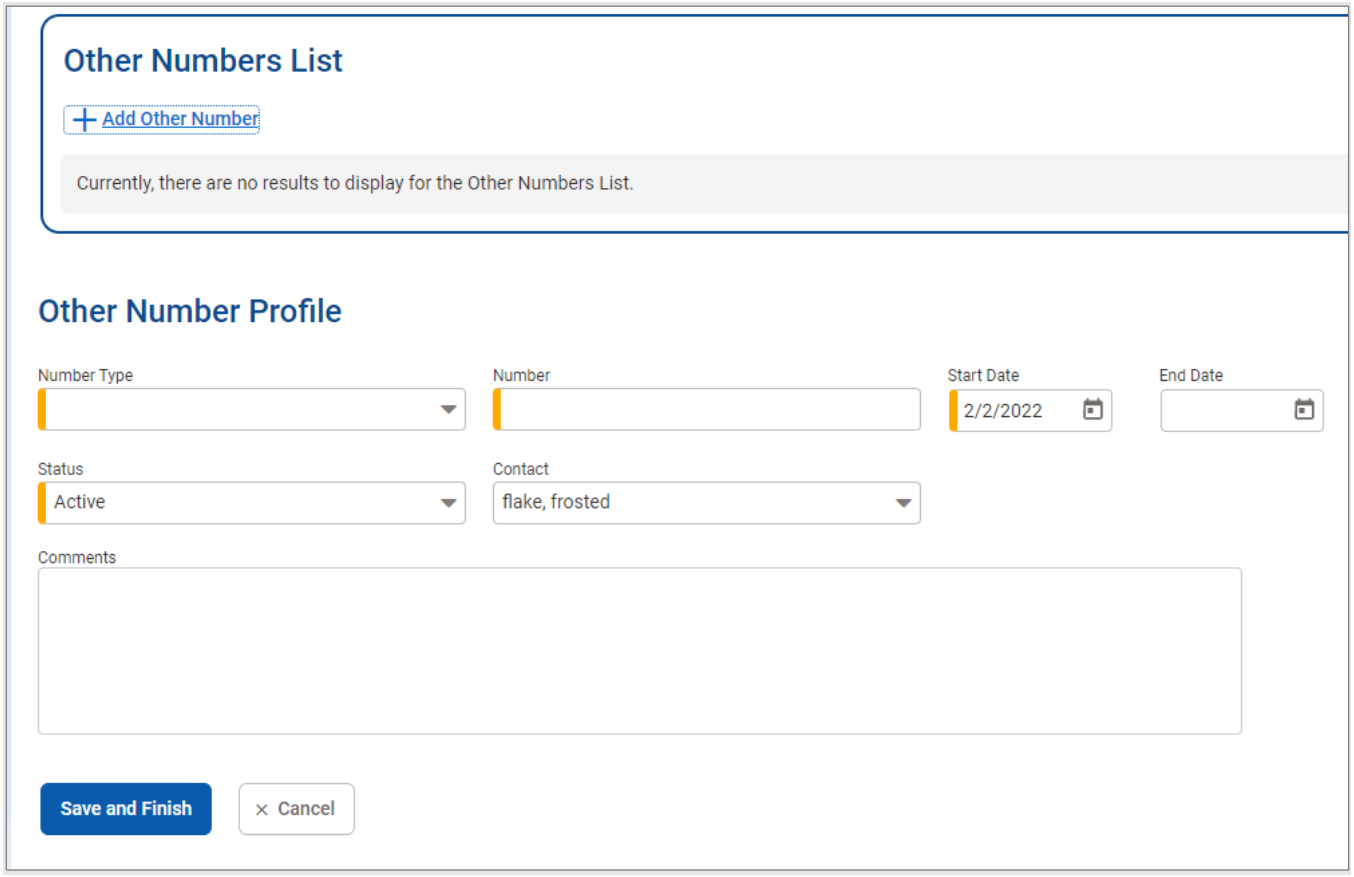


Figure 2-12: Other Numbers screen

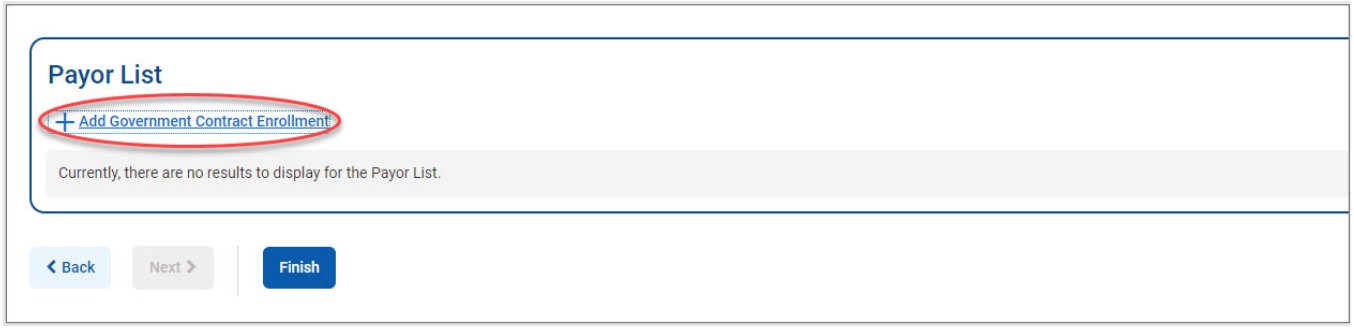
14. The **Contact** drop-down box will display the names of any contacts that were previously entered in the **Collateral Contacts** screen. If no name is available in the drop down, click on the **"Collateral Contacts"** screen to add a new record.
15. When complete, click "**Save and Finish"**. The numbers now show up in the table on top of the screen.
16. Click "**Save"**, then click the **"Next>"** button to move to the **Client Group Enrollment**.

Client Group Enrollment

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

Where: Client List > Client Profile > Client Group Enrollment

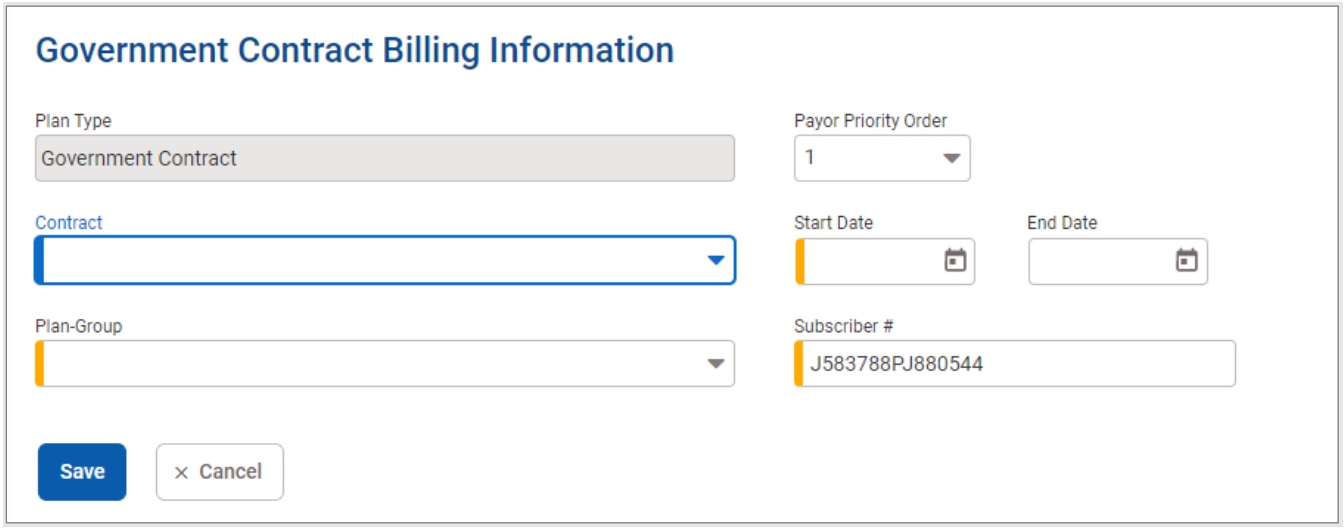
1. Click "**Add Government Contract Enrollment"**



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

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

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

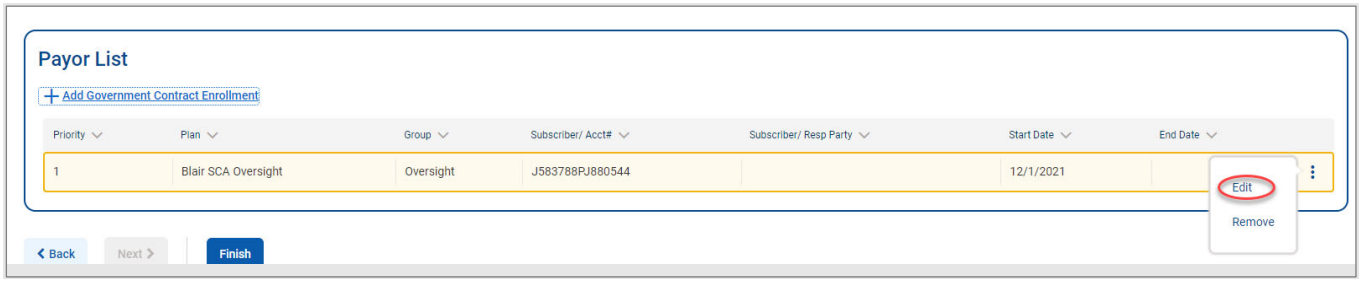


3. Enter the date the selected funding source will begin covering services in the **Start Date** field**.**
4. Click **"Save".**
5. On the **Payor List**, click **"Finish",** you will be returned to the **Client Search** screen.

Update Funding Source

If a client's funding source changes, you can update the previous funding source and add the new funding source within the **Client Group Enrollment**.

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



2. Enter the **End Date** for the funding source.
3. Click **"Save".**

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

History

The **History** sub-menu displays a list of all changes that have been made to the client's record. This includes the name of the person who entered that portion of the record, who has viewed the record and what, if any, actions were taken.

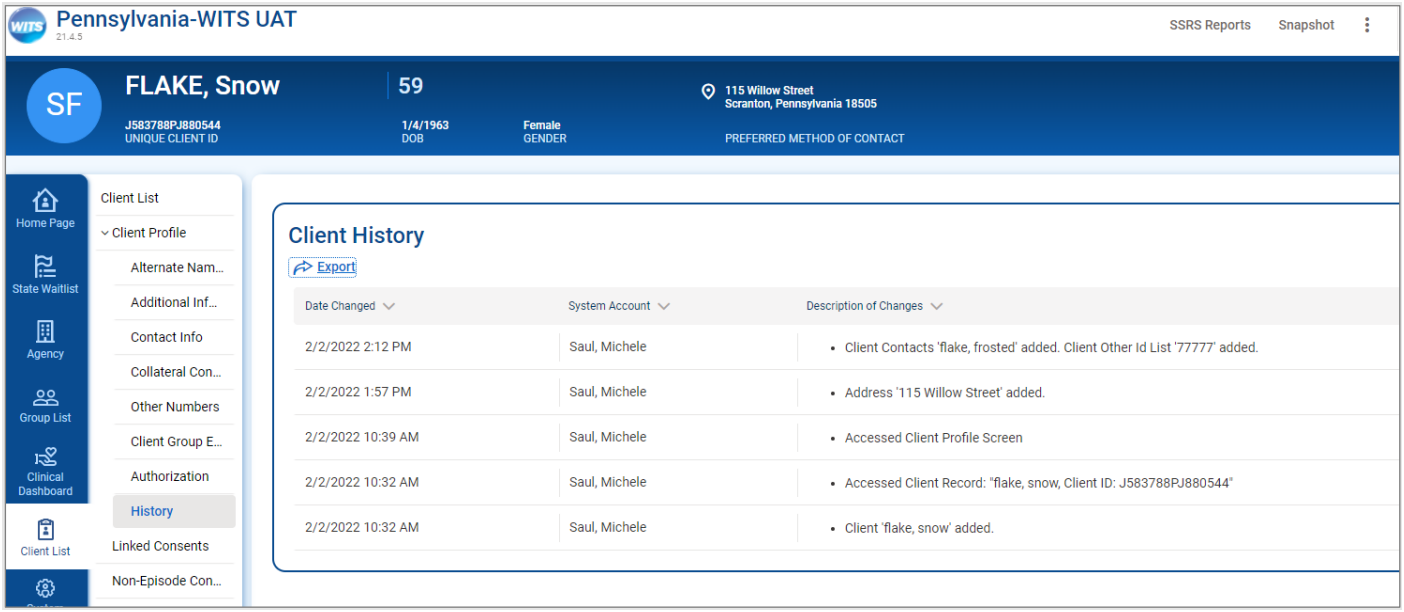


Figure 2-13: Client History screen

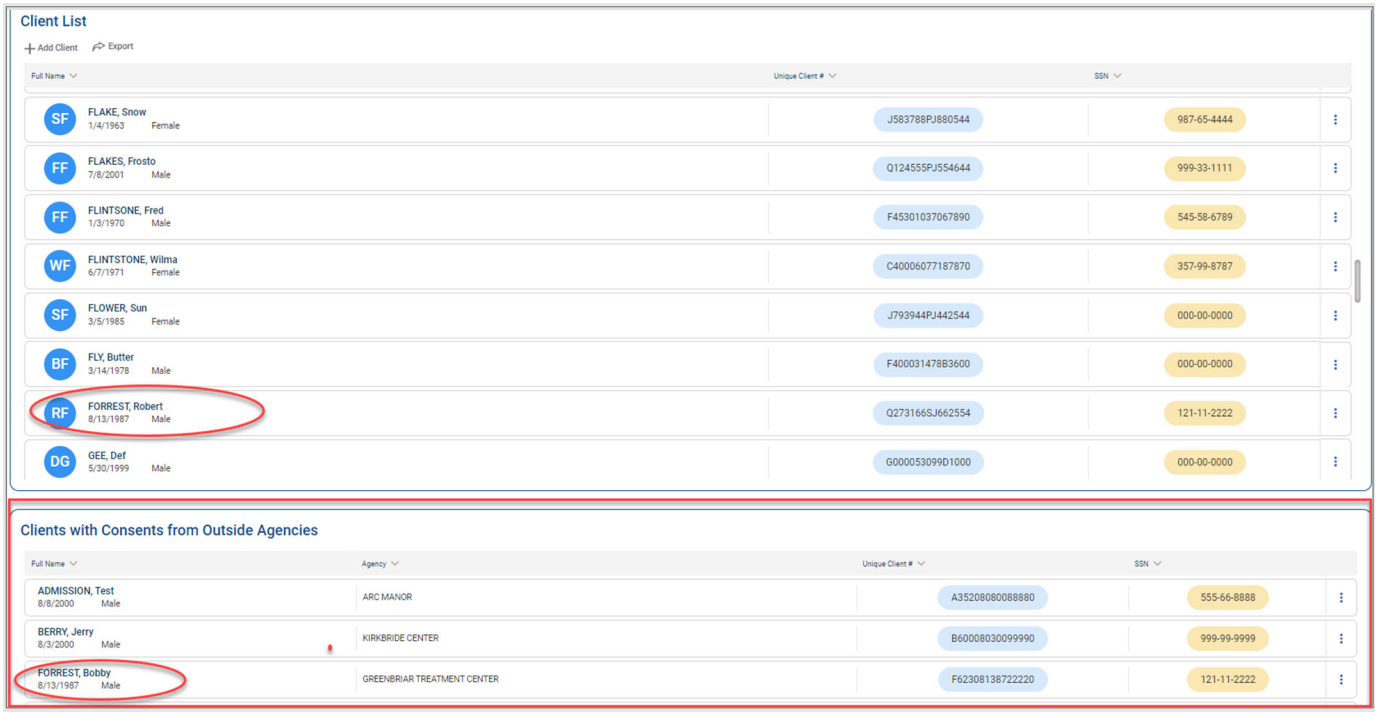
Linked Consents

Where: Client List > Clients with Consents from Outside Agencies

Each time another agency consents client information to your agency, a row will be displayed in the **Clients with Consents from Outside Agencies** section of the **Client List** screen.

If the **Consent** AND its accompanying **Referral** is accepted at the receiving agency, users with a **Clinical Supervisor** role may manually link and unlink that client's existing consents.

This action is available when a client with consented information is in fact, the **same person** as a client that already has a record in the user's agency. They may not have been automatically linked because the names or other identifying information may have been similar enough upon input at the "Sending" agency to recognize the client already exists in the system at the "Receiving" agency.



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

Link to Consented Client

NOTE: Users must have the **"Link Consents"** role added to their profiles to be able to perform this function. Your **Staff Administrator** can add this role to a user's profile as needed.

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

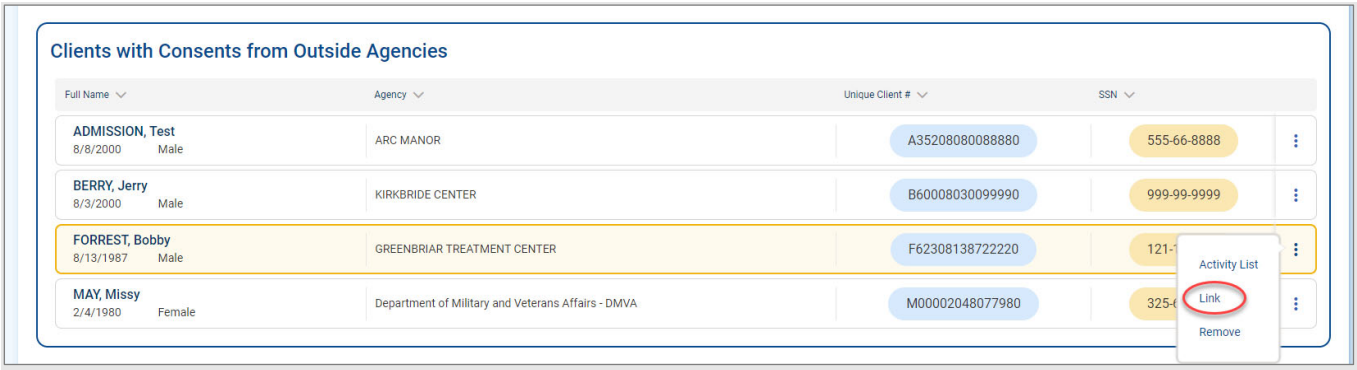


Figure 2-14: Client List screen, Clients with Consents from Outside Agencies section, Link action item

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

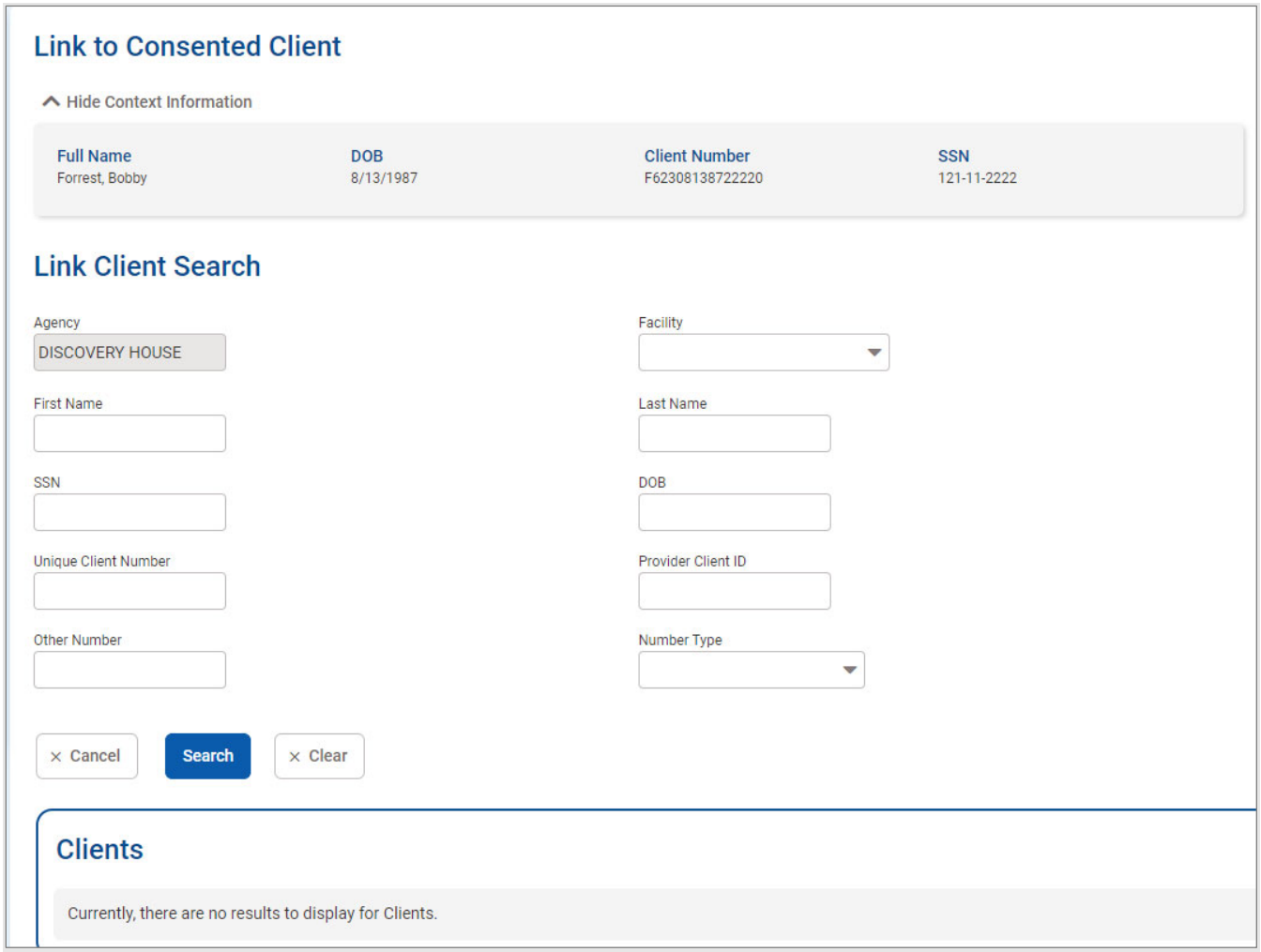


Figure 2-15: Link Client Search screen

Use the search fields to find a client with similar information.

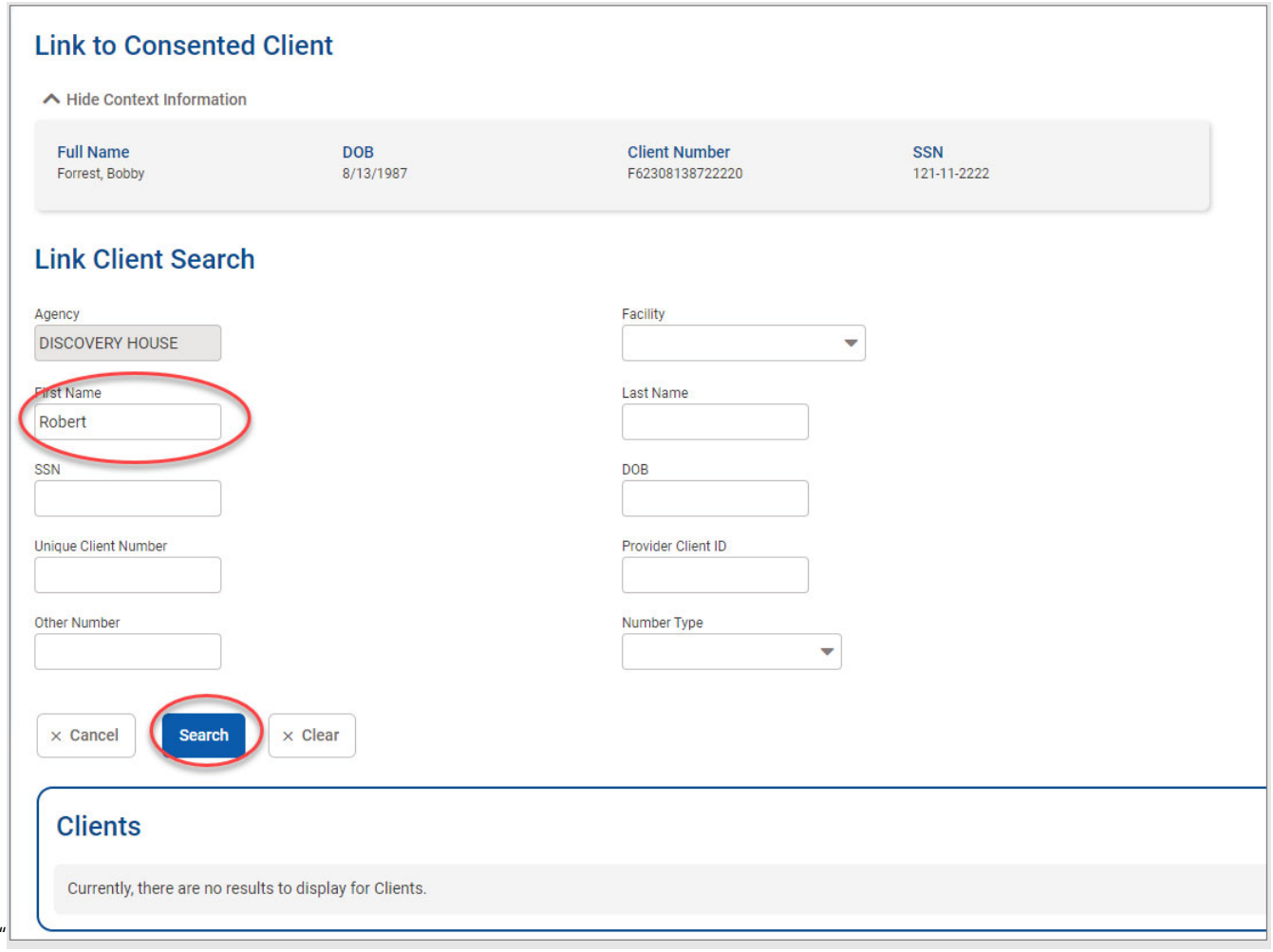


Figure 2-16: Link Client Search screen, search by First Name

4. After filling out one or more search fields, click **"Search"** and then review the search results.

Figure 2-17: Link Client Search screen with search results

5. If the information in the search results matches the **Consented Client** information, hover over the ellipsis and then click **"Link"**.

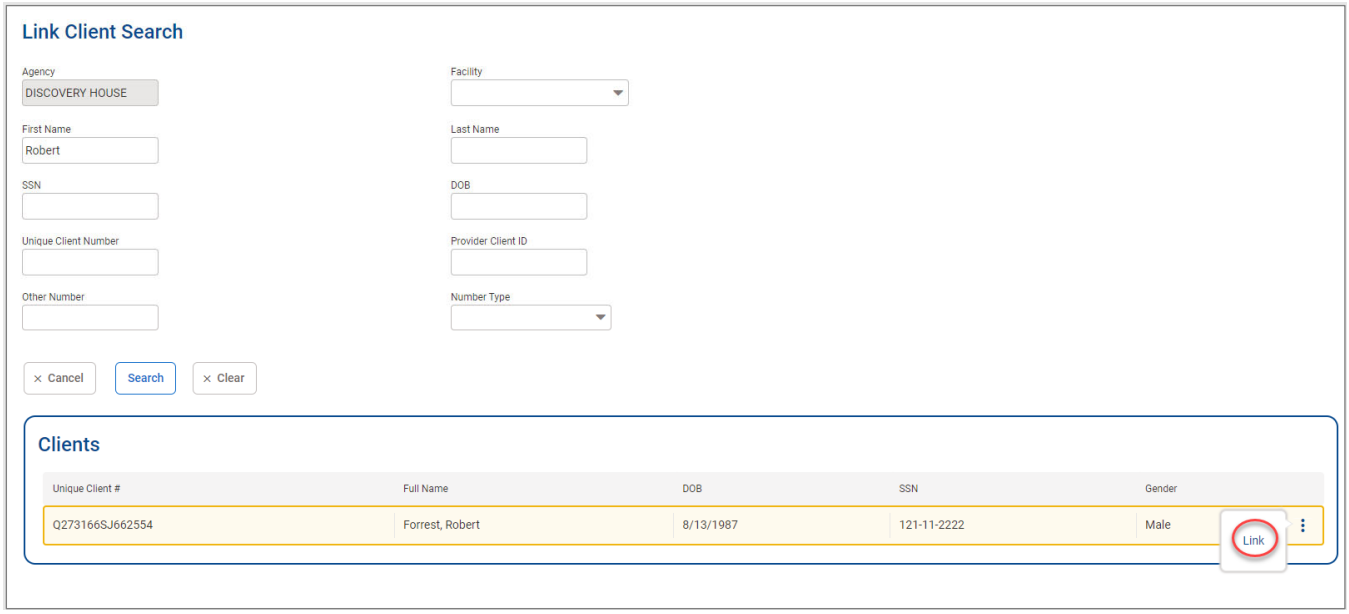


Figure 2-18: Link Client Search screen, Link Consent record

6. Click **"Yes".**

Figure 2-19: Are you sure you want to link current consented client to the consent client?

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

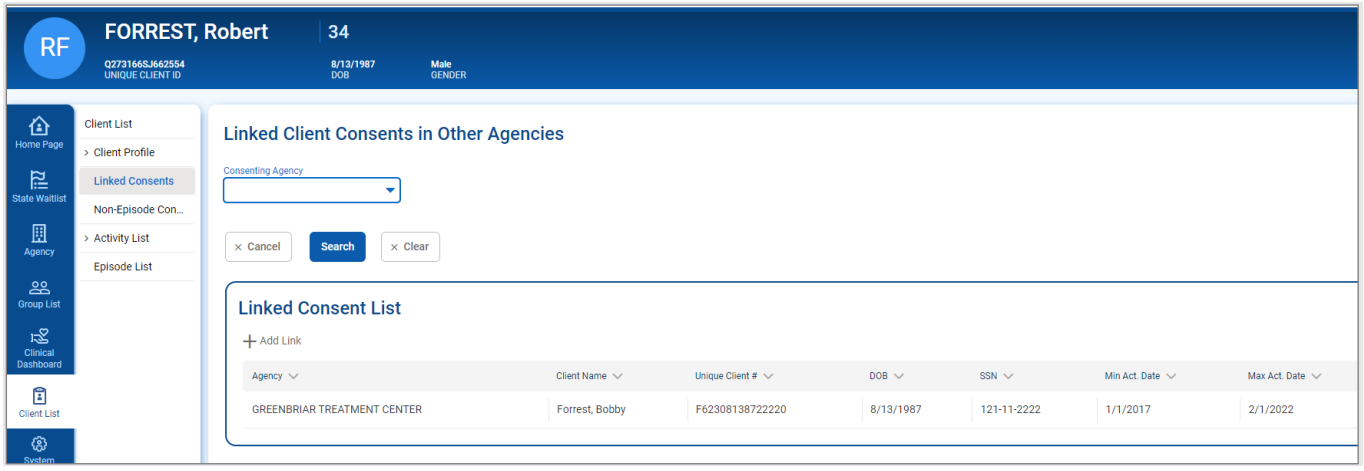


Figure 2-20: Linked Consents screen

Non-Episode Contact

Where: Client List > Non-Episode Contact

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

1. On the left menu, click **"Client List"** and search for a client.
2. Hover over the ellipsis (three vertical dots) of the client you want to select and click **"Profile".**
3. On the left menu, click **"Non-Episode Contact"**.
4. Click the **"Add New Non-Episode Contact Record"** link.

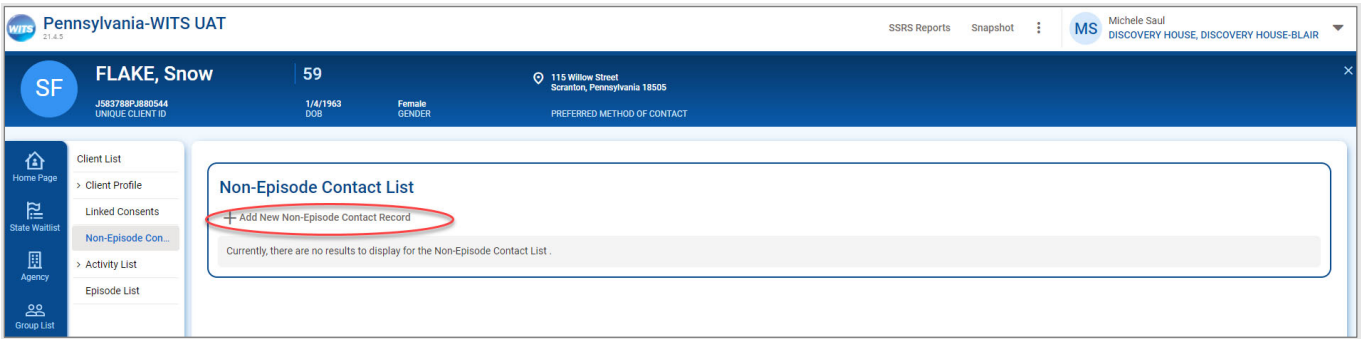


Figure 2-21: Non-Episode Contact List

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

Table 2-4: Non-Episode Contact Note fields

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

Field	Description
Unsigned Notes	Type notes about the event.
Outcome	(Optional) Select from the drop-down list.
Reason for ineligibility	(Optional)
Follow-Up Steps Selected	Select one or more options. **NOTE:** These values are controlled by the "Followup Step" code table.

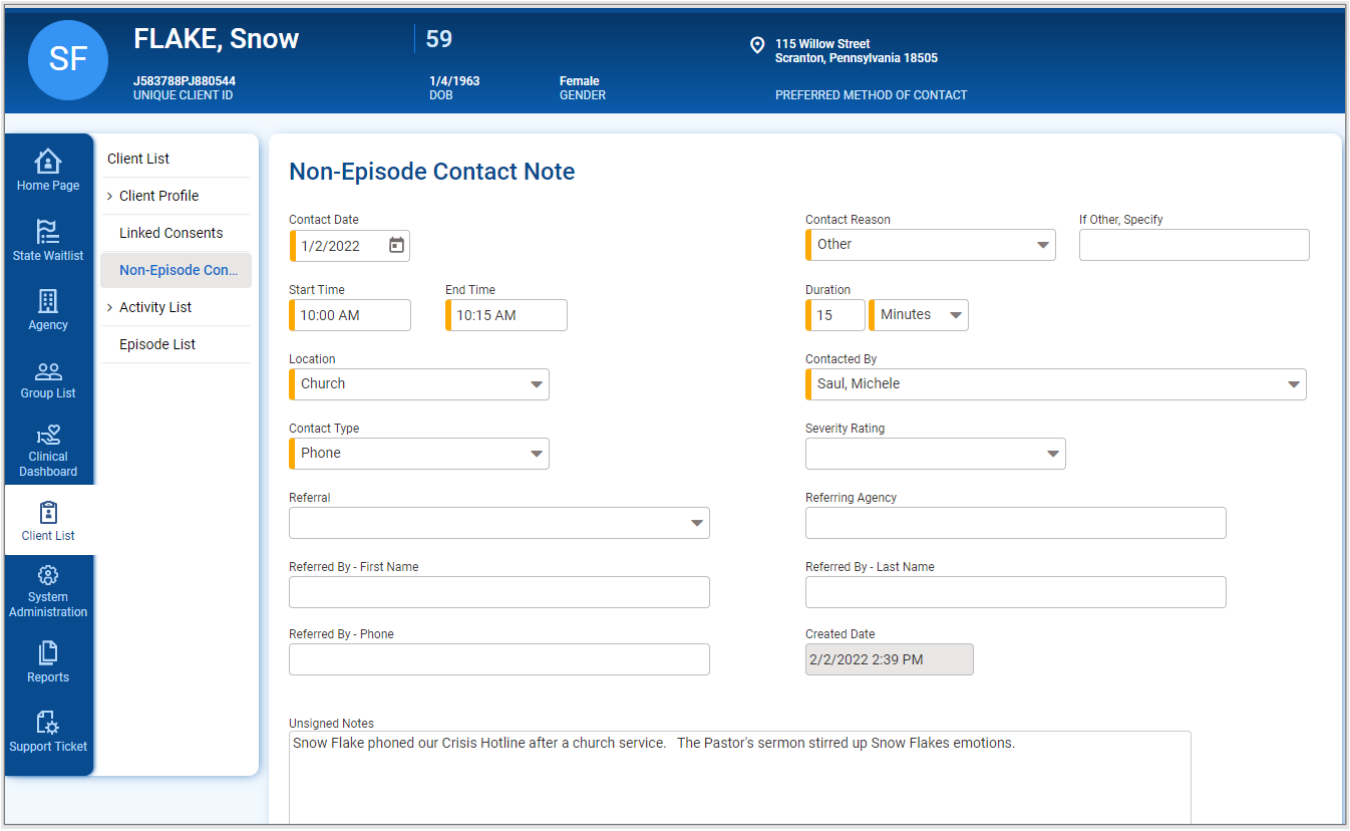


Figure 2-22: Non-Episode Contact Note Profile screen

6. Click **"Save"** and then click **"Sign Note".**

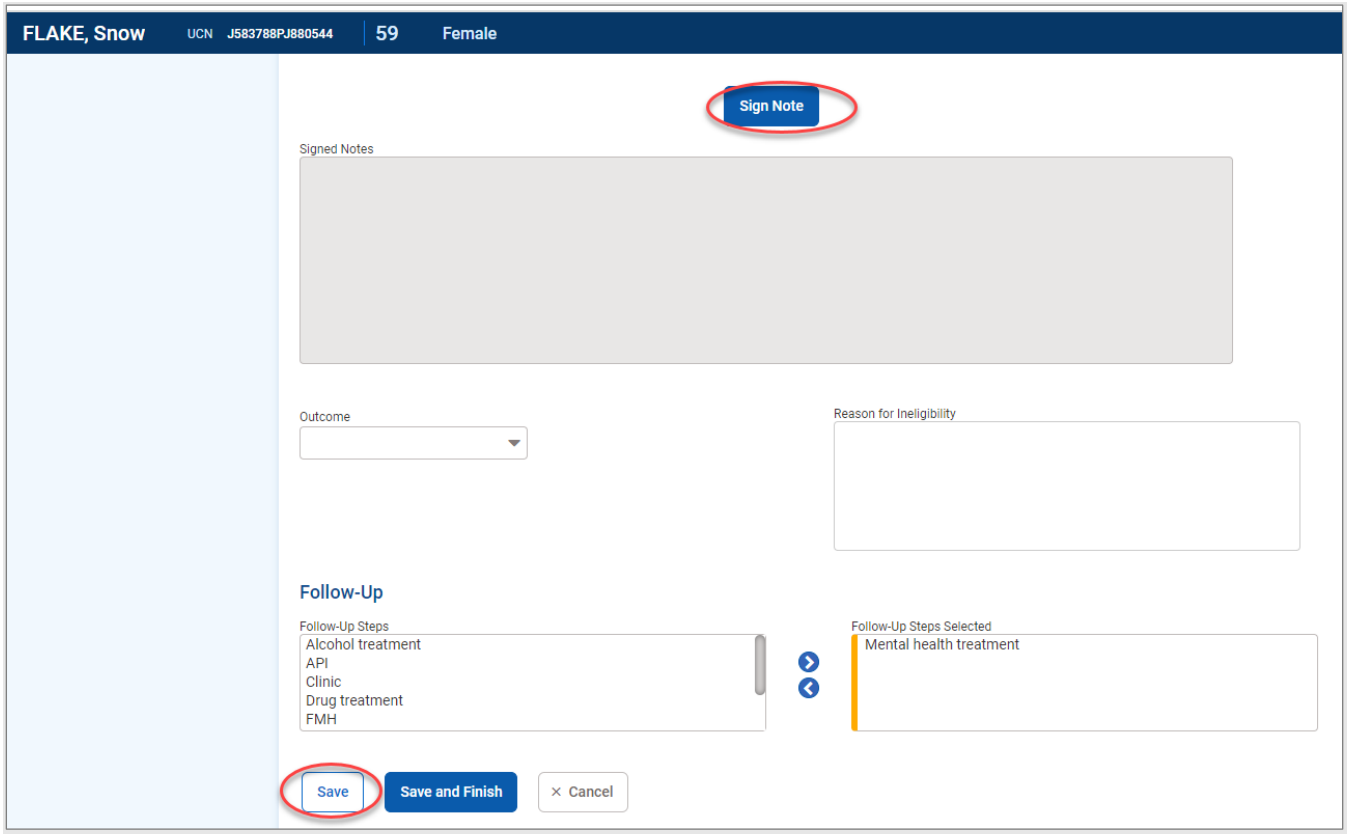


Figure 2-23: Sign Note

7. The **Signed Note** will now be displayed in the read-only field. Click **"Save and Finish".**

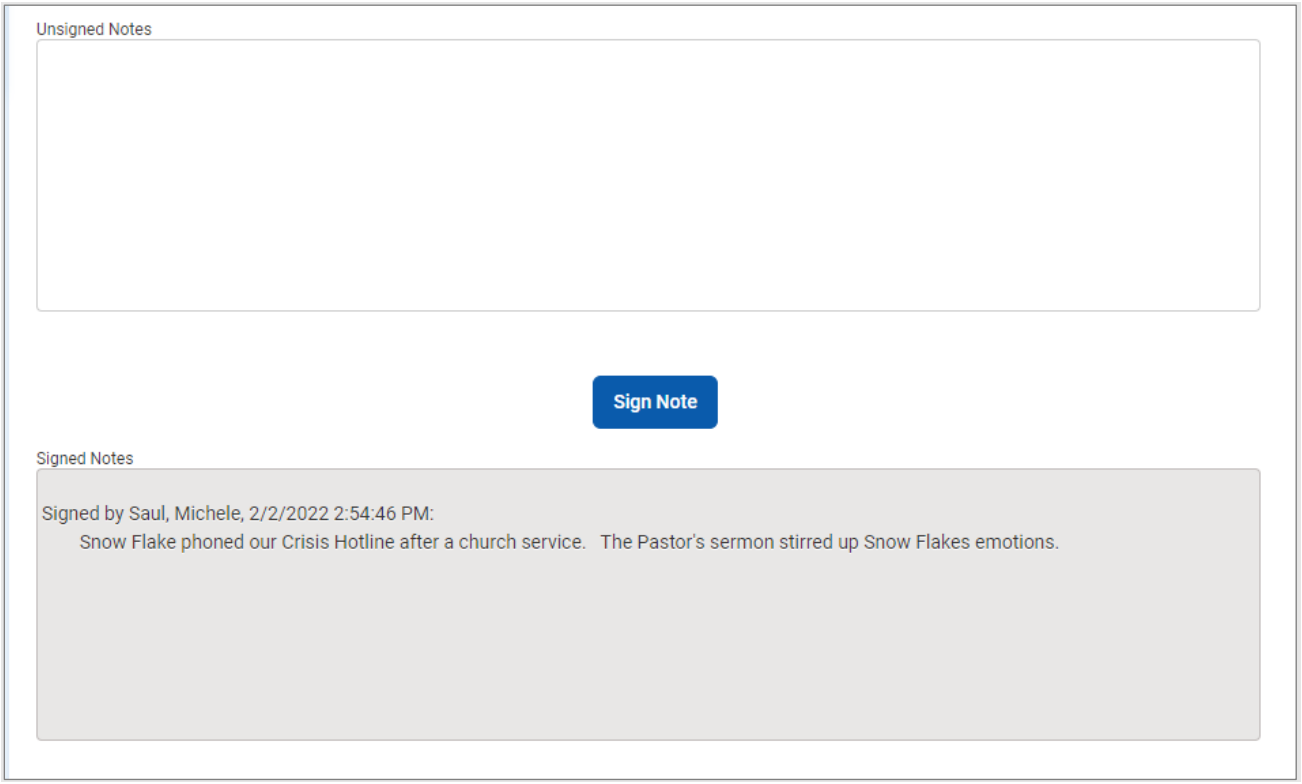


Figure 2-24: Signed Notes

Part 3: Activity List

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

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

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

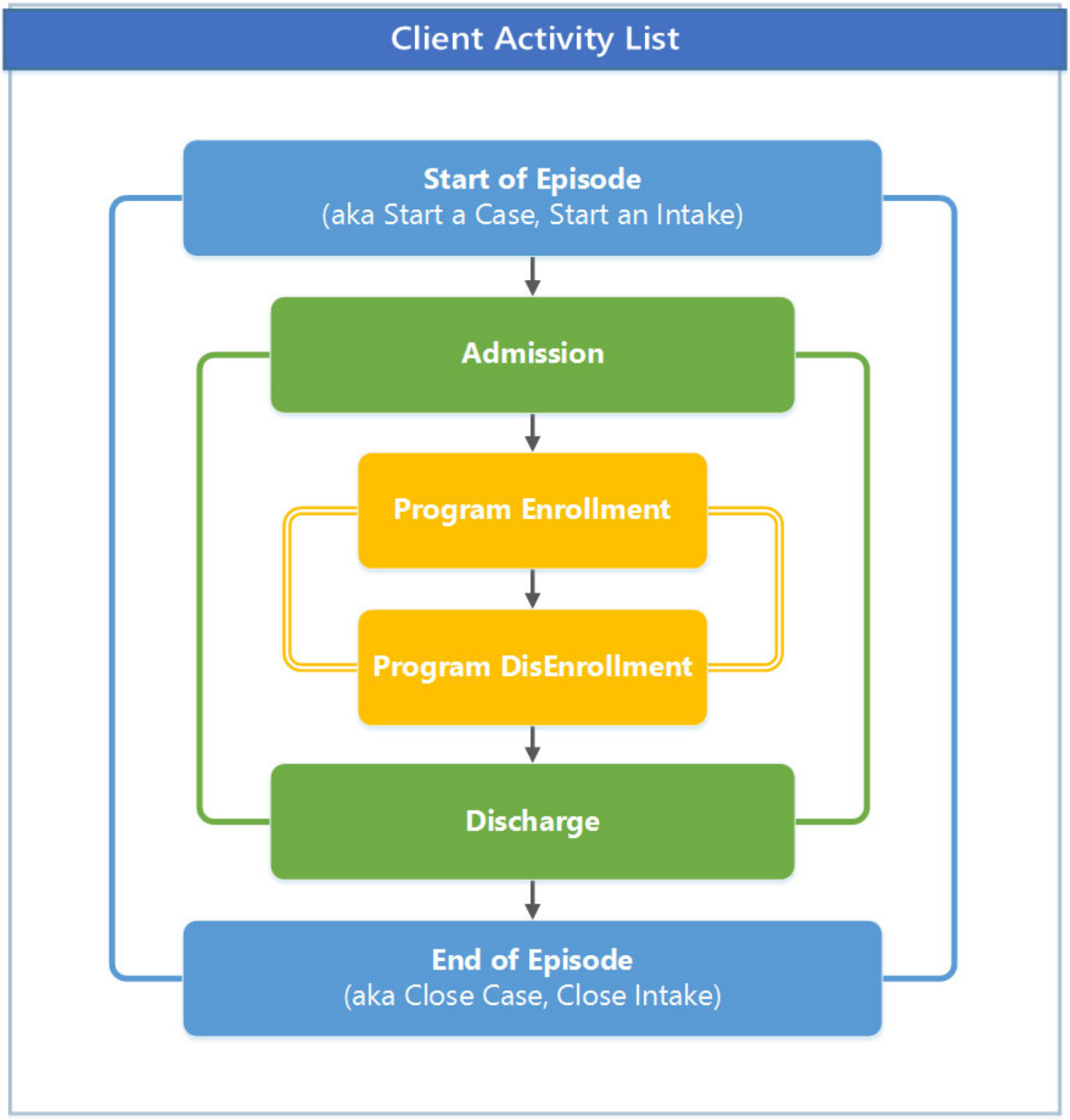


Figure 3-1: Concept Diagram of Data Collection Structure within Client Activity List

When client activities are recorded in PA WITS, the **Client Activity List** screen serves as a "dashboard" view.

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

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

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

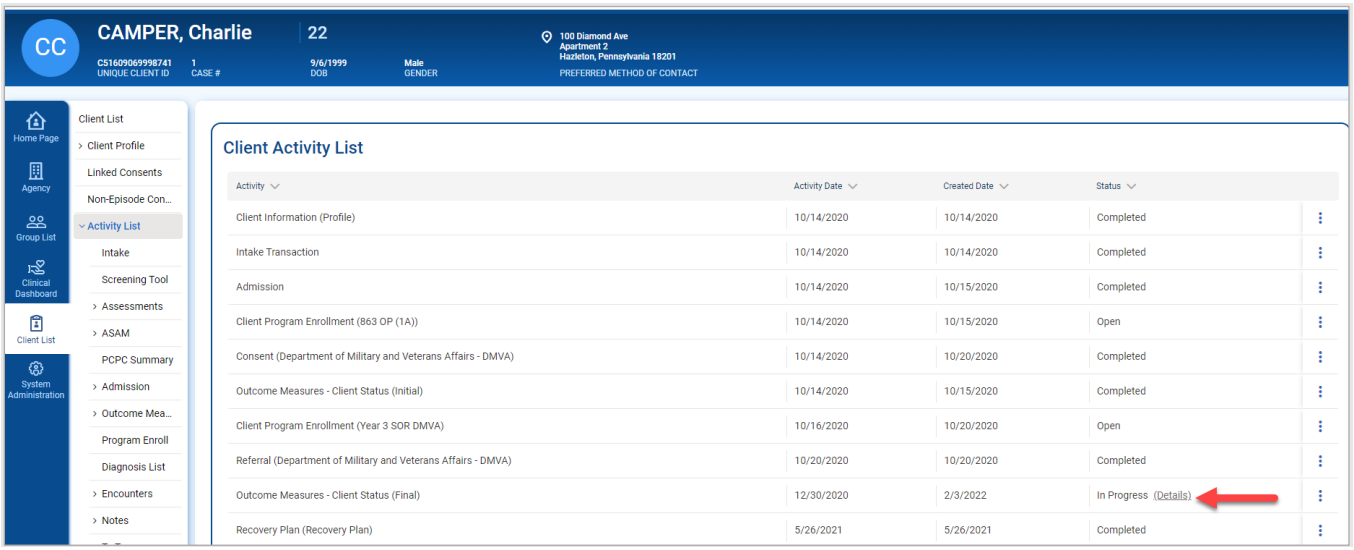


Figure 3-2: Client Activity List, Details link

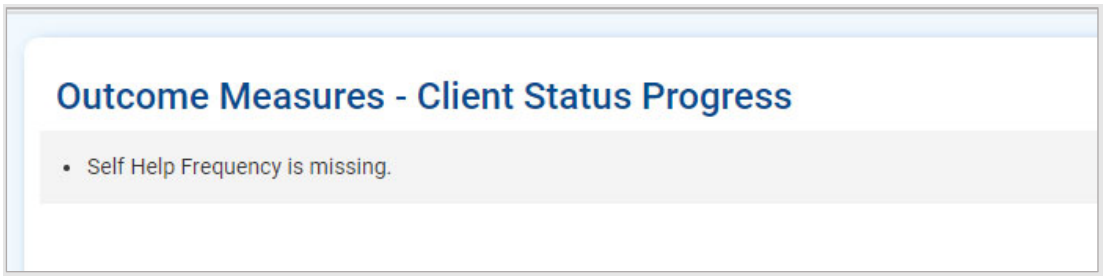


Figure 3-3: Details link, list of missing information

NOTE: A Client Program Enrollments typically have a status of **"Open"** while the client is actively participating in a program, or **"Closed"** once an **End Date** is entered. Some **Client Activities** do not have a concept of being **"Complete"**. For those activities, the **Status** will be listed as **"Not Applicable"**.

Start New Episode (New Clients)

Where: Client List > Activity List > Episode List

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

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

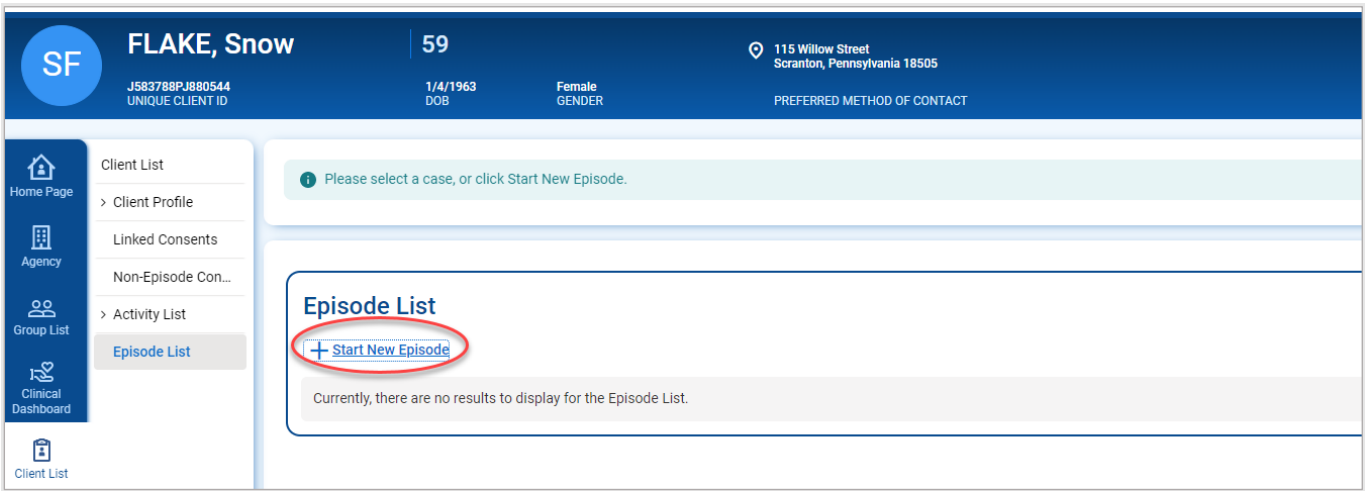


Figure 3-4: Episode List screen, Start New Episode link

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

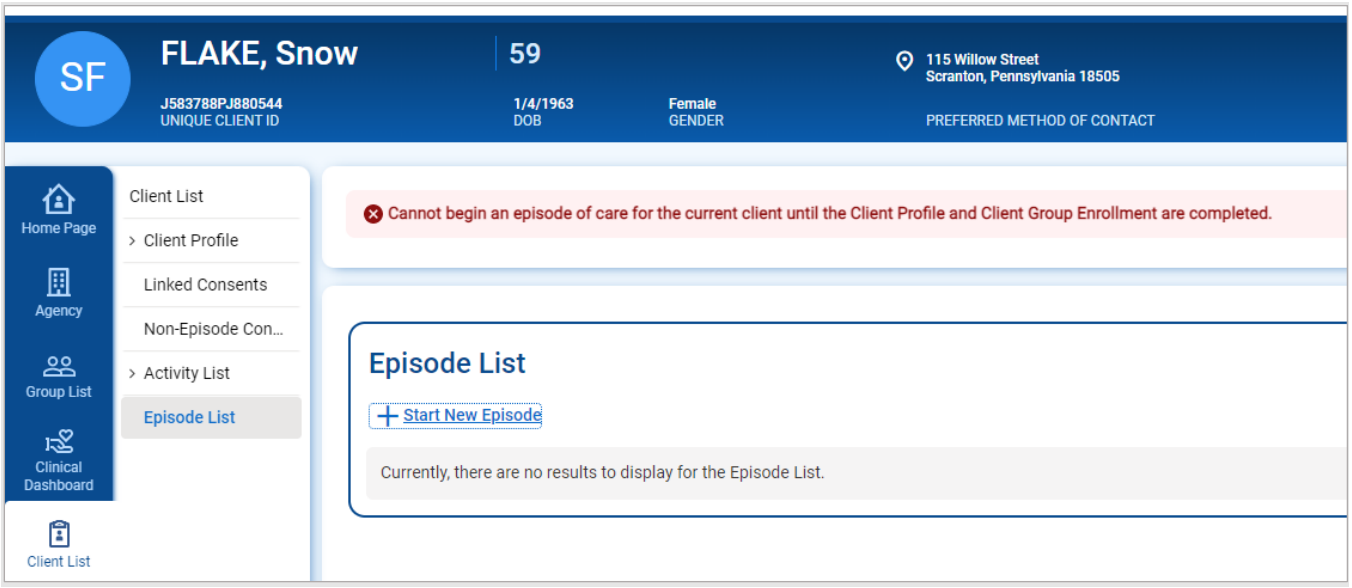


Figure 3-5: Episode List screen, Error Message

4. If the client profile is complete, clicking **"Start New Episode"** will open the **Intake Case Information** screen, shown in Figure 3-6: Intake Case Information screen at the end of the **Intake"** section that follows.

Intake

Where: Client List > Activity List > Intake

NOTE: When completing the client's first **Intake**, click **"Save and Finish"**, and system will take you to the **Screening Tool**.

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

Table 3-1: Intake Case Information Fields

Field	Description
Intake Facility	Pre-populates with the current facility location.
Intake Staff	Pre-populates with the current staff member name.
Initial Contact	Select from the drop-down list.
Case Status	Defaults to "Open Active".
Initial Contact Date	The date when the Client first reached out for treatment. For the clients first intake in PA-WITS this field will be editable. When a client is referred from one agency to another, the Initial Date of Contact will be in a Read-Only mode. This field is used in calculations for the Case Management Resource Report.
Intake Date	Enter the client's intake date, (which also marks the beginning of the client's Episode). This field is used in calculations for the Case Management Resource Report.
As a result of the screening for TB, was this individual referred for testing or treatment?	Select from the drop-down list.
Is Client Public Funded?	(Optional)
Funding SCA	Select from the drop-down list.
Source of Referral	Select from the drop-down list. **NOTE:** The Source of Referral should be the original/initial referral source.
Referral Contact	(Optional) Select from a list of the client's collateral contacts.
Pregnant	Is the client pregnant at the time of admission? Complete if applicable.
Due Date	(Optional)
Prenatal Treatment	(Optional) Is the client also receiving prenatal treatment? Select Yes/No if applicable.
Injection Drug User	Select Yes or No.
Problem Area	(Optional)
Presenting Problem (In Client's Own Words)	(Optional)
Scheduled Assessment Date	This field is used in calculations for the Case Management Resource Report.
Assessment Date	This field is used in calculations for the Case Management Resource Report. **NOTE:** Changing the value of this field will cause the screen to be refreshed.

Field	Description
If assessment cannot be scheduled within 7 days, why?	This field is used in or the Case Management Resource Report. **NOTE:** Changing the value of this field will cause the screen to be refreshed.
Did client complete scheduled assessment?	This field is used in or the Case Management Resource Report. **NOTE:** Changing the value of this field will cause the screen to be refreshed.
Why was scheduled assessment missed?	This field is used in or the Case Management Resource Report. **NOTE:** Changing the value of this field will cause the screen to be refreshed.
Scheduled Admission Date	This field is used in or the Case Management Resource Report. **NOTE:** Changing the value of this field will cause the screen to be refreshed.
Special Initiatives/Populations Selected	Select one or more options. If client is not part of a Special Initiative or Population, select None.
Inter-Agency Service Selected	(Optional)
Selected Domains	This field will be pre-populated and read-only if there is only one domain associated with the agency. If the agency has multiple domains, select the appropriate domain(s) for the client.
Date Closed 	The Date Closed field is used to mark the end of the client's Episode.

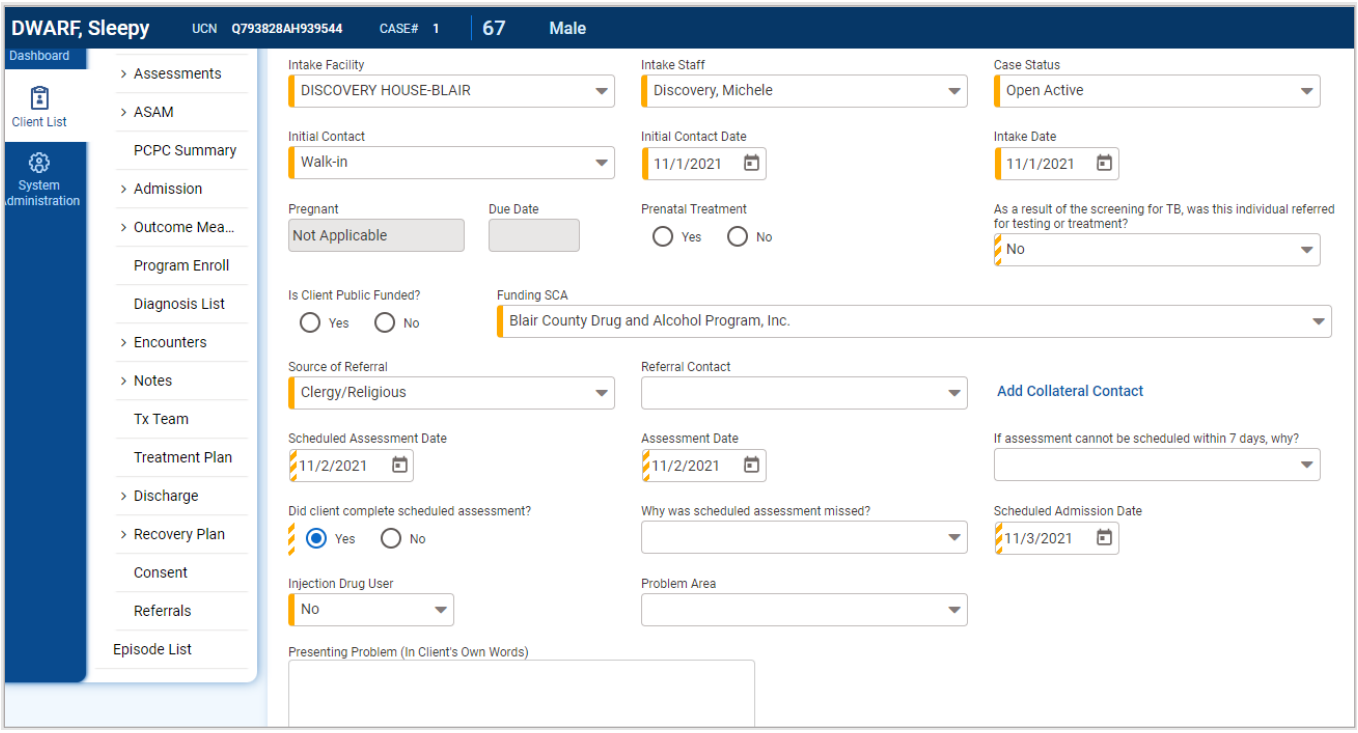


Figure 3-6: Intake Case Information screen

5. Click **"Save and Finish"**, the **Screening Tool** will appear.

Screening Tool

Where: Client List > Activity List > Screening Tool

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

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

Table 3-2: Screening Tool Fields

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

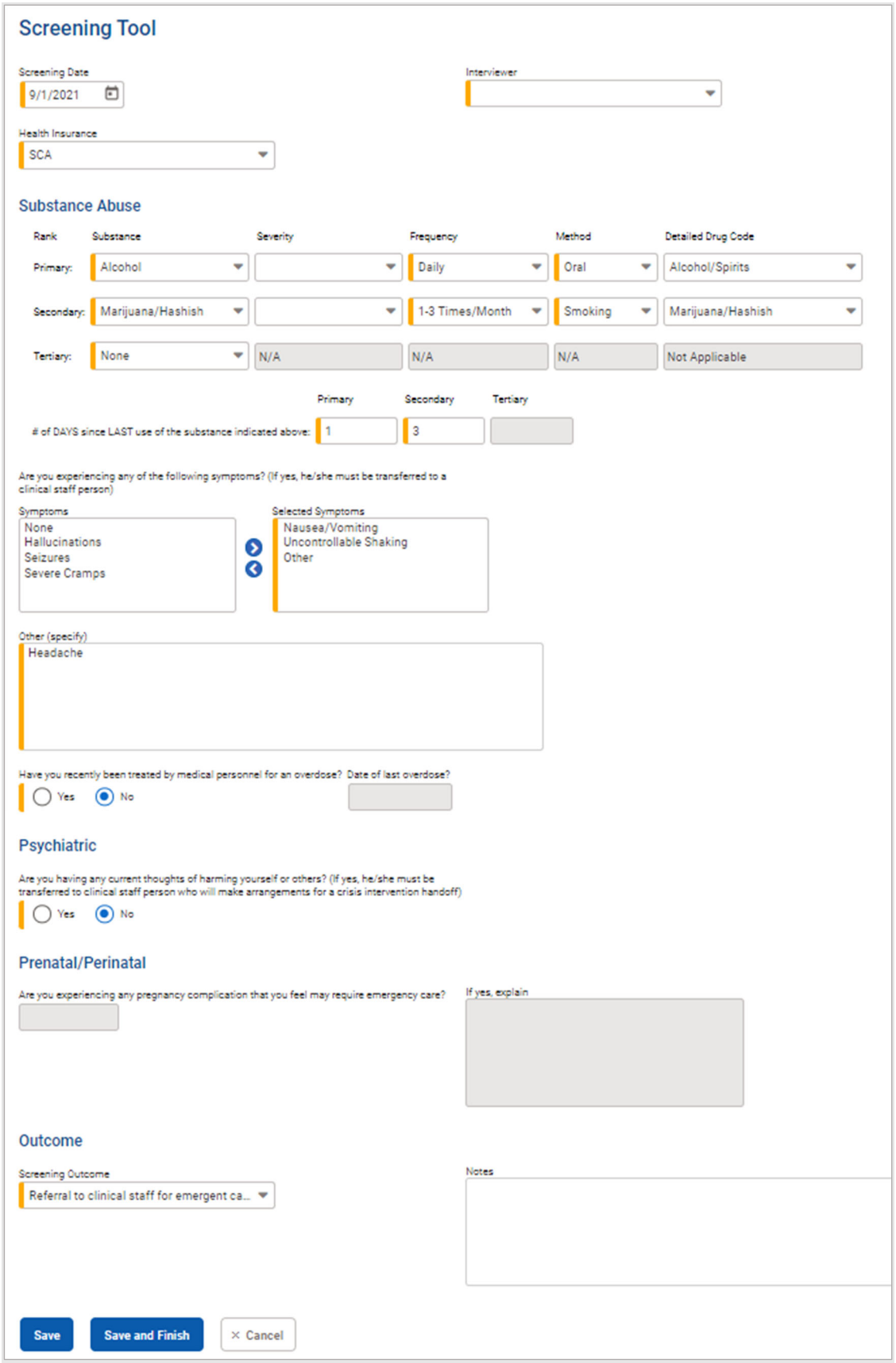


Figure 3-7: Screening Tool

5. Click "**Save and Finish**", the **Client Activity List** appears.

Tx Team (Treatment Team)*

Where: Client List > Activity List > Treatment Team

***Optional section** - Each client may have a **Treatment Team** created to ensure the appropriate staff have access to each client record.

1. On the left menu, click **"Client List"** and search for a client.
2. Hover over the ellipsis icon corresponding to your client and click "**Activity List"**.
3. On the left menu, click **"Tx Team".**

Add Team Member

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

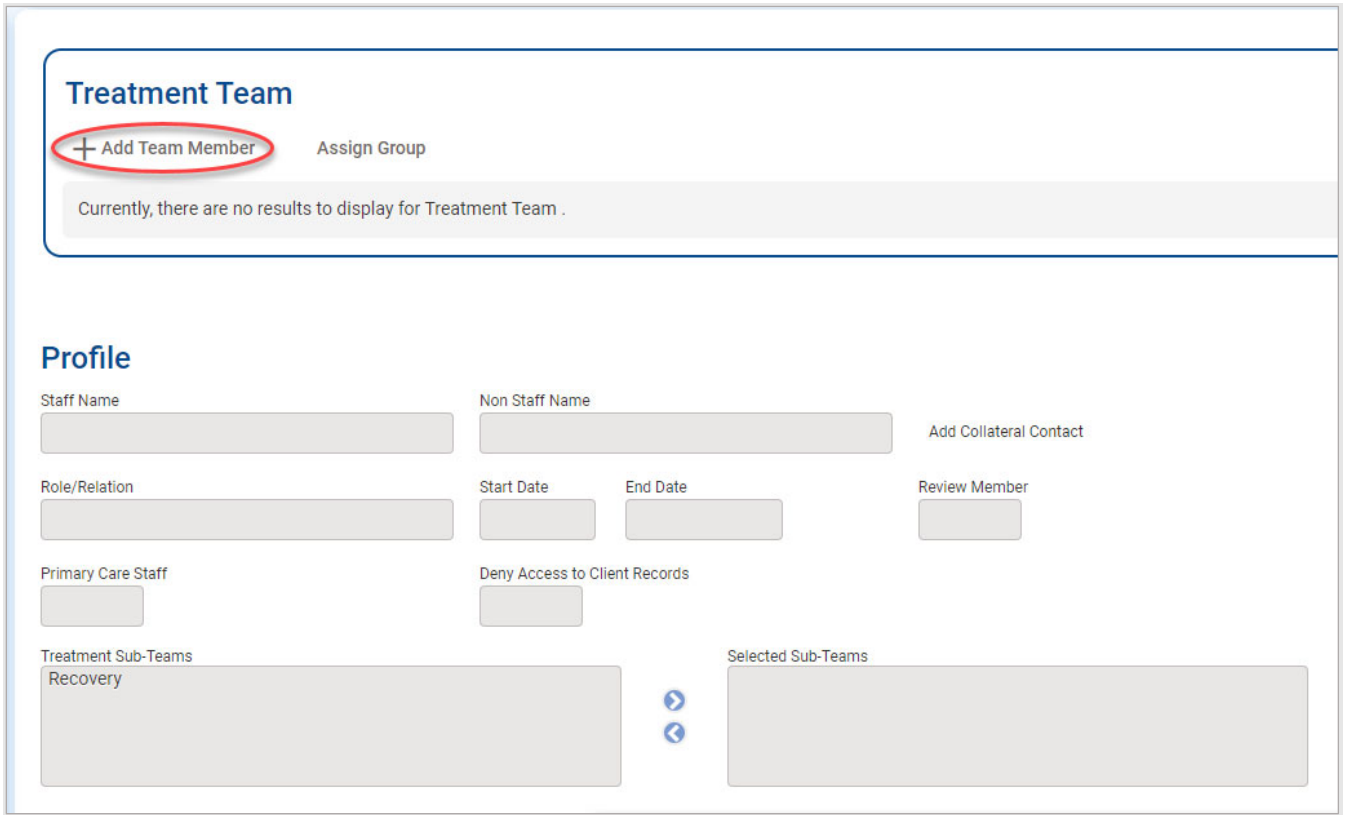


Figure 3-8: Treatment Team screen, Add Team Member link

5. Complete the **Team Member** fields.

Table 3-3: Treatment Team Member fields

Field	Description
Staff Name	Select available agency Staff Members from the drop-down list.
Non Staff Name	This drop-down list includes collateral contacts previously entered for the client. Select a contact who is part of the client's treatment team. If the drop-down list is missing a contact, click the Add Collateral Contact link to enter that contact for the client.
Role/Relation	Select an option from the drop-down list.
Review Member	Will the team member review the client's record, including the treatment plan? Select Yes/No.
Primary Care Staff	Is the team member primarily responsible for the client's treatment? Select Yes/No.

Field	Description
Deny Access to Client Records	Will the client's records be hidden from this team member? Select Yes/No. If this is set as "Yes", then the selected staff will not be able to see that Client record in the Agency Client List screen.
Selected Sub-Teams	"Recovery" must be selected for this Team Member to appear on the Recovery Plan.
Start Date	Defaults to today's date. May need to be updated for each Tx Team Member.
End Date	
Notes	(Optional)

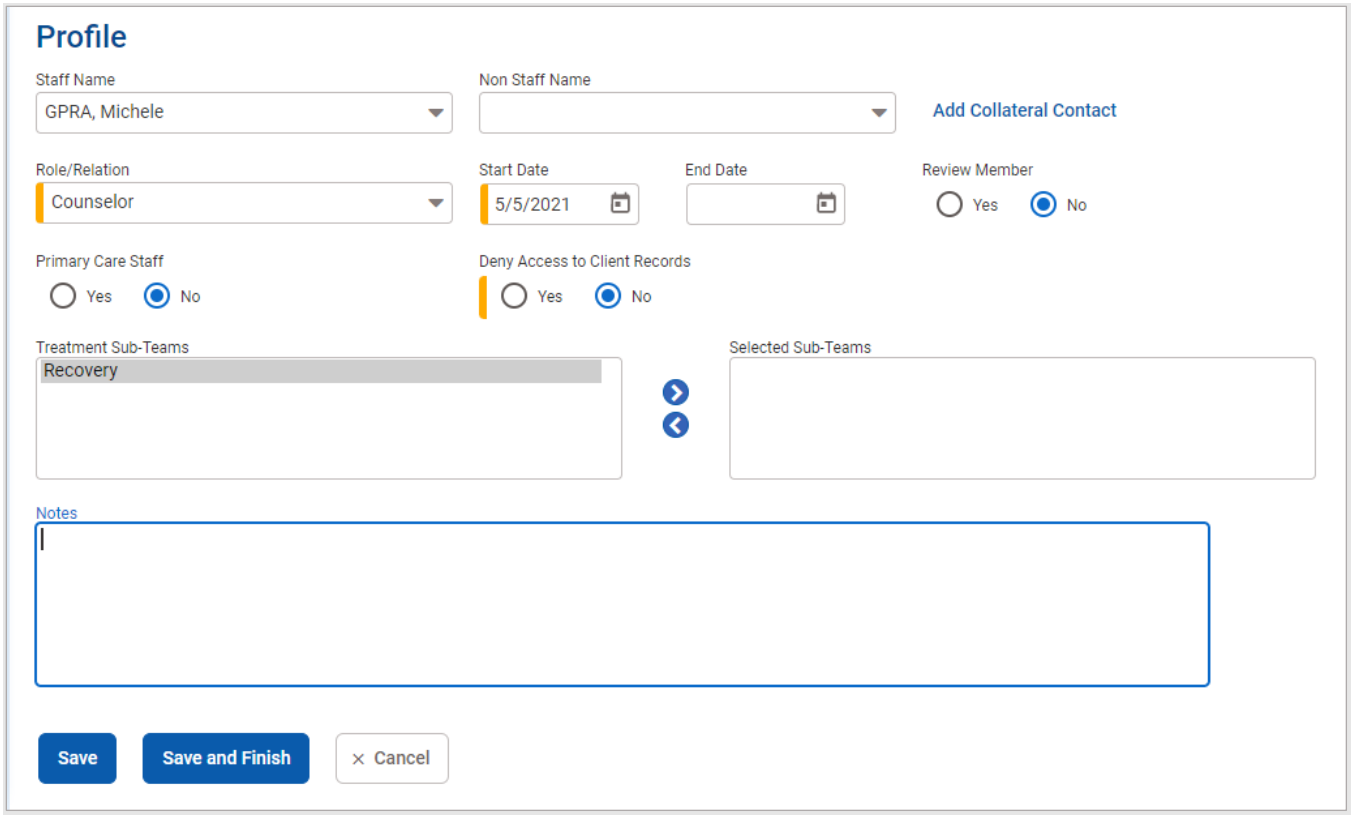


Figure 3-9: Treatment Team screen, Add New Team Member

6. Click **"Save".** Add additional team members as needed.

Assign Group*

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

7. Click **"Assign Group".**

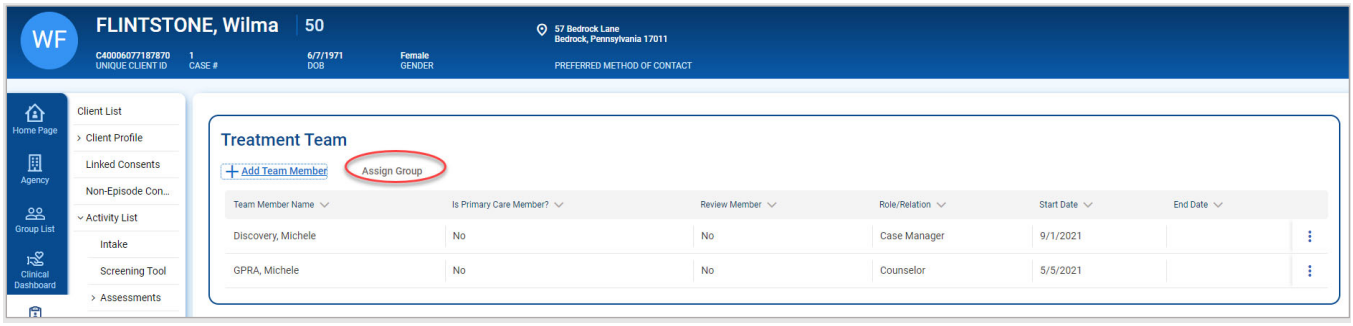


Figure 3-10: Treatment Team screen, Assign Group link

8. Select the appropriate **Treatment Team** group(s), if available.

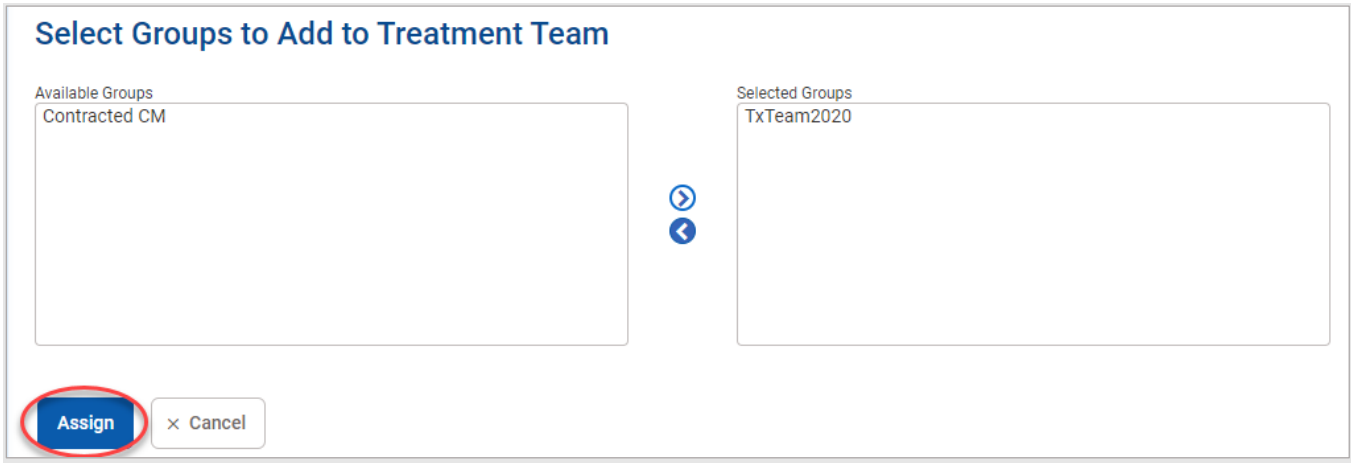


Figure 3-11: Select Groups to Add to Treatment Team

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

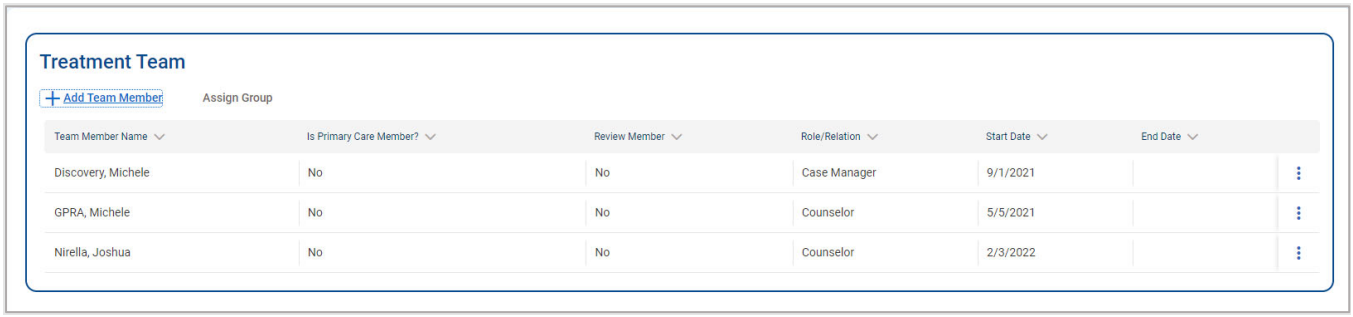


Figure 3-12: Treatment Team with team members added to list

9. To update information for an individual team member, hover over the ellipsis icon and then click **"Review".**

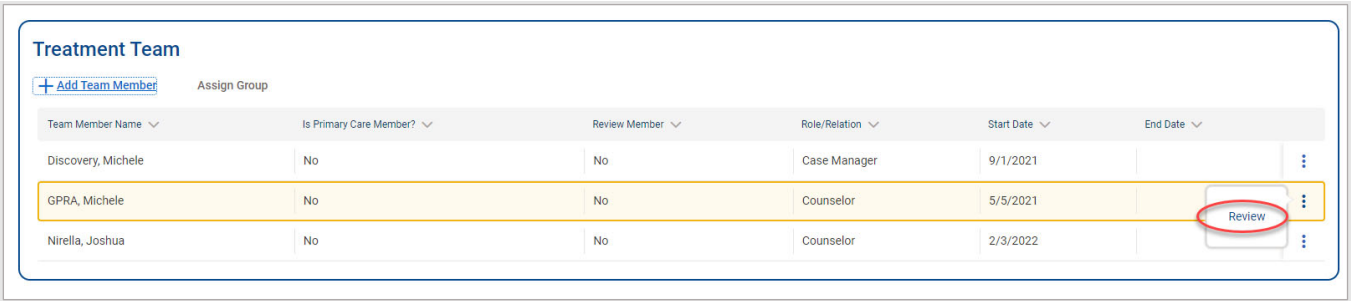


Figure 3-13: Treatment Team screen, Review Team Member link

10. Update the **Team Member** fields as needed.

NOTE: Pay attention to the **Start Date**, as it may need to be changed.

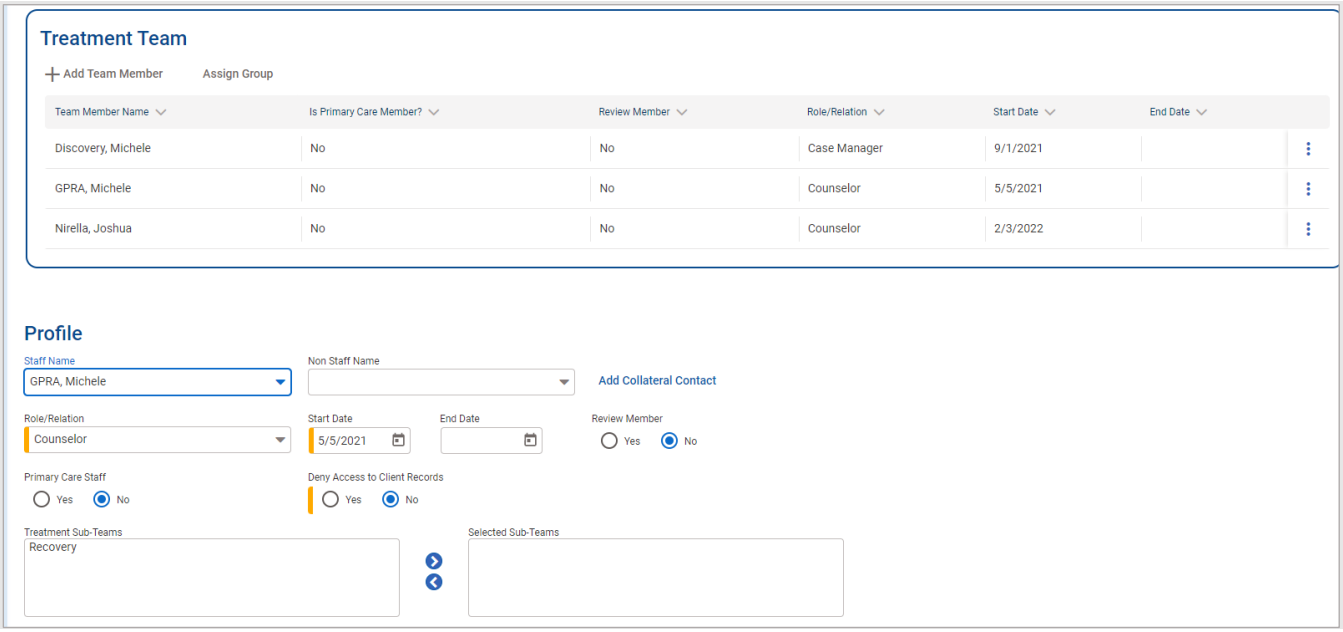


Figure 3-14: Treatment Team screen, Review and Update Team Member information

11. Click **"Save and Finish".**

Assessments - TAP (Treatment Assignment Protocol)

Where: Client List > Activity List > Assessments > TAP

NOTES: Providers are not required to use the TAP in WITS as their assessment tool, but it is available.

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

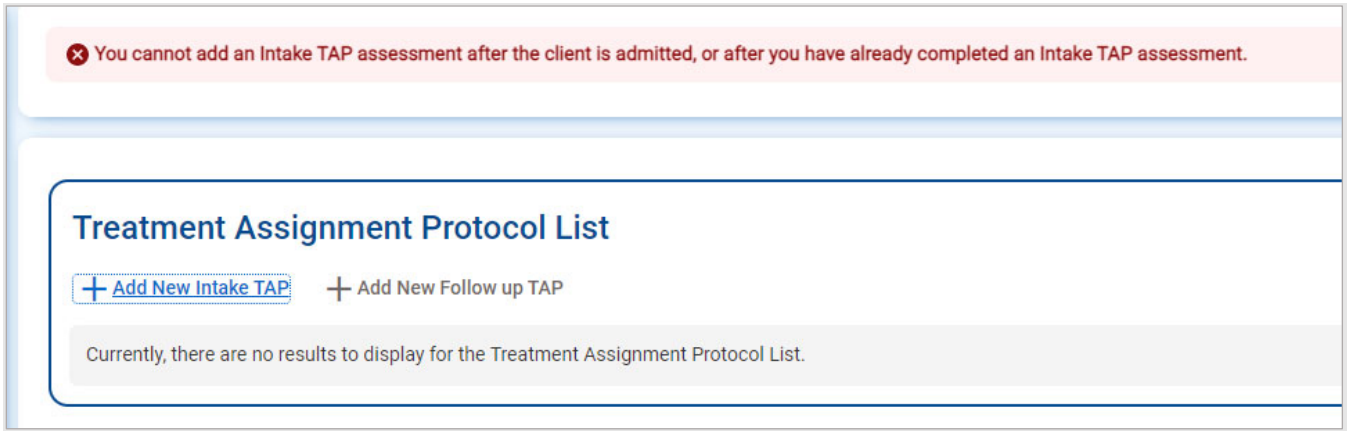


Figure 3-15: Intake TAP Assessment Error Message

Add New Intake TAP

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

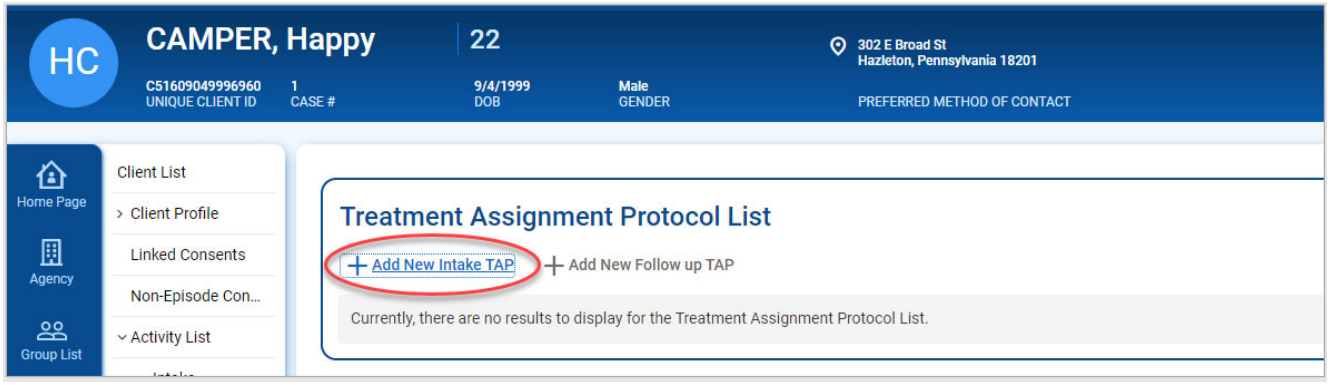
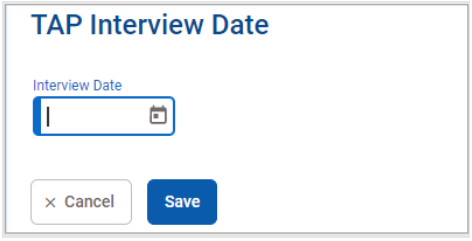


Figure 3-16: Treatment Assignment Protocol: Add New Intake TAP

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



TAP: Client Profile

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

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

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

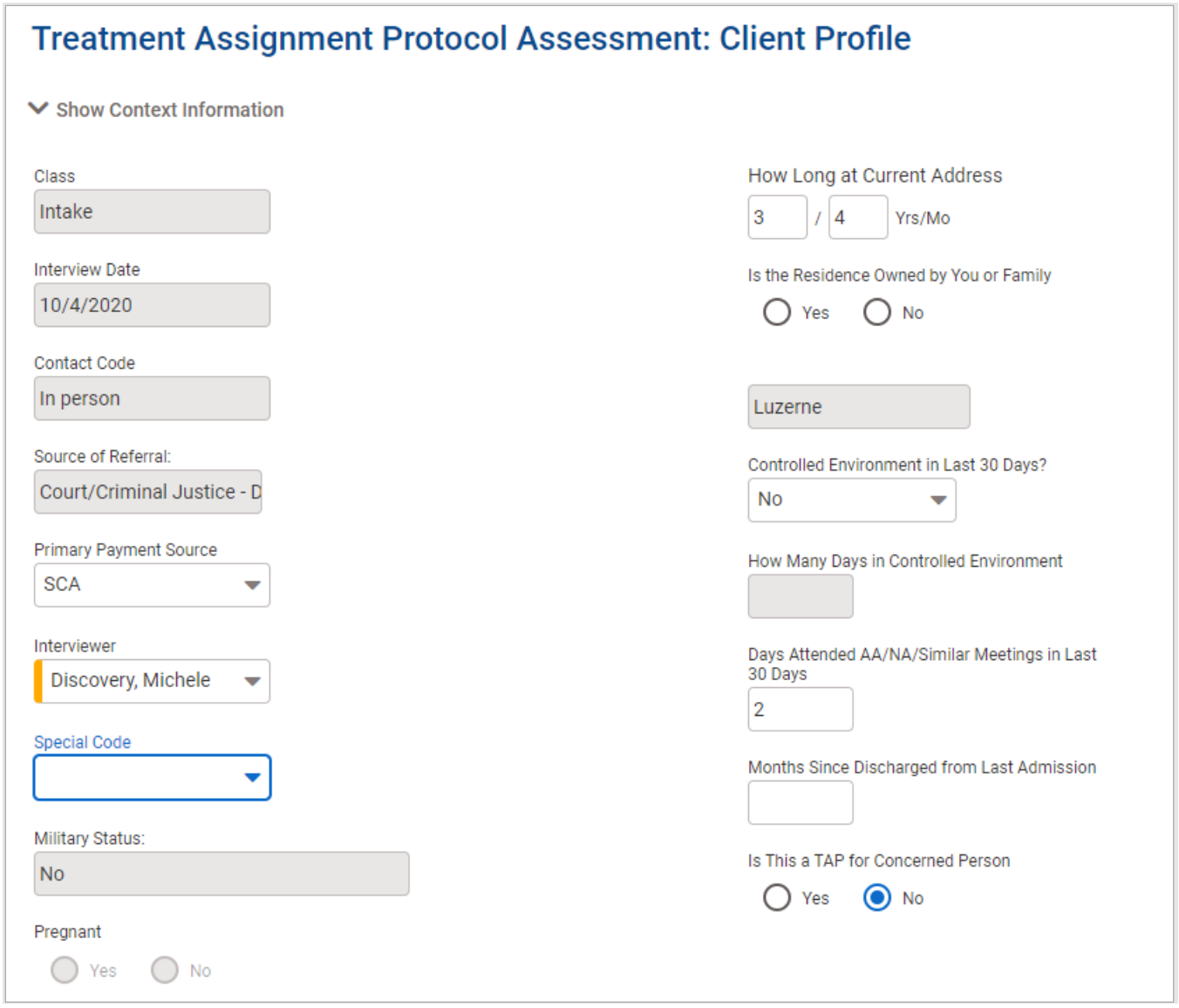


Figure 3-17: Treatment Assignment Protocol Assessment: Client Profile screen

7. Click **"Save".**
8. Click the **"Next>"** button.

9. Complete the fields on the **TAP Withdrawal** screen.

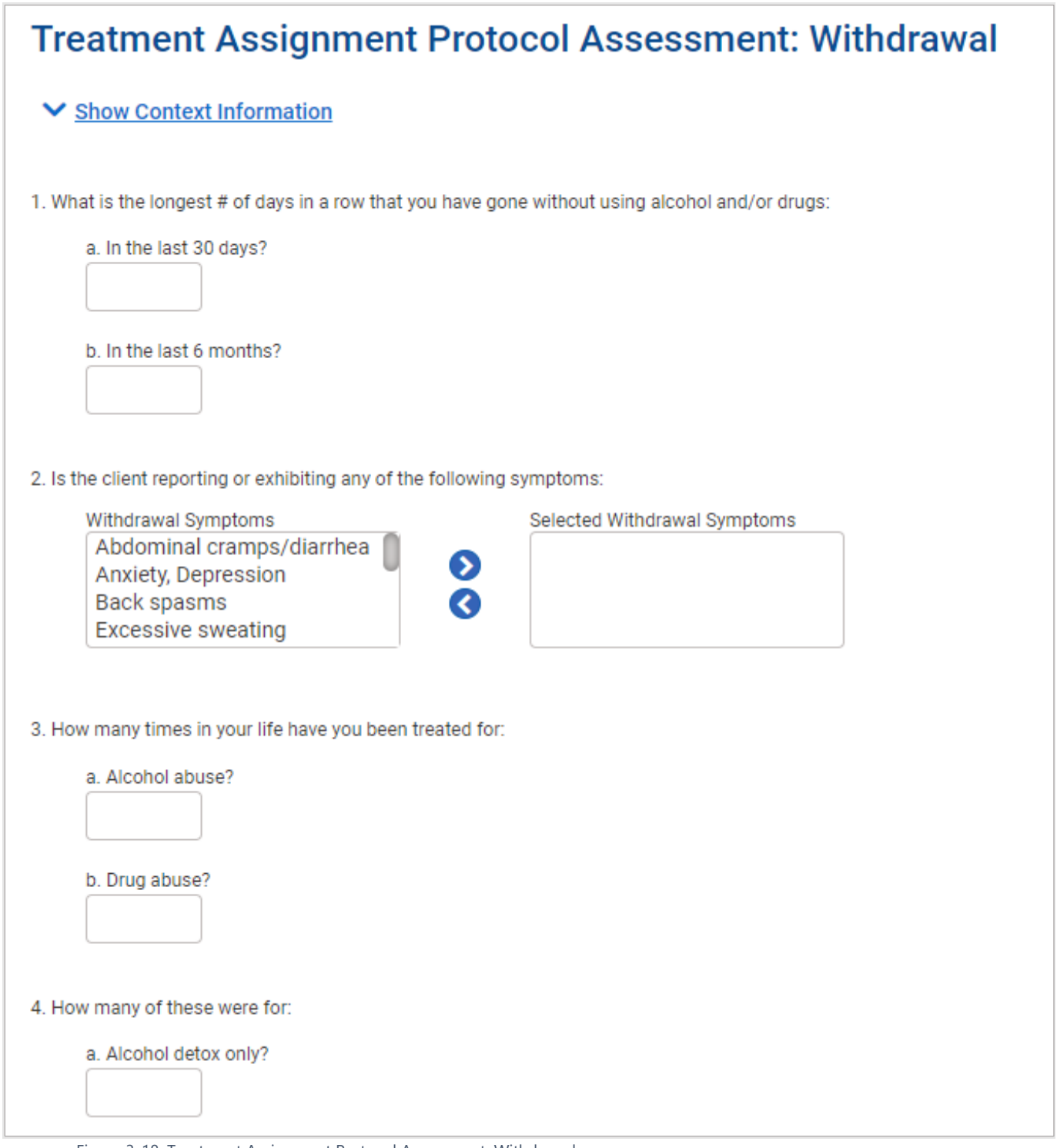


Figure 3-18: Treatment Assignment Protocol Assessment: Withdrawal screen

10. Click **"Save".**
11. Click the **"Next>"** button.

TAP: Medical

12. Complete the fields on the **TAP: Medical** screen.

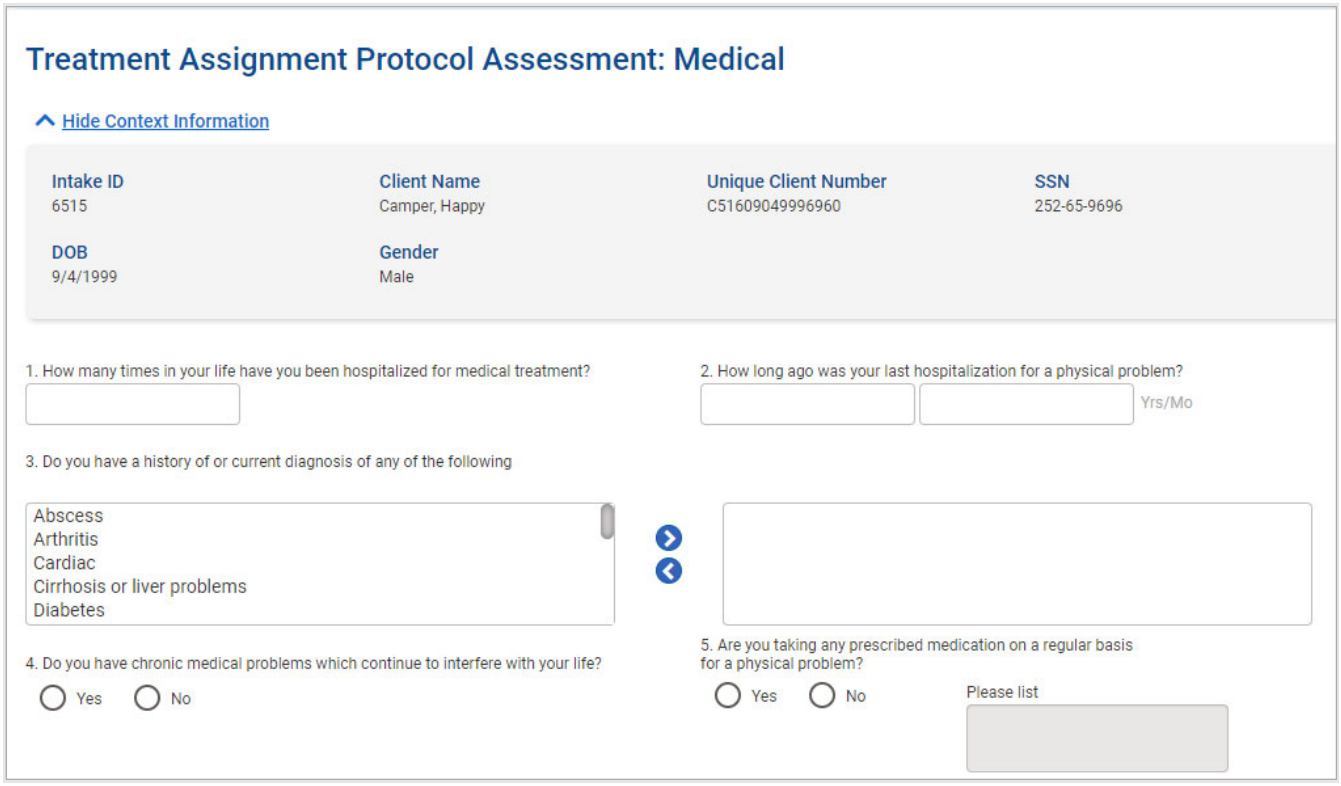


Figure 3-19: Treatment Assignment Protocol Assessment: Medical

13. Click **"Save".**
14. Click the **"Next>"** button.

TAP: Co-occurring

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

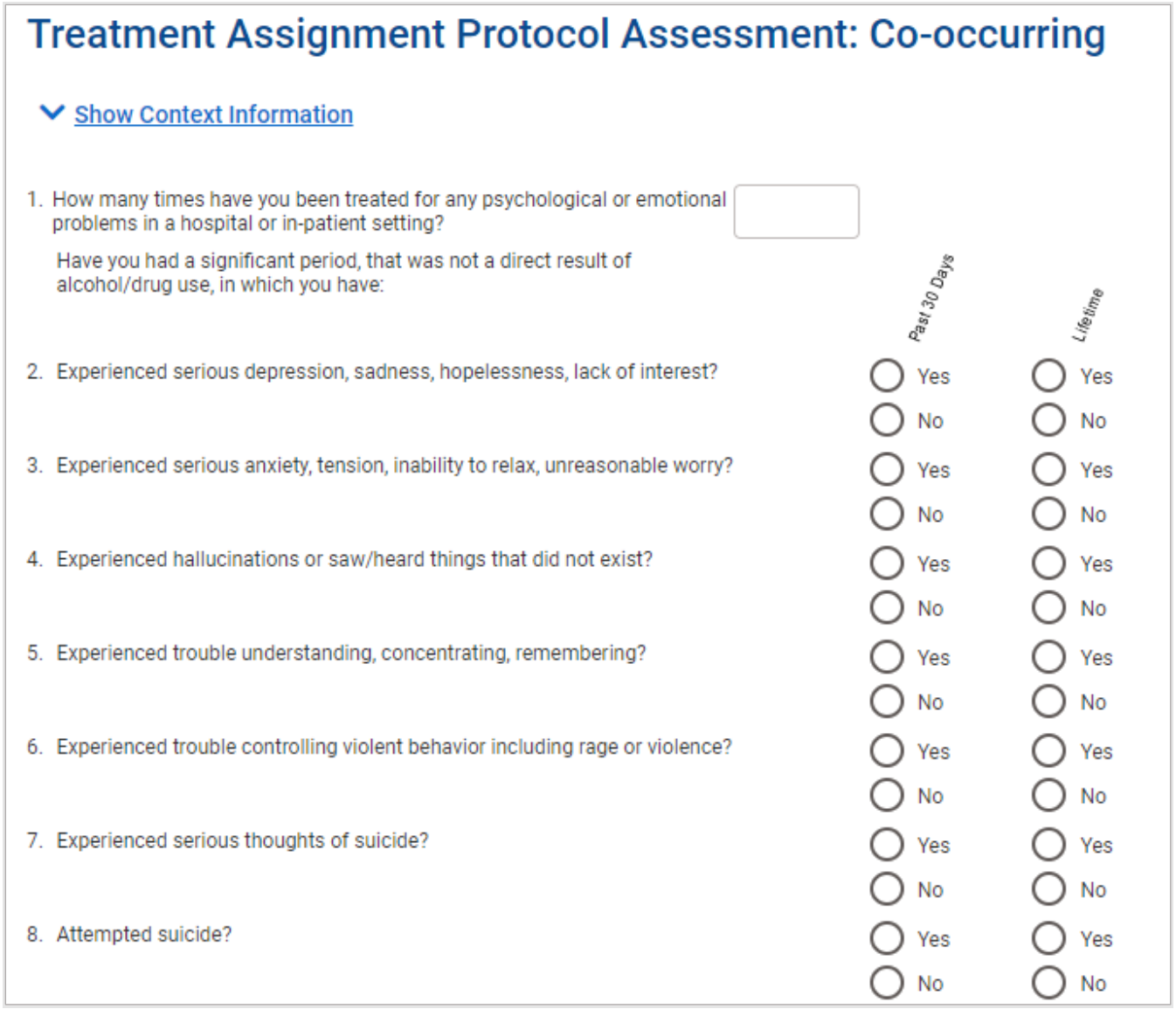


Figure 3-20: Treatment Assignment Protocol Assessment: Co-occurring

16. Click **"Save".**
17. Click the **"Next>"** button.

TAP: Motivation

18. Complete the fields on the **TAP: Motivation** screen.

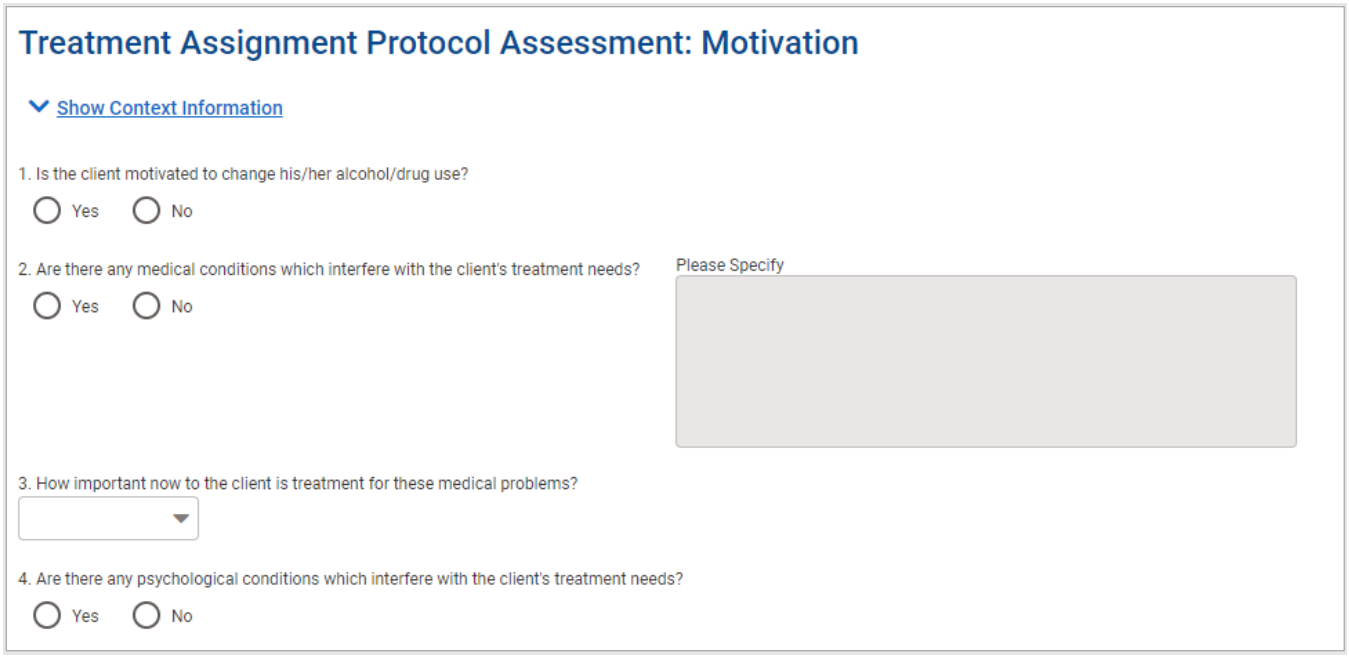


Figure 3-21: Treatment Assignment Protocol Assessment: Motivation

19. Click **"Save".**
20. Click the **"Next>"** button.

TAP: Alcohol/Drug Usage

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

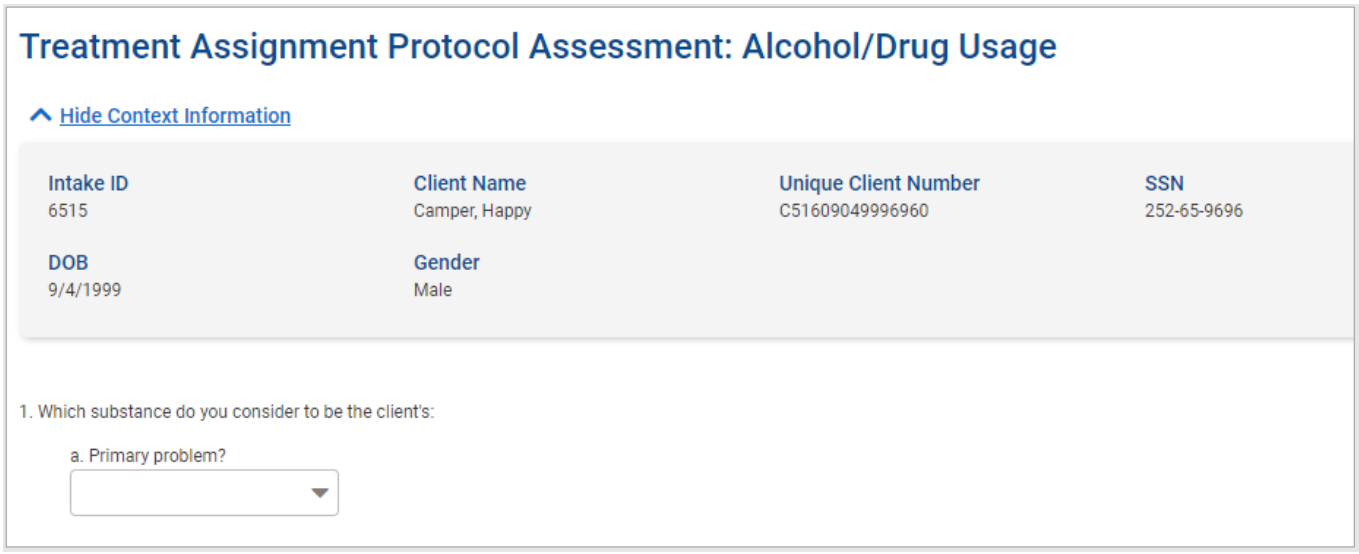


Figure 3-22: Treatment Assignment Protocol Assessment: Alcohol/Drug Usage

22. Click **"Save".**
23. Click the **"Next>"** button.

Support Systems (Systems)

TAP: Employment

24. Complete the fields on the **TAP: Employment** screen.

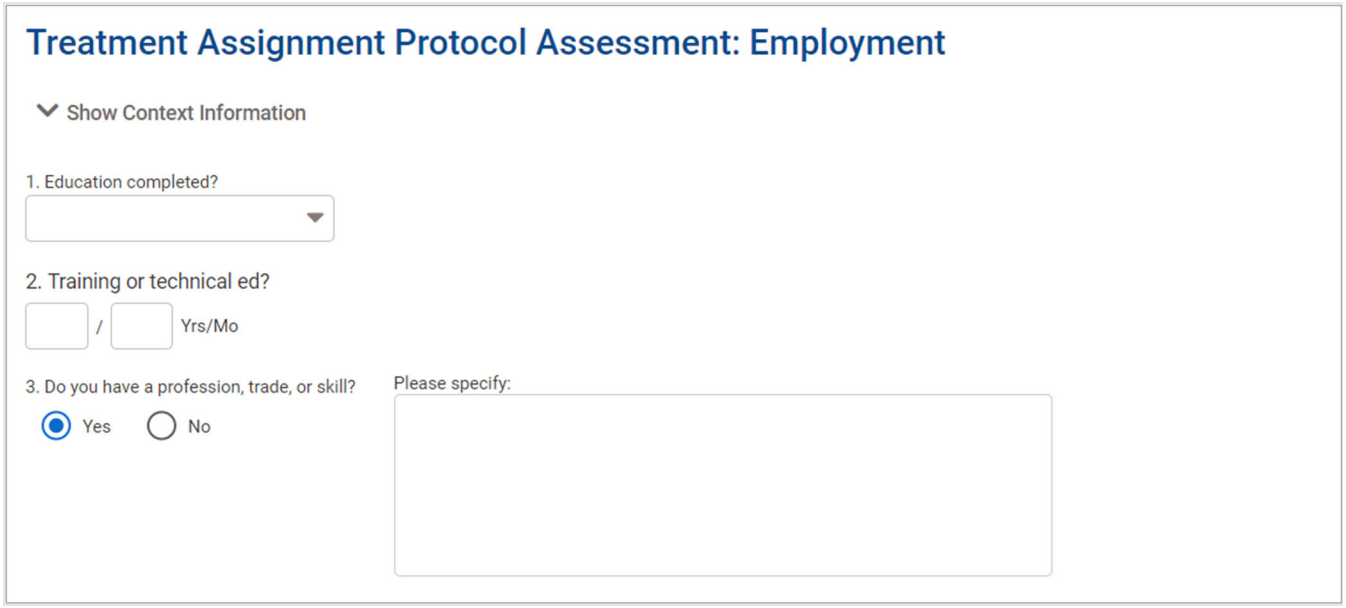


Figure 3-23: Treatment Assignment Protocol Assessment: Employment

25. Click **"Save".**
26. Click the **"Next>"** button.

TAP: Social

27. Complete the fields on the **TAP: Social** screen.

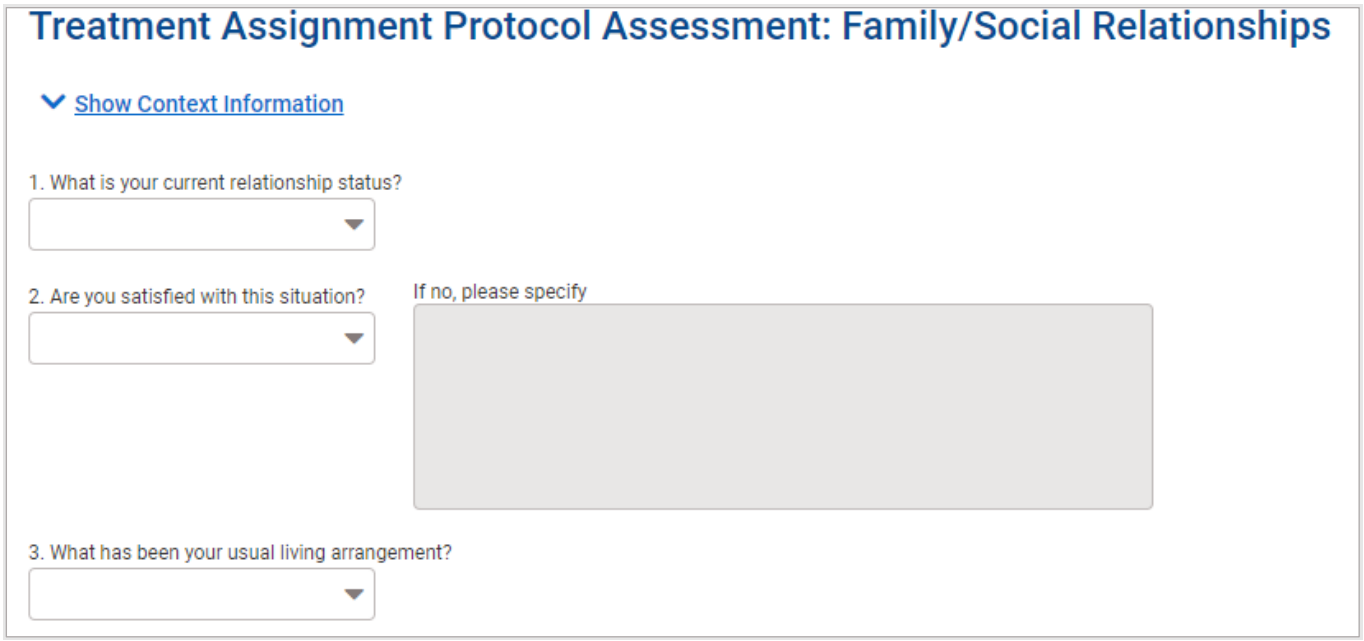


Figure 3-24: Treatment Assignment Protocol Assessment: Social

28. Click **"Save".**
29. Click the **"Next>"** button.

TAP: Legal

30. Complete the fields on the **TAP: Legal** screen.

Figure 3-25: Treatment Assignment Protocol Assessment: Legal

31. Click **"Save".**
32. Click the **"Next>"** button.

TAP: Summary

33. Complete the fields on the **TAP: Summary** screen.

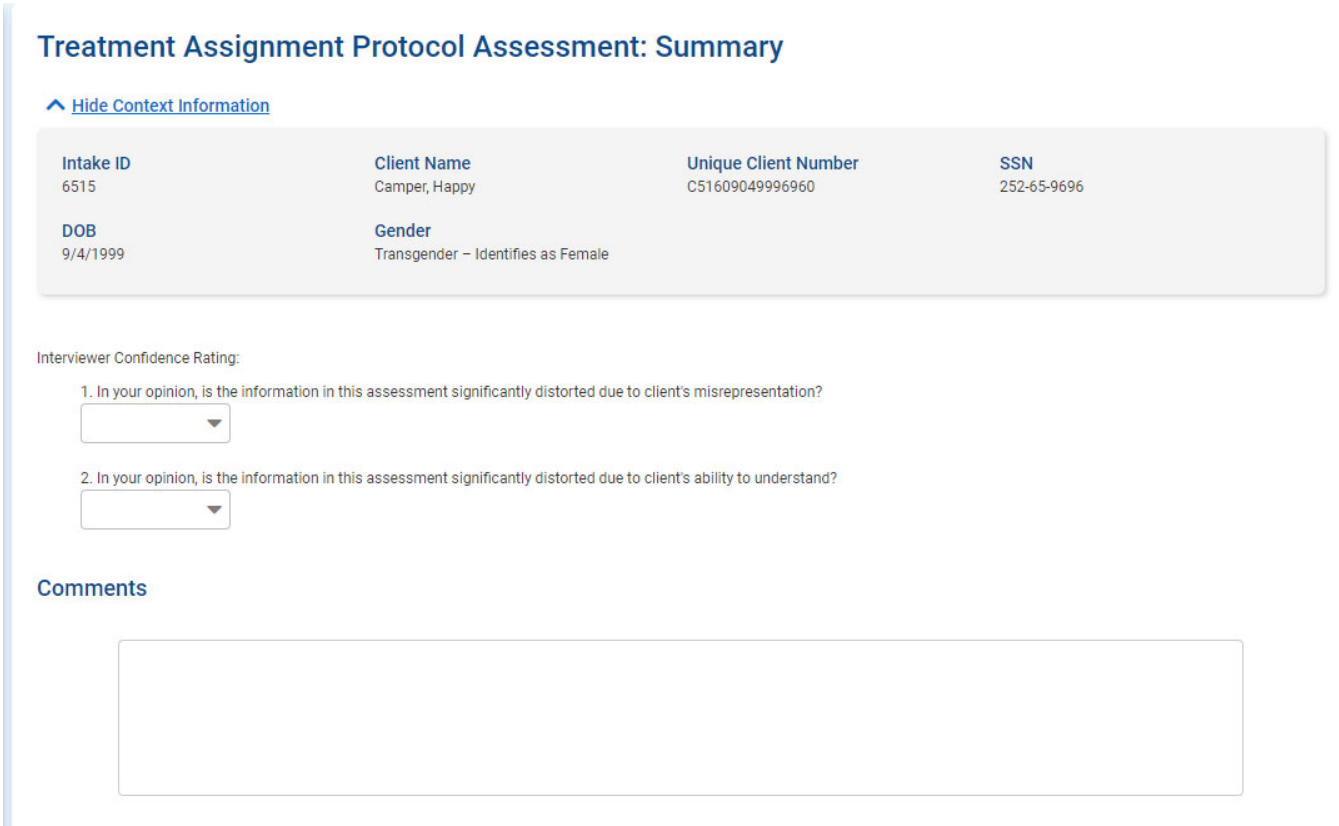


Figure 3-26: Treatment Assignment Protocol Assessment: Summary

34. Click **"Save".**
35. Click the **"Next>"** button.

TAP: Narrative

36. Review the information on the **TAP: Narrative** screen.

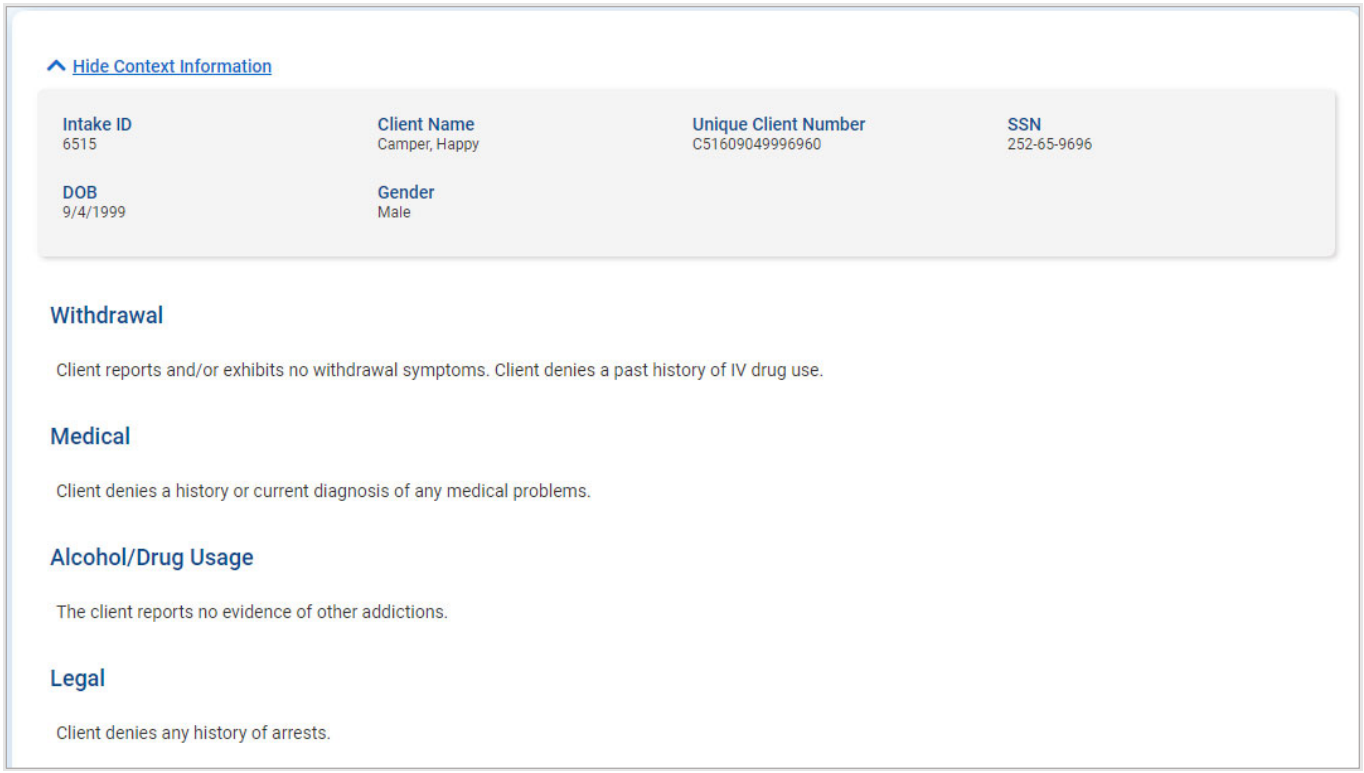
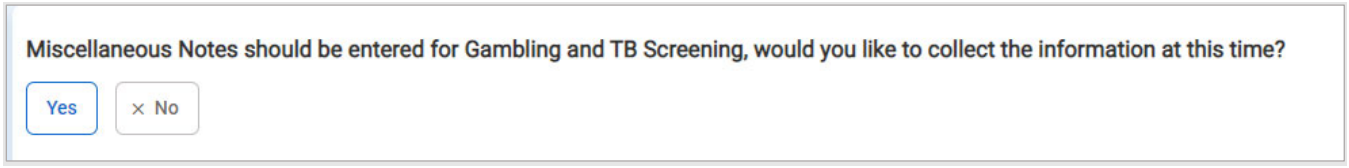


Figure 3-27: Treatment Assignment Protocol Assessment: Narrative

37. Click **"Save and Finish".**

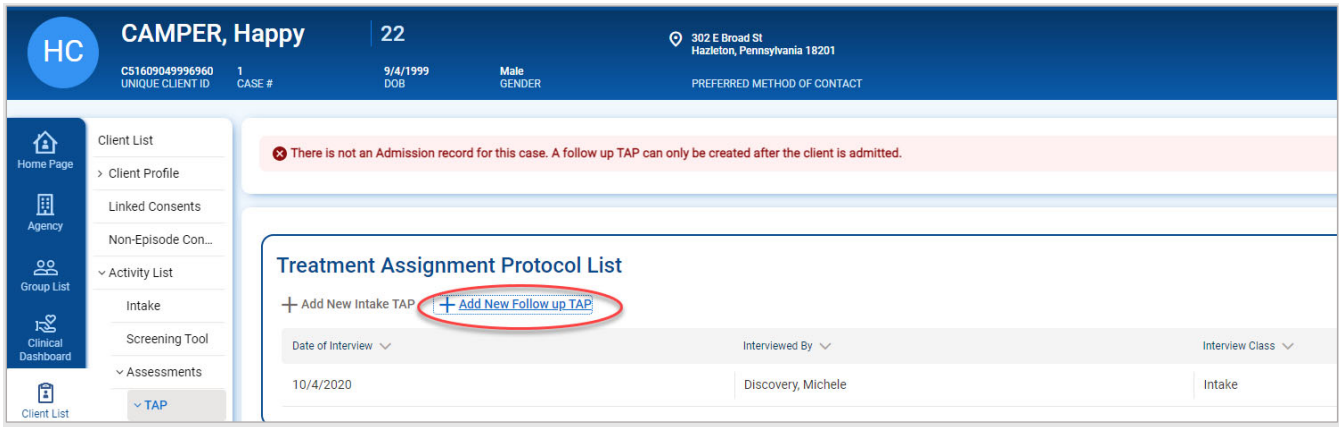
If **Miscellaneous Notes** have not already been entered for the **Gambling** and **TB Screening** questions, a new screen will appear with a prompt stating, *"Miscellaneous Notes should be entered for Gambling and TB Screening, would you like to collect the information at this time?"* Select **"Yes".**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



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

Add New Follow up TAP

Once an **Admission** record has been entered, users will only be able to add a **Follow-up TAP**. If users try to enter a **Follow-up TAP Assessment** before an **Admission** record has been added, they will see the following error message:



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

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

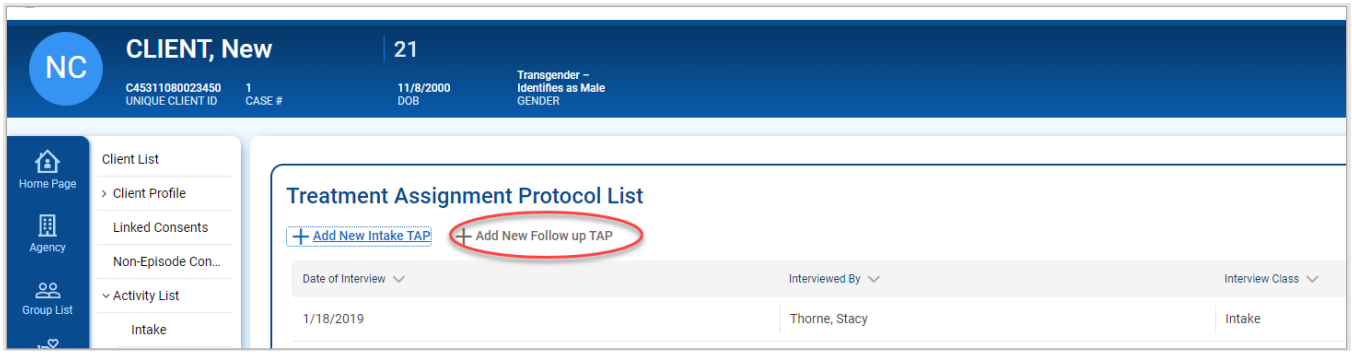
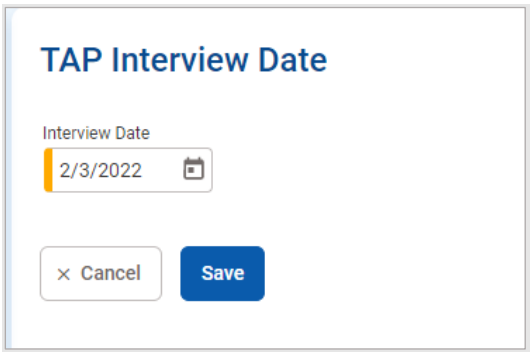


Figure 3-28: Add New Follow up TAP

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



6. If a **TAP** was completed within the last 6 months, you will be given the option to pull forward that information into the **Follow-up TAP**. You can then edit the previously entered information.

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

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

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

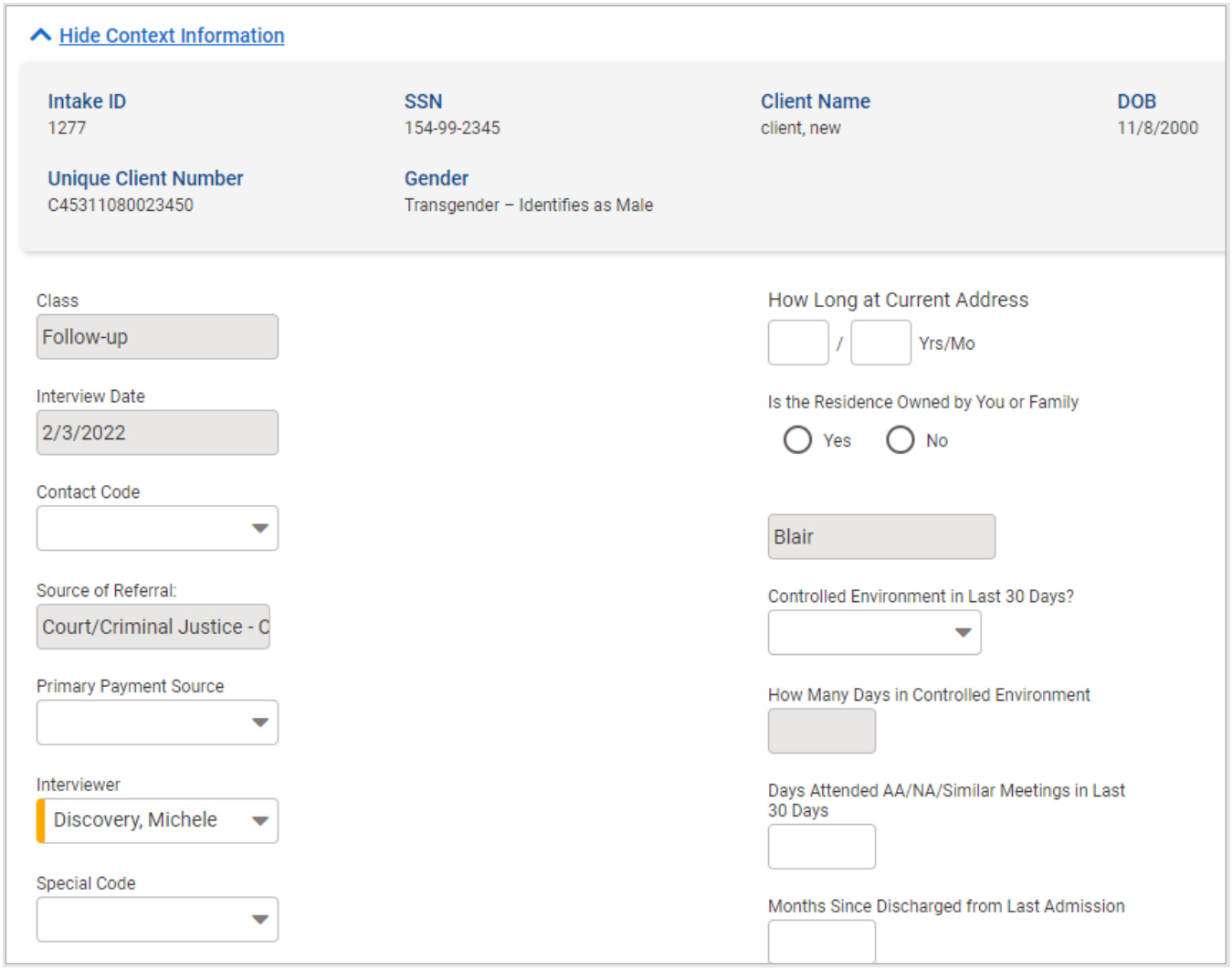


Figure 3-29: Follow-up TAP Client Profile screen

8. Complete the **Follow-up TAP** by reviewing and updating the client's answers to the nine questionnaires in the following topics: **Withdrawal, Medical, Co-Occurring, Motivation, Drug Alcohol Usage, Employment, Social, Legal, and Summary**. Use the **Next>** and **<Back** buttons to move between screens and click **"Save"** to save the client's responses.

9. Review the information on the **Narrative** screen, then click **"Save and Finish".**

If **Miscellaneous Notes** have not already been entered for the **Gambling** and **TB Screening** questions, a new screen will appear with a prompt stating, *"Miscellaneous Notes should be entered for Gambling and TB Screening, would you like to collect the information at this time?"* Select "**Yes"**.

Selecting **"Yes"** will open the **Notes** screen, and steps for adding these miscellaneous notes are included in Part 4 of this guide.

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

Placement Summary

ASAM

Where: Client List > Activity List > ASAM

Once a **Level of Care Assessment** using ASAM criteria has been completed, the **ASAM Summary** can be entered.

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

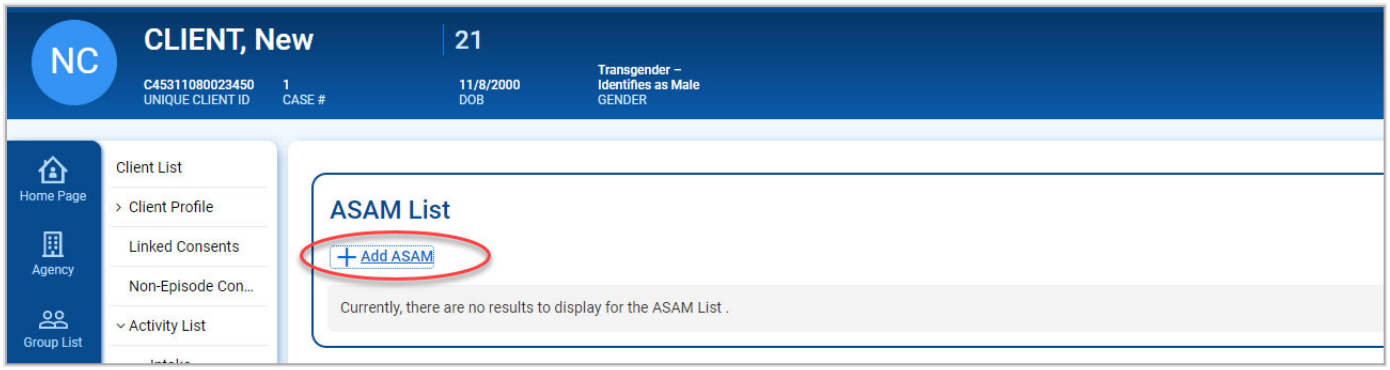


Figure 3-30: ASAM List screen, Add ASAM

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

Table 3-6: ASAM Fields

Field	Description
Type	In the drop-down list, select "Admission", "Continued Stay", or "Discharge".
Dimensions **For each of the following six (6) dimensions, complete these three (3) fields:** • **Level of Risk (optional) – select a number from the drop-down list** • **Level of Care – select an option from the drop-down list.** • **Criteria Included/Comments – type applicable comments**	
***Dimension 1 - Acute Intoxication and/or Withdrawal Potential**	Select the **Level of Risk** (optional), **Level of Care**, and complete the **Criteria Included/Comments** field.
***Dimension 2 - Biomedical Conditions and *Complications**	Select the **Level of Risk** (optional), **Level of Care**, and complete the **Criteria Included/Comments** field.
***Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and Complications**	Select the **Level of Risk** (optional), **Level of Care**, and complete the **Criteria Included/Comments** field.
***Dimension 4 - Readiness to Change**	Select the **Level of Risk** (optional), **Level of Care**, and complete the **Criteria Included/Comments** field.
***Dimension 5 - Relapse, Continued Use, or Continued Problem Potential**	Select the **Level of Risk** (optional), **Level of Care**, and complete the **Criteria Included/Comments** field.
***Dimension 6 - Recovery / Living Environment**	Select the **Level of Risk** (optional), **Level of Care**, and complete the **Criteria Included/Comments** field.
Recommended Level of Care	Select from the drop-down list.
Actual Level of Care	Select from the drop-down list.

Field	Description
Clinical Override	This field becomes required when the Recommended Level of Care and the Actual Level of Care fields do not match.
Comments	Type any applicable comments.
Date	Enter the date when the ASAM was administered.
Program	This field will be empty unless a client has a program enrollment.

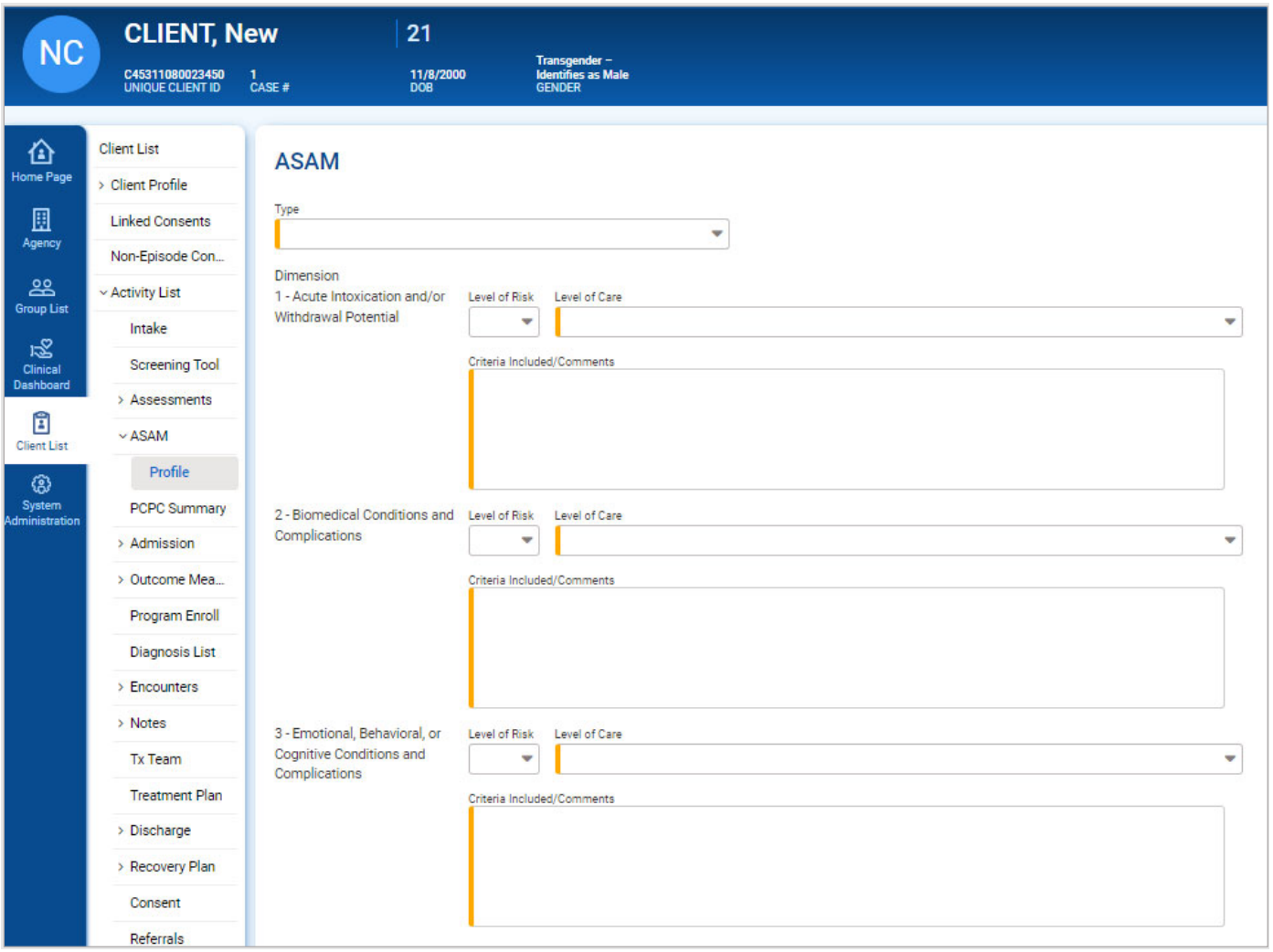
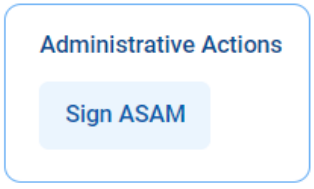


Figure 3-31: ASAM Placement screen

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

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



7. Click "**Save and Finish**".

Admission

Where: Client List > Activity List > Admission

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

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

Table 3-7: Admission Profile Fields

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

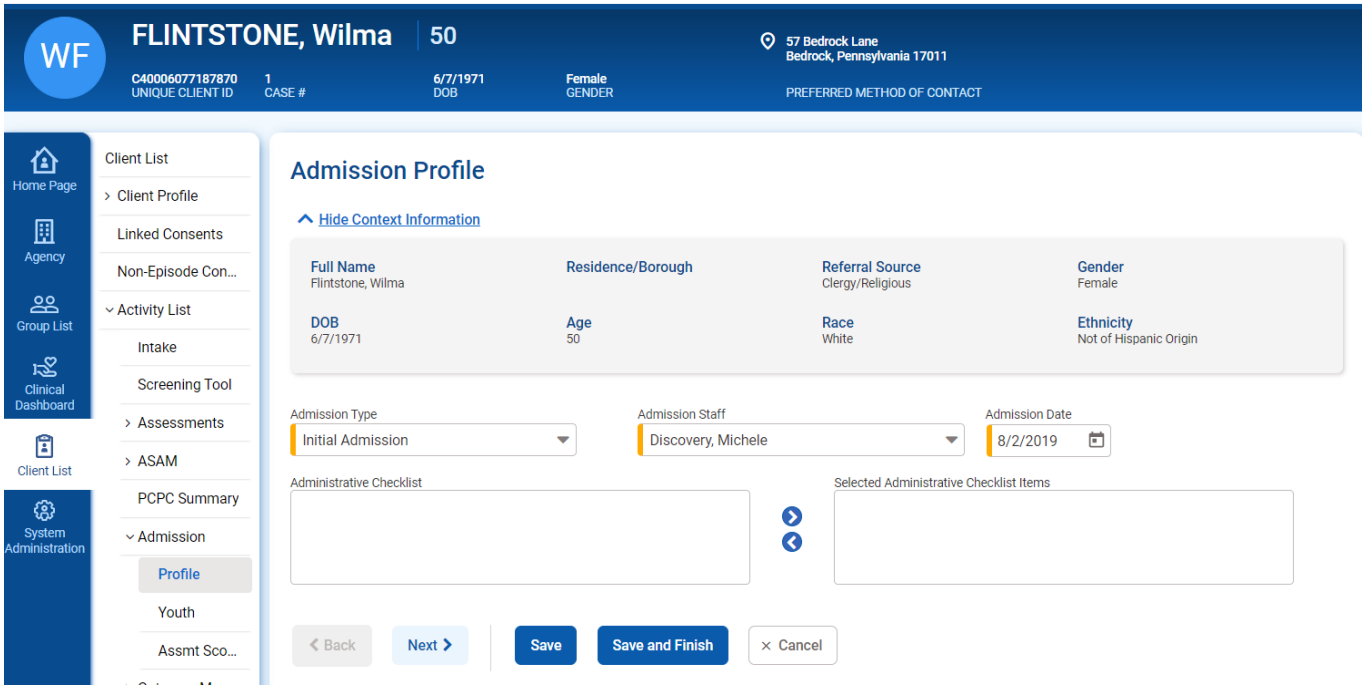


Figure 3-32: Admission Profile screen

5. Click **"Save and Finish".**

NOTE: Optional information can be entered by clicking the **"Next>"** button. Please see the following page.

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

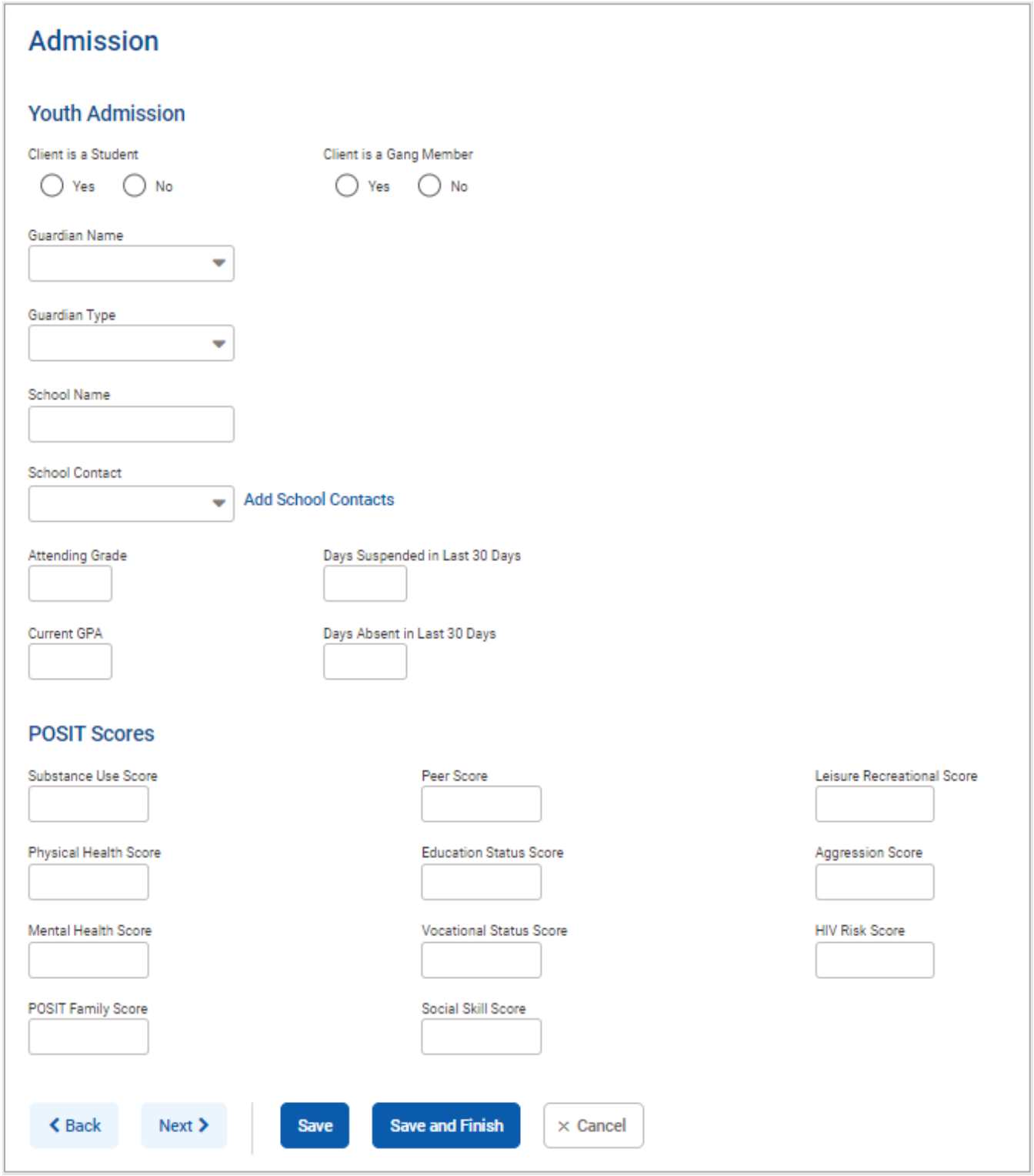


Figure 3-33: Admission, Youth Admission screen

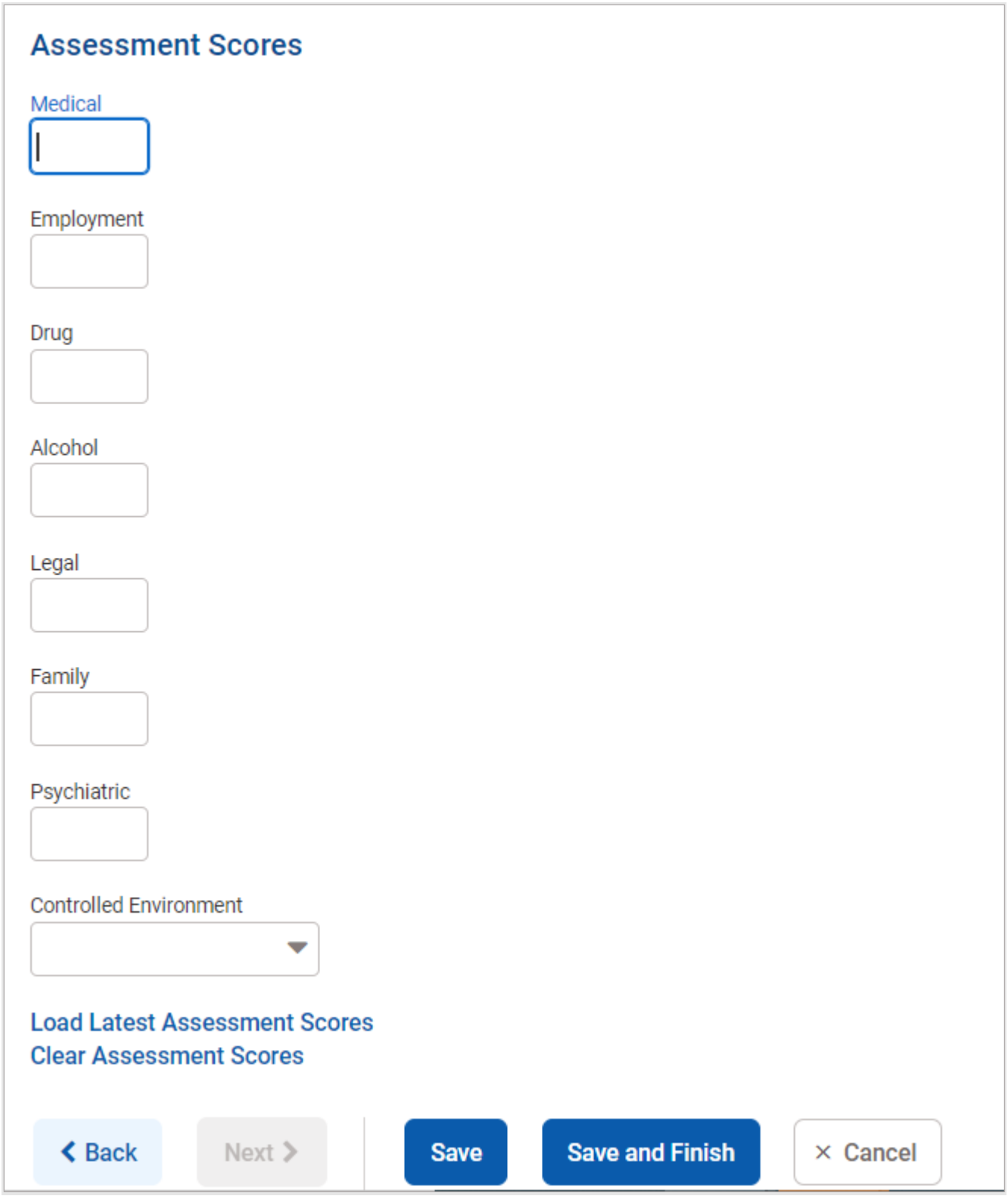


Figure 3-34: Admission, Assessment Scores screen

Outcome Measures (Initial)

Where: Client List > Activity List > Outcome Measures

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

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

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

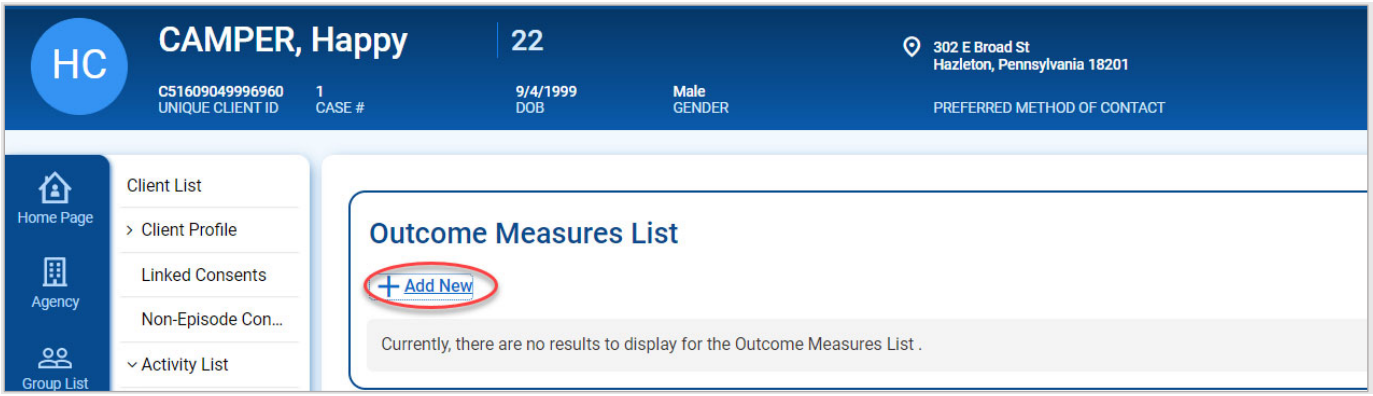
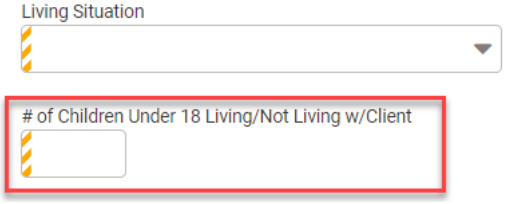


Figure 3-35: Outcome Measure screen, Add New link

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

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

Field	Description
Date	Pre-populates with the Admission Date.
Type	Defaults to "Initial" when adding first Outcome Measure.
Pregnant	Pre-populates with the selection entered on the Intake screen. Select Yes or No, if applicable.
Due Date	Pre-populates with the selection entered on the Intake screen. Enter client's Due Date, if applicable.
Profile	
Codependent/Collateral	Select Yes/No.
Co-Occurring SA and MH Problem	Select from Drop Down.
Medication Assisted Tx	Select from Drop Down.
SMI/SED Status	Not required
# of Prior SA Tx Episodes	Enter # of Prior Episodes
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	
Education	
Education Status	Select from Drop Down.
Financial/Household	
Employment Status	Select from Drop Down.
Source of Income	Select from Drop Down.
Primary Payment Source	Select from Drop Down.
Health Insurance	Select from Drop Down.
Marital Status	Select from Drop Down.
Living Situation	Select from Drop Down.
# of Other Dependents	Not required
# of Children Under 18 Living/Not Living w/Client	This field will be required for state reporting when the client's gender (entered on the Client Profile screen) is either "Female" or "Transgender – Identifies as Female". 
Legal	

Field	Description
# of Arrests in Past 30 Days	
Mental Health Legal Status	Not required
Add Selected Legal History **Remove Selected Legal History** **Selected Legal History**	Not required
Substance Abuse - For the following fields marked with an asterisk*, select options for **Primary, Secondary**, and **Tertiary** as applicable. For the following fields marked with two asterisks**, these fields will pre-populate with information entered on the most recent **Screening Tool**. This includes **Screening Tool** records that the client consented to share, and records created within the context agency.	
****Substance**	
****Severity**	Not Required.
****Frequency**	
****Method**	
****Detailed Drug Code**	
***At what age did the client FIRST use the substances indicated above (if unknown, enter '97')**	
***# of DAYS since LAST use of the substances indicated above:**	Not Required.
Tobacco/Nicotine	
Have you ever used Tobacco/Nicotine products?	Not Required. Select Yes, No, or Unknown. If "Yes" is selected, the following fields will become editable.
Smoker Status?	
Age of First Use	
In the past 30 days, what tobacco/nicotine product did you use most frequently?	
Other (Please Describe)	
In the past 30 days, how often did you use tobacco/nicotine product(s)?	

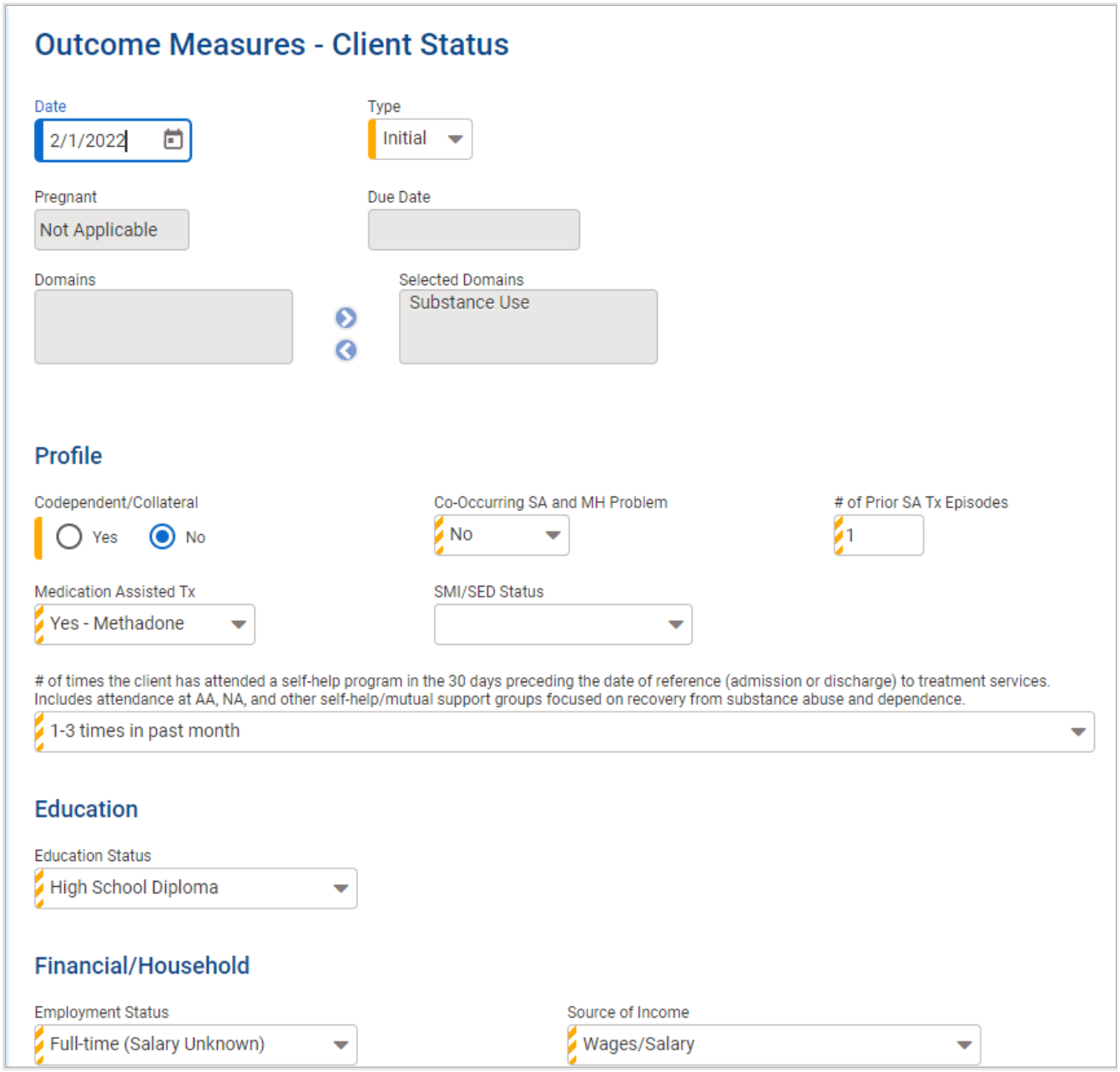


Figure 3-36: Outcome Measures – Client Status screen, Initial Outcome Measure

6. Click **"Save".**
7. Click the **"Next>"** button.

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

NOTE: TEDS does not require a **Secondary** and **Tertiary** diagnoses. DDAP also does not require **Medical** or **Psychological** diagnoses to be entered.

Table 3-9: Client Diagnosis fields

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

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

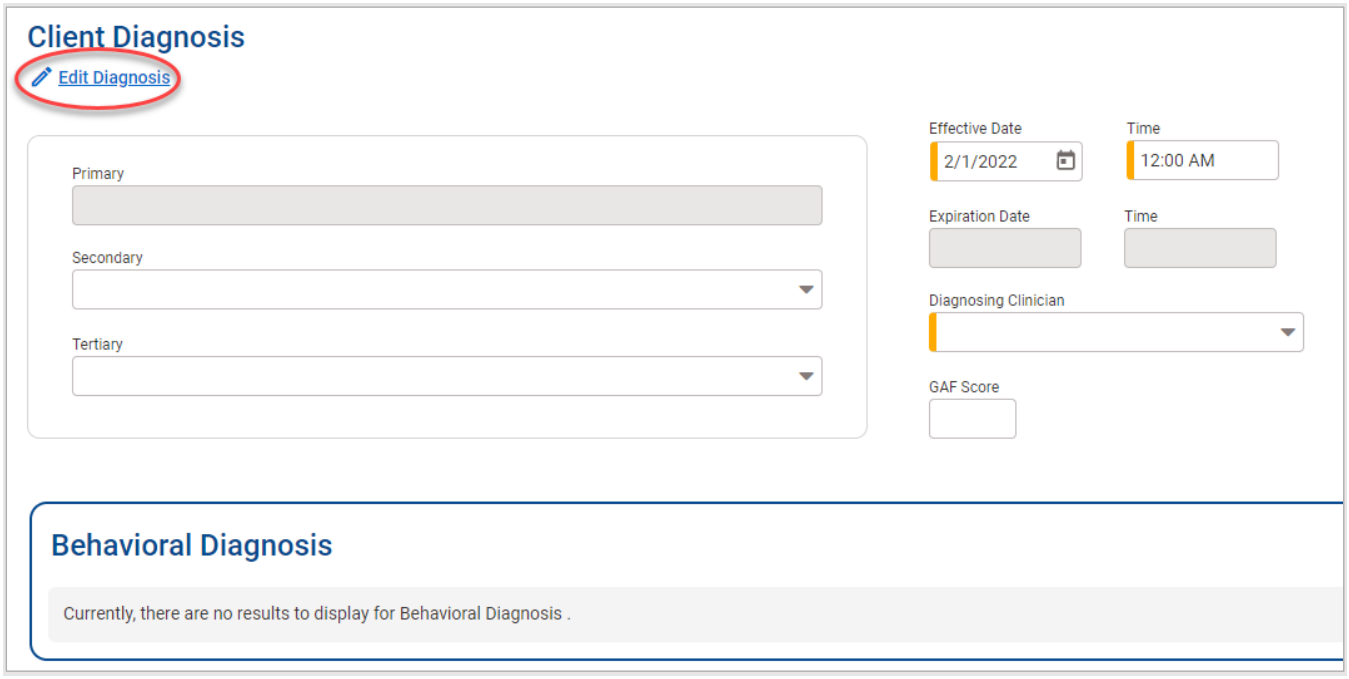


Figure 3-37: Outcome Measures - Client Diagnosis screen, Edit Diagnosis link

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

Table 3-10: Client Diagnosis, Edit Diagnoses fields

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

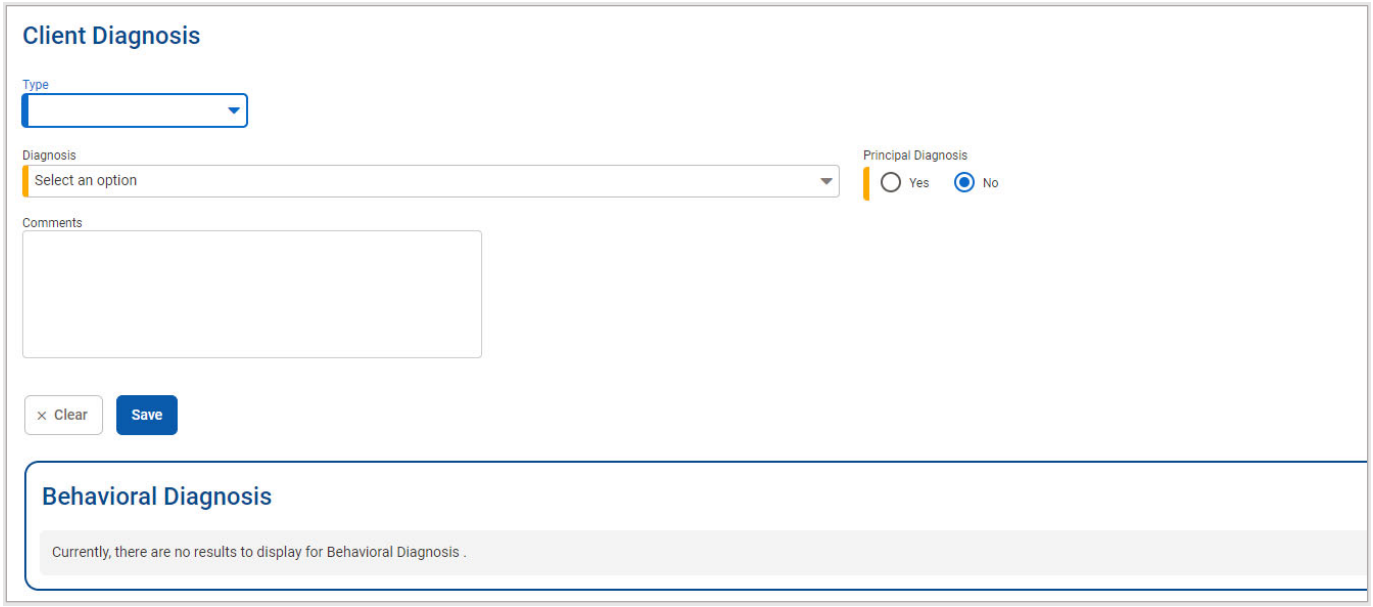


Figure 3-38: Outcome Measures - Client Diagnosis, Edit Diagnosis screen

Figure 3-39: Client Diagnosis, Edit Diagnosis screen, select Type of diagnosis

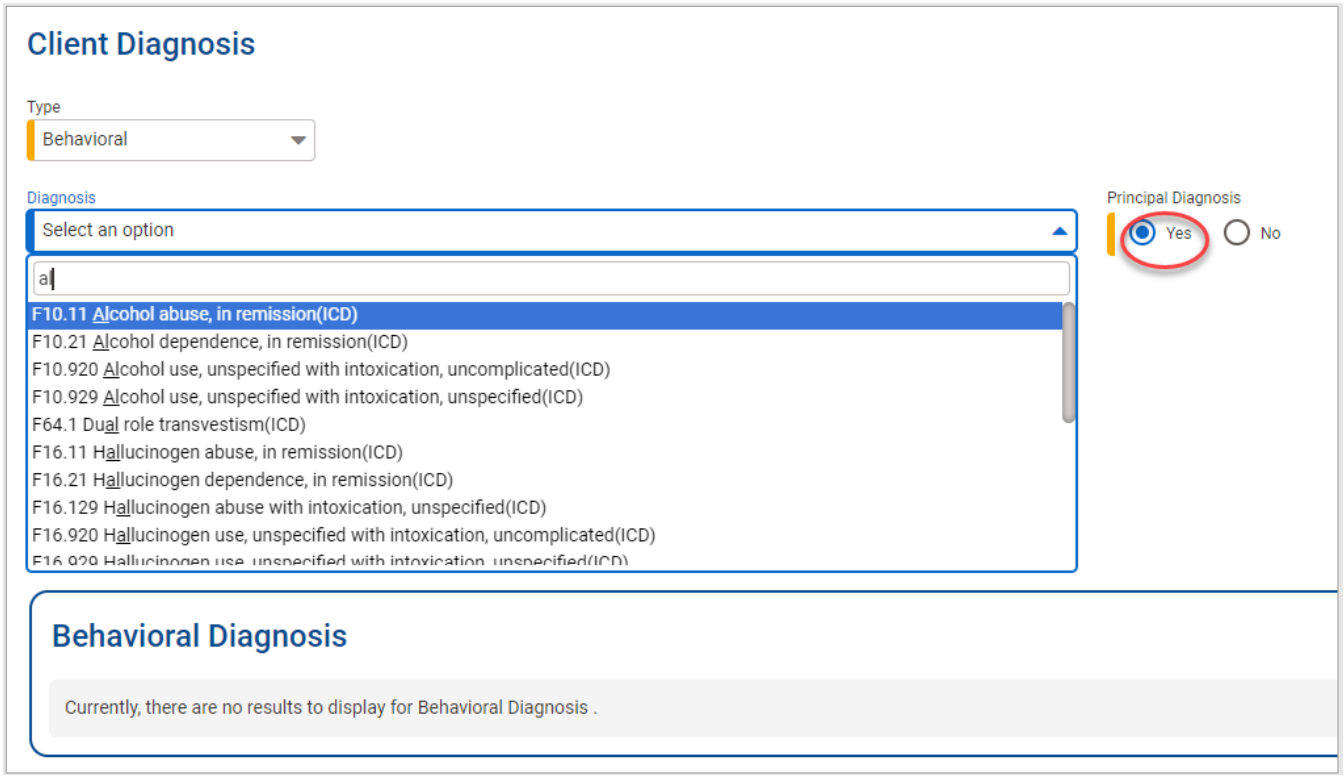


Figure 3-40: Client Diagnosis, Edit Diagnosis screen, select client's diagnosis

11. Click **"Save"**. The **Diagnosis** information will update in the **Behavioral Diagnosis** section of the screen.
12. Enter the **Secondary Diagnosis** and/or **Tertiary Diagnosis**, if applicable.

NOTE: TEDS does not collect **Secondary** and **Tertiary** diagnoses.

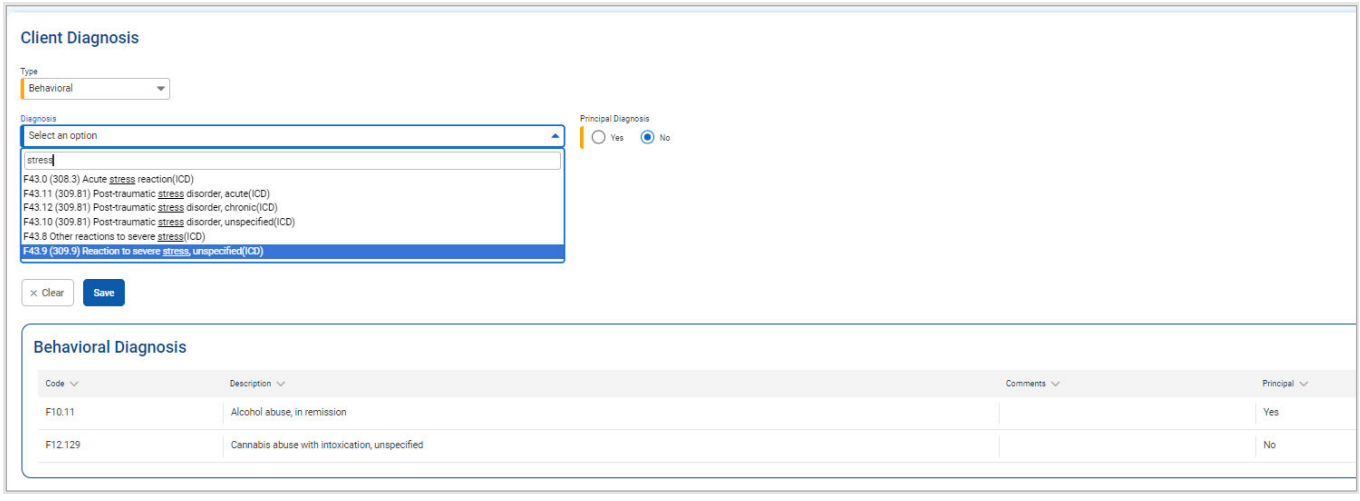


Figure 3-41: Client Diagnosis, Edit Diagnosis screen with multiple diagnoses

13. Click **"Finish"**. You will be redirected to the main **Client Diagnosis** screen.

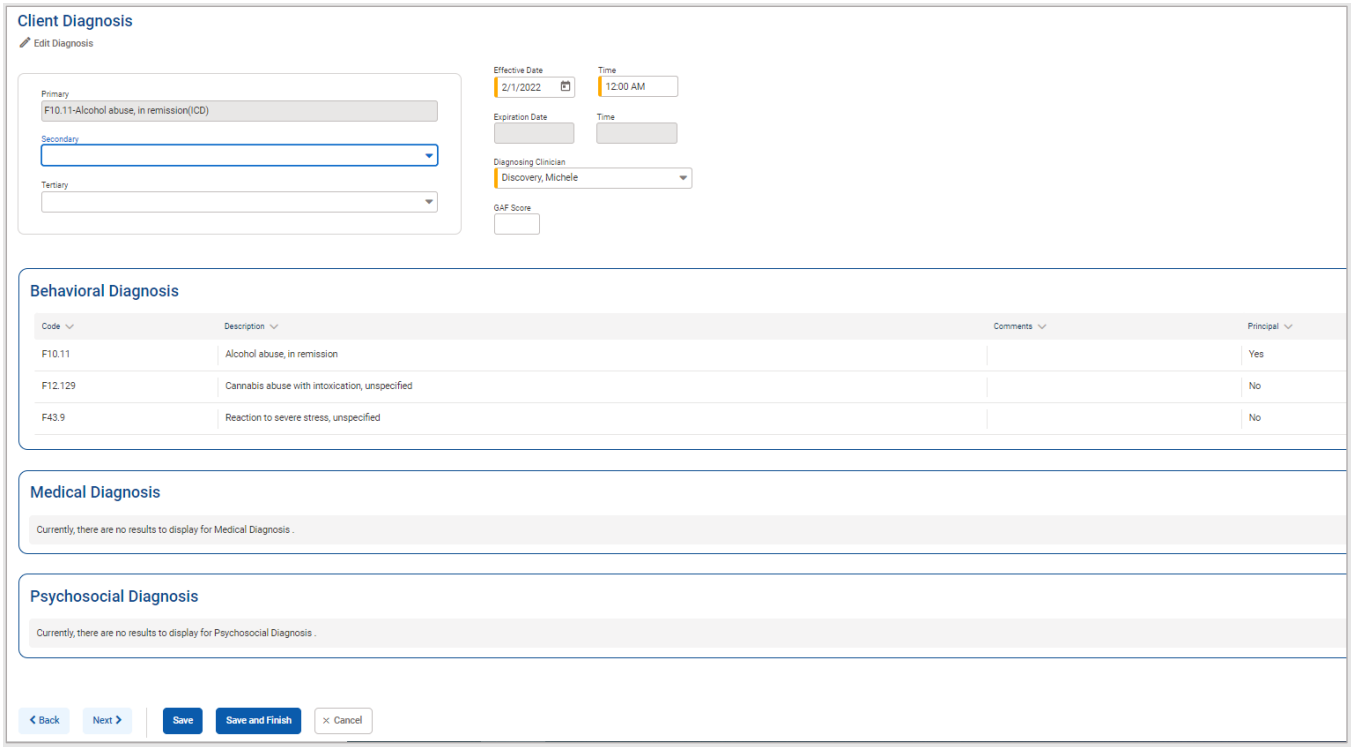


Figure 3-42: Client Diagnosis screen with list of client's diagnoses

14. Select the client's **Secondary** diagnosis, if applicable.

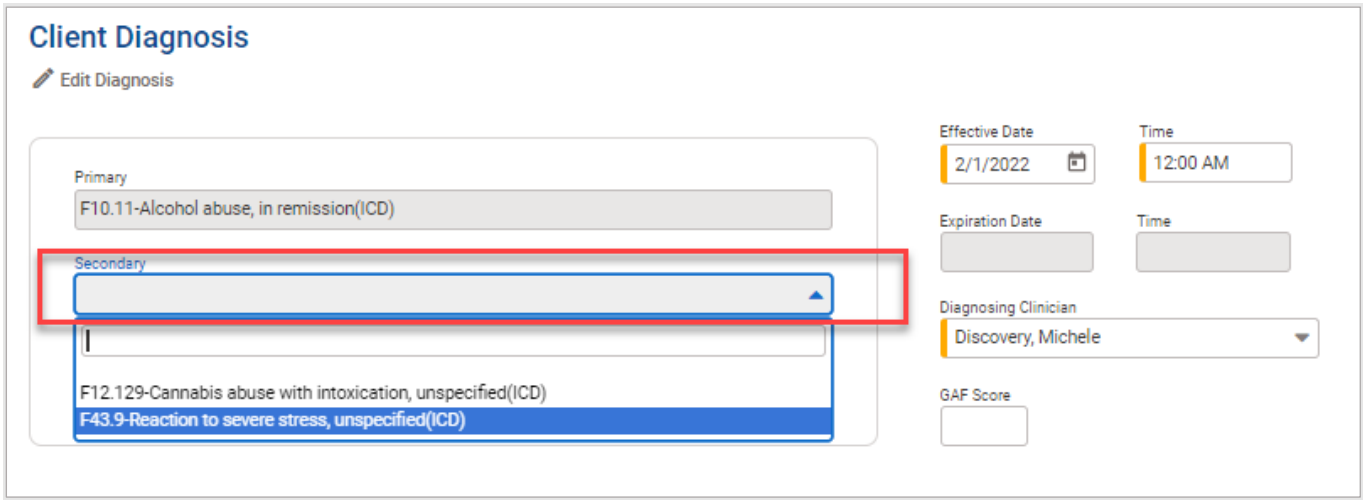


Figure 3-43: Client Diagnosis screen, select Secondary diagnosis

15. Select the client's **Tertiary** diagnosis, if applicable.

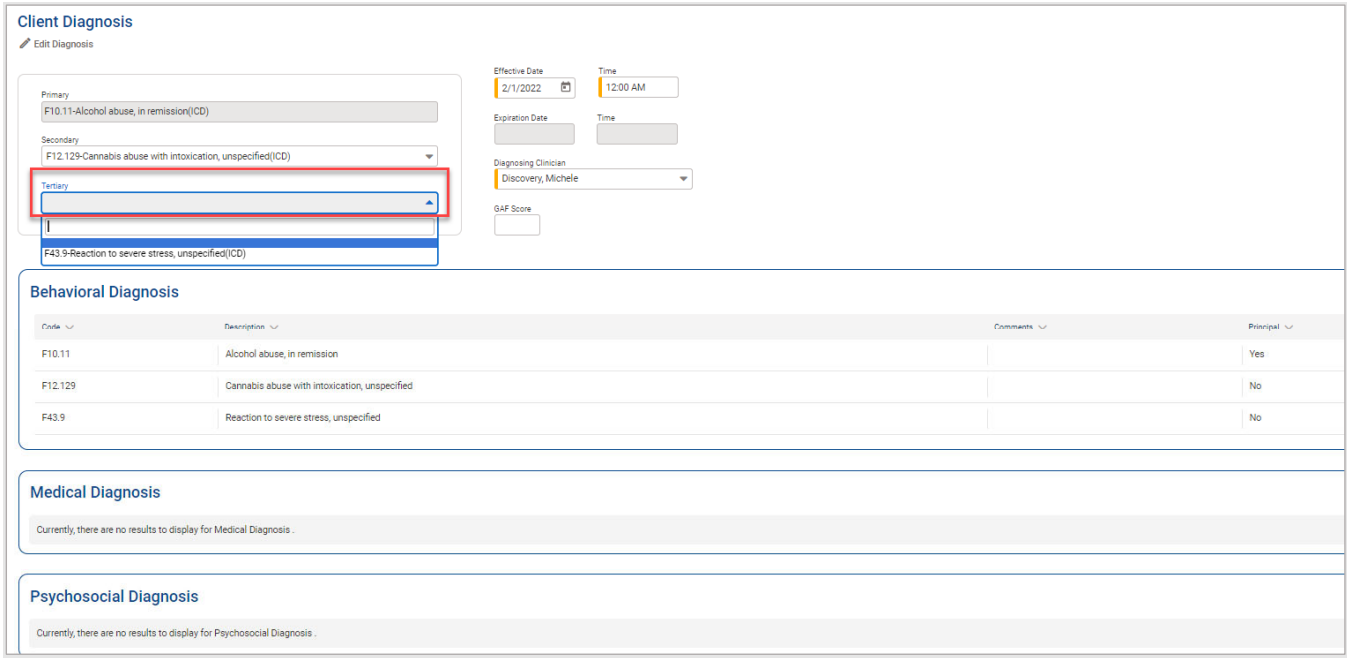


Figure 3-44: Client Diagnosis screen, select Tertiary diagnosis

16. Click **"Save".**
17. Click the **"Next>"** button.

Program Enroll

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

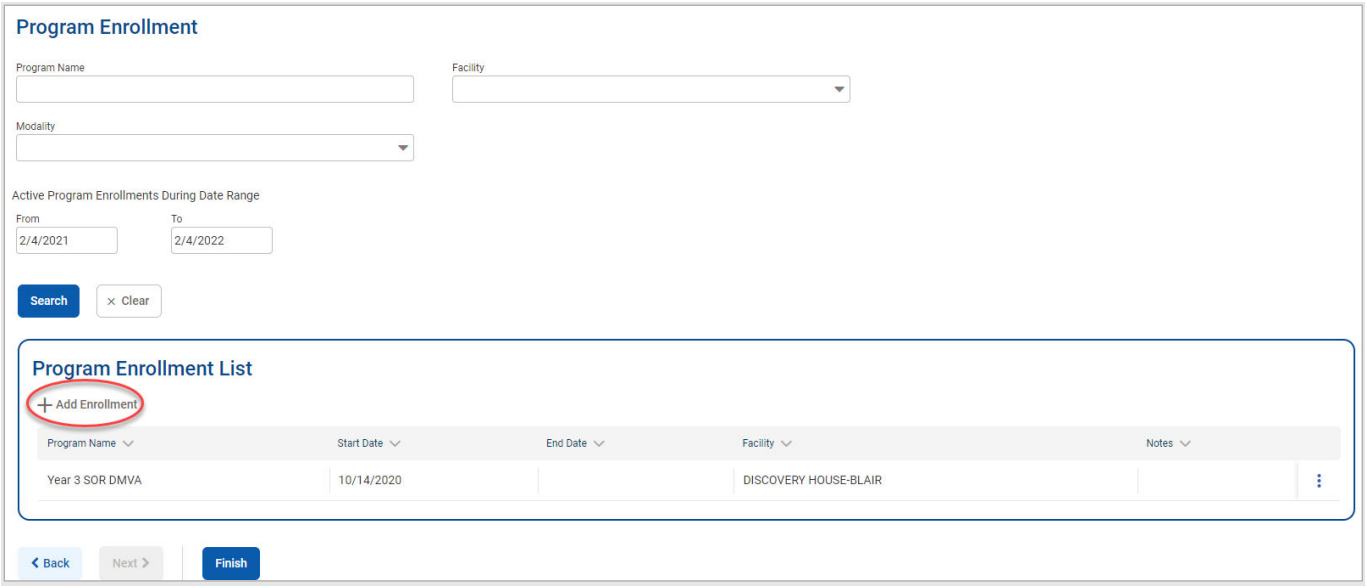


Figure 3-45: Outcome Measures – Program Enrollment screen

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

Table 3-11: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the currently Facility name.
Program Name	Select from the programs available.
Program Staff	Pre-populates with the current staff member name.
Start Date	Pre-populates with the Outcome Measure date.
Days on Wait List	
Reason for waiting?	If the client had to wait longer than two weeks to access the recommended level of care, select the reason from the drop-down list. This field will be required if: The program enrollment start date is more than 14 days from the most recent ASAM date. The LOC associated with the program is different than the Recommended LOC of the most recent ASAM (consented or client activity).
Notes	Type any notes as needed.

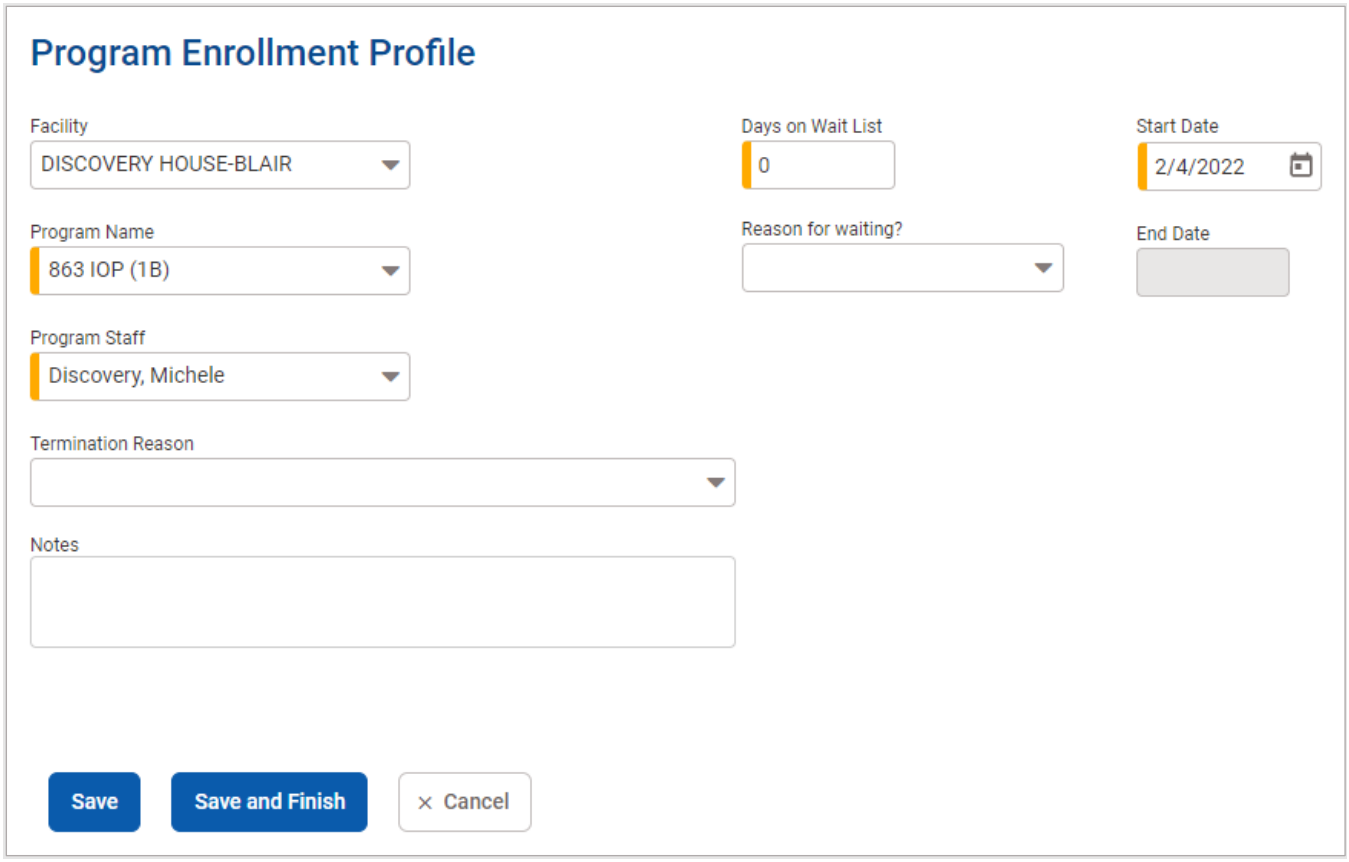


Figure 3-46: Program Enrollment Profile screen

20. On the **Program Enrollment Profile** screen, click **"Save and Finish"**.
21. On the **Program Enrollment** screen, click **"Finish"**.

Outcome Measures (Update and Final)

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

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

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

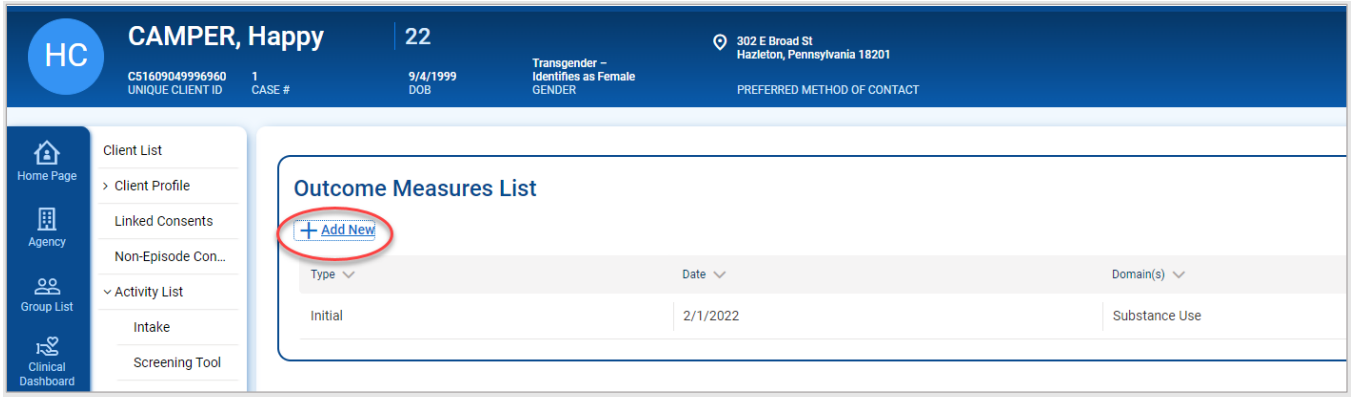


Figure 3-47: Add New Outcome Measure

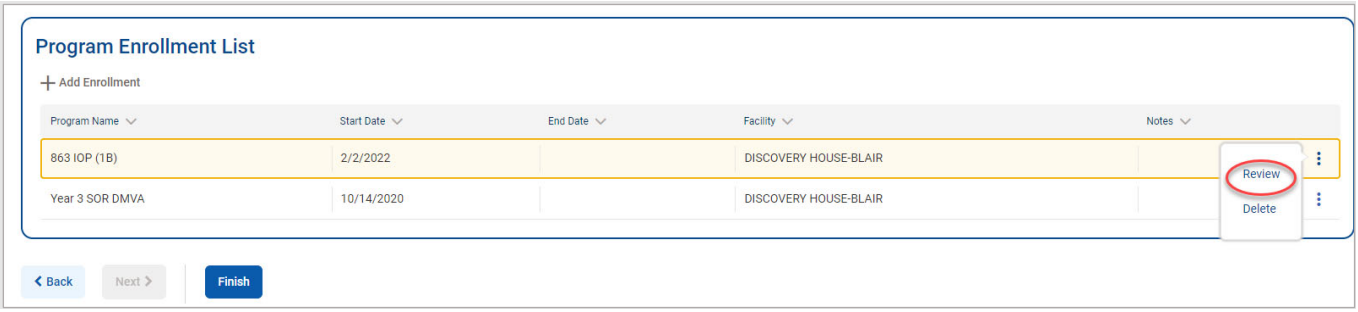
2. On the **Outcome Measures Client Status** screen, complete the following information:

Field	Description
Date	Enter the date of discharge from the current level of care
Type	Select Update or Final
Date of Last Contact	Enter the last date when treatment occurred
Was this individual offered case management services at the time of discharge from this level of care?	Select "yes" or "no" from the drop down.
Profile	
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	
Legal	
# of Arrests in Past 30 Days	
Substance Abuse	
Frequency	Select the updated Frequency from the drop-down menu.

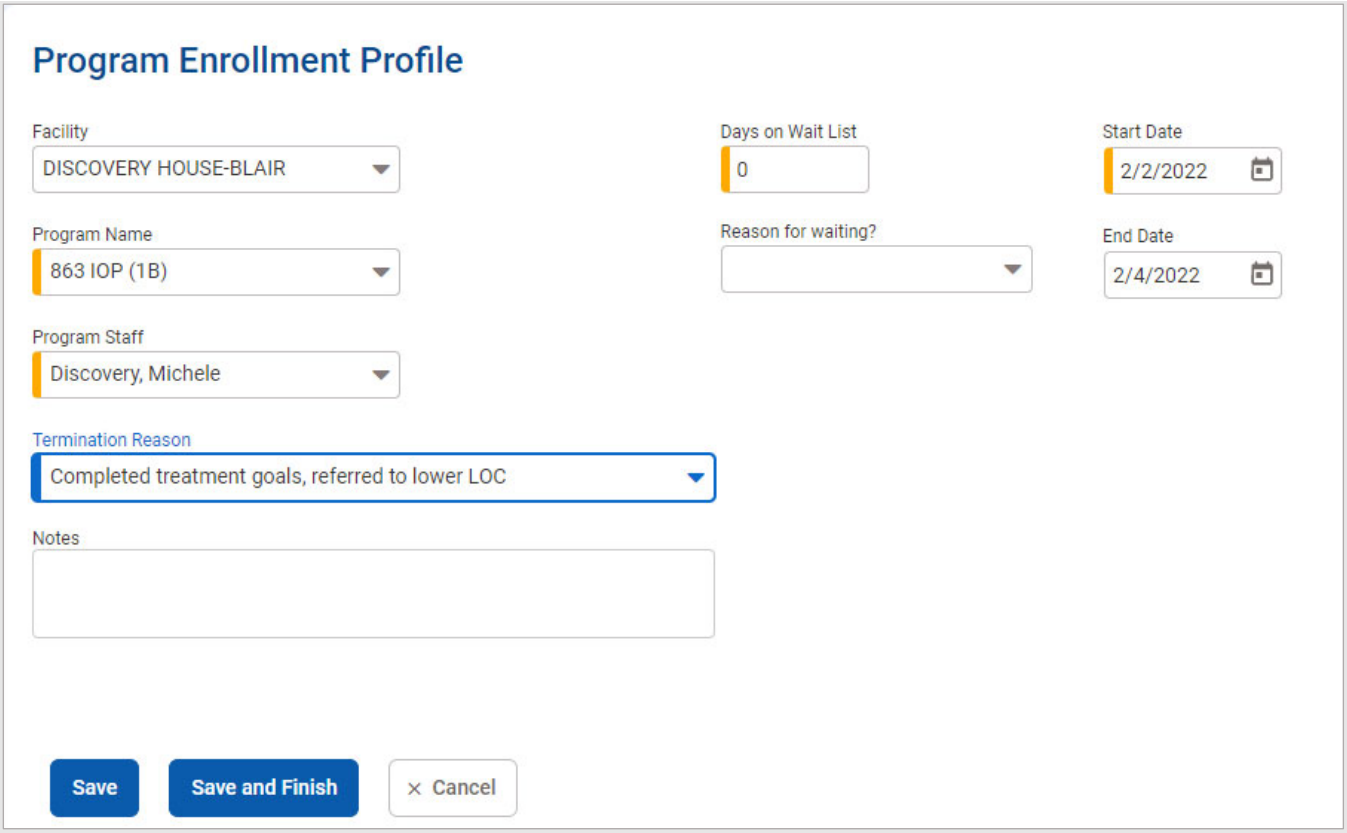
3. Click **"Save"** and then the **"Next>"** button.
4. On the **Diagnosis** screen, you only need to update information if the **Diagnosis** has changed. If no changes are needed, click the **"Next>"** button.

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

5. **Hover** over the ellipsis of the current program. Click **"Review".**



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



8. Click **"Save and Finish".**

Next you will complete the enrollment into the new **Level of Care**.

NOTE: This will not be done if completing a **Final Outcome Measure**.

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

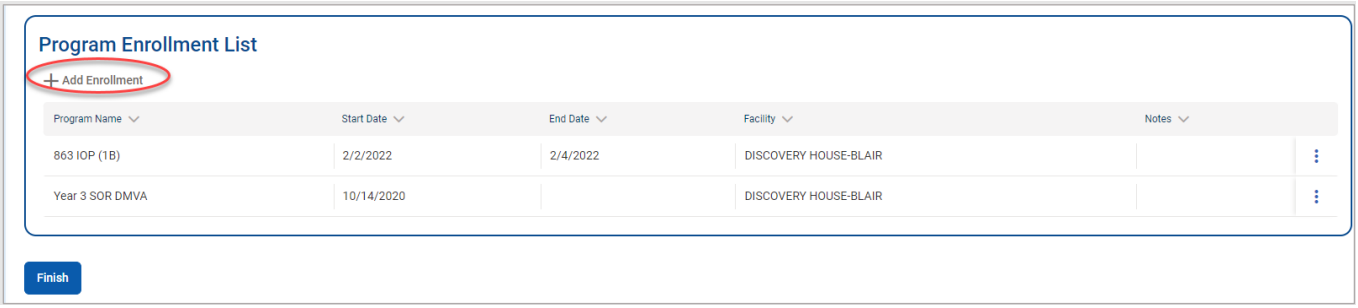


Figure 3-48: Outcome Measures – Program Enrollment screen

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

Table 3-12: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the currently Facility name.
Program Name	Select from the programs available.
Program Staff	Pre-populates with the current staff member name.
Start Date	Pre-populates with the Outcome Measure date.
Days on Wait List	
Reason for waiting?	If the client had to wait longer than two weeks to access the recommended level of care, select the reason from the drop-down list. This field will be required if: The program enrollment start date is more than 14 days from the most recent ASAM date. The LOC associated with the program is different than the Recommended LOC of the most recent ASAM (consented or client activity).
Notes	Type any notes as needed.

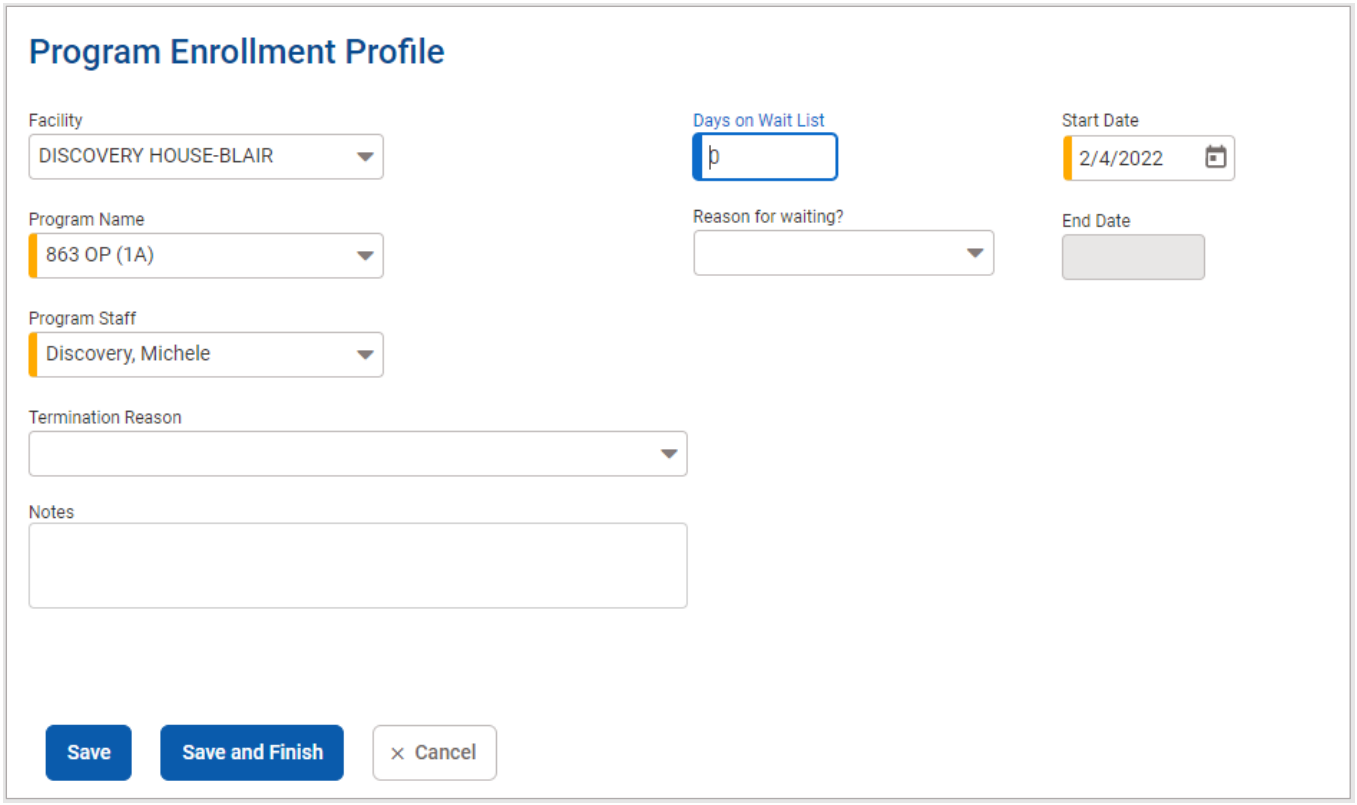


Figure 3-49: Program Enrollment Profile screen

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

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

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

Consent

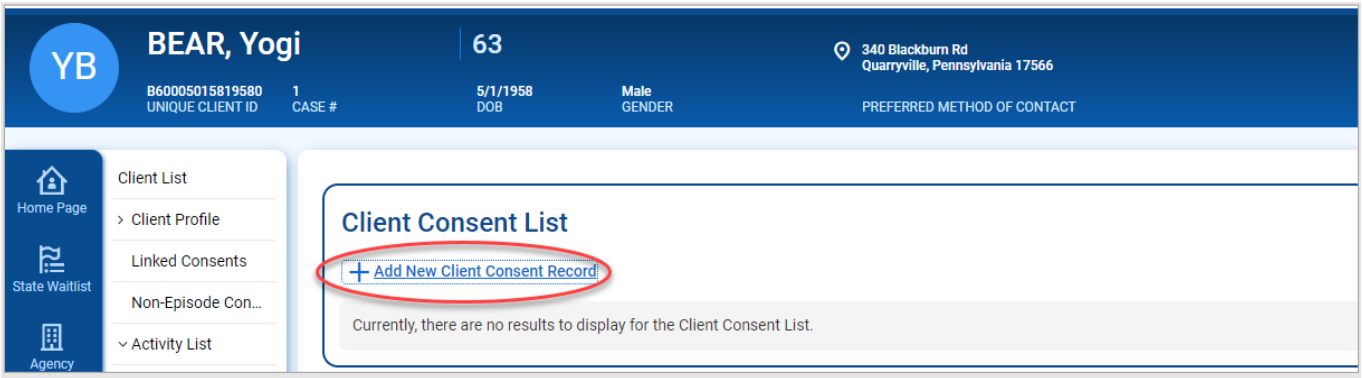
Create Client Consent Record

Where: Client List > Activity List > Consent

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

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

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



5. Select **"No".**

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

Table 3-13: Client Disclosure Agreement fields

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

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

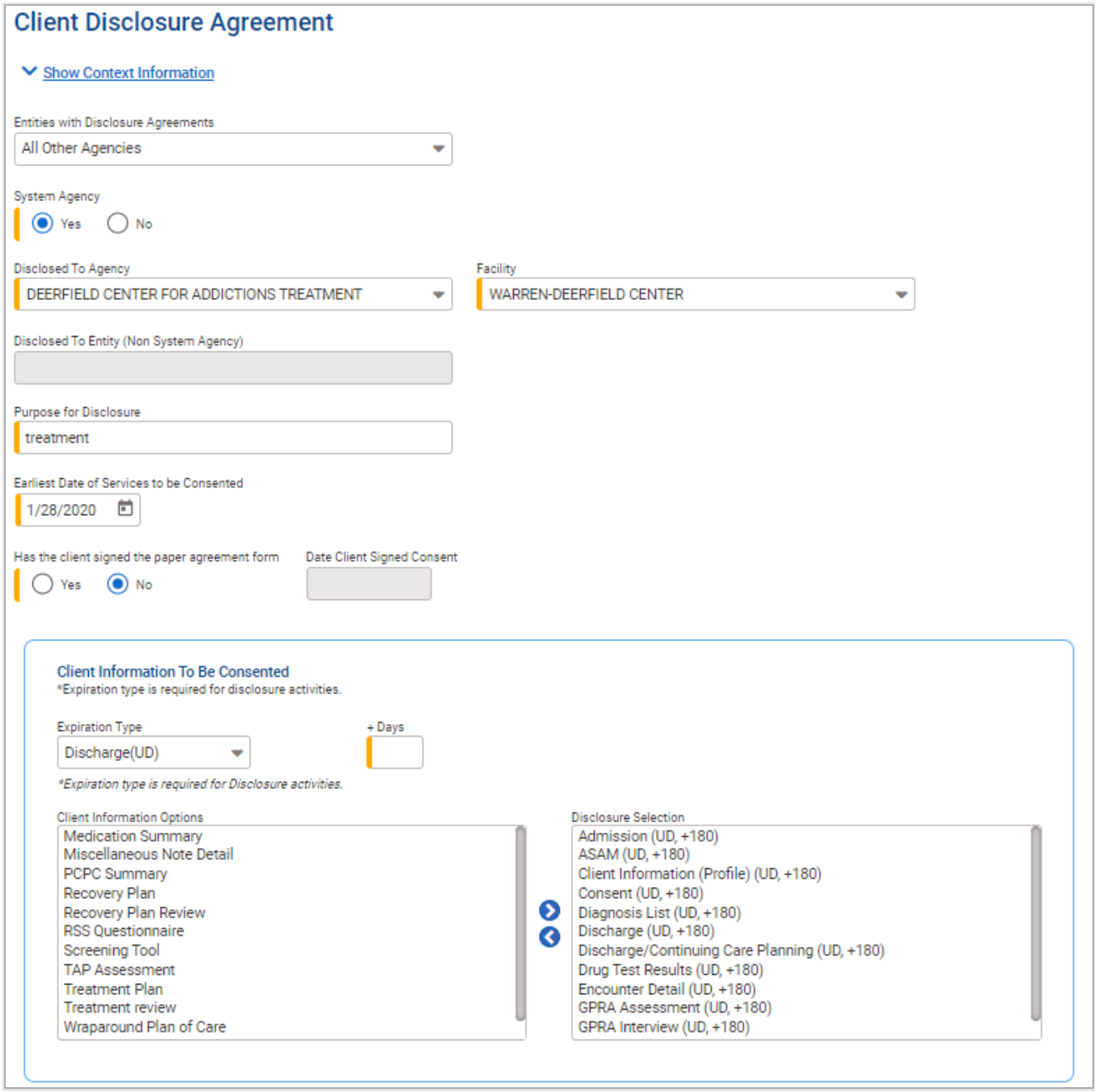


Figure 3-50: Client Disclosure Agreement screen

7. If additional consent information needs to be added or removed from the client's disclosure agreement, update the options from the **Client Information to Be Consented** section. Your **Agency Administrator** may have set up templates for the disclosure agreement.

Table 3-14: Client Information To Be Consented fields

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

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

8. When all required fields are complete, click **"Save".**

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

Print the Client Consent Form

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

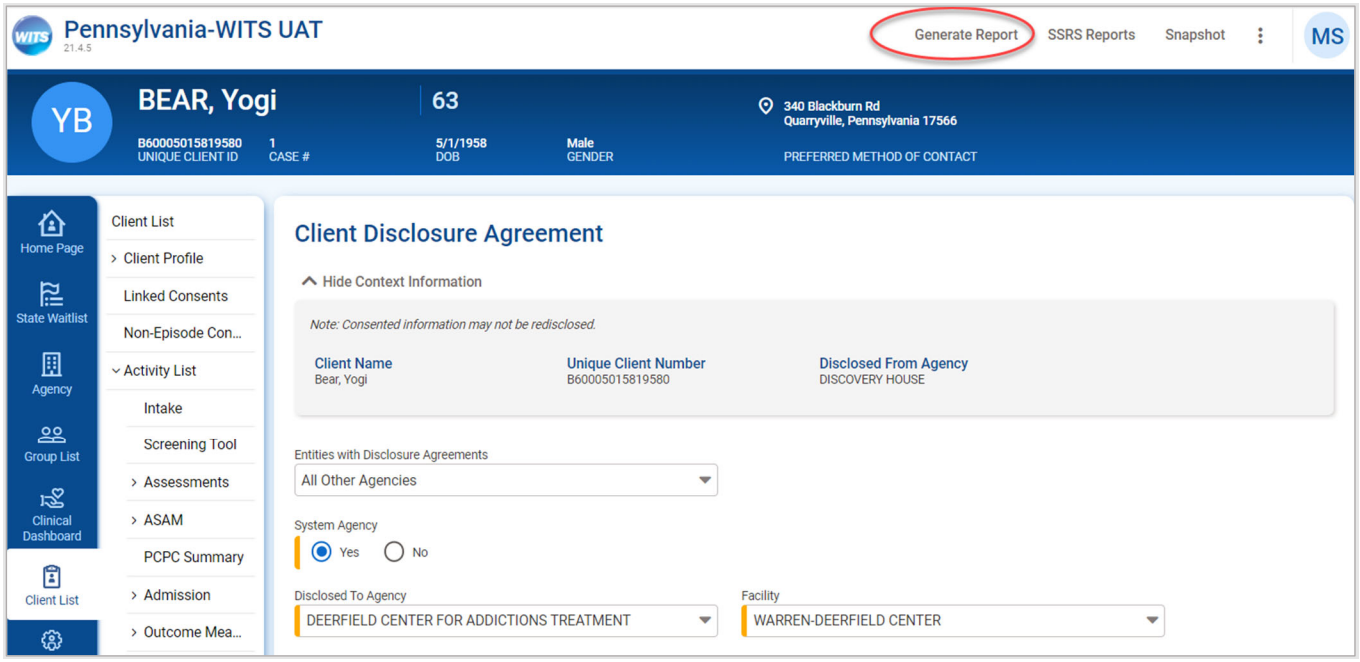


Figure 3-51: Client Disclosure Agreement screen, Generate Report

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

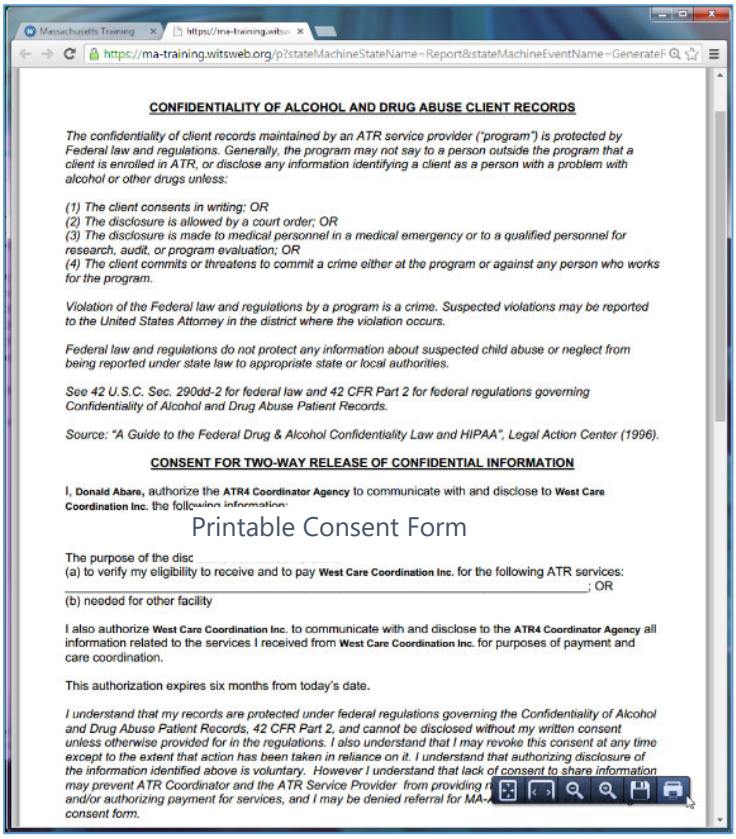
    Has client signed the paper agreement form: select **"Yes"**

    Date client signed consent: defaults to current date

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

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

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



CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS

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

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

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

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

See 42 U.S.C. Sec. 290dd-2 for federal law and 42 CFR Part 2 for federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records.

Source: "A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA", Legal Action Center (1996).

CONSENT FOR TWO-WAY RELEASE OF CONFIDENTIAL INFORMATION

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

Printable Consent Form

The purpose of the disc
(a) to verify my eligibility to receive and to pay **West Care Coordination Inc.** for the following ATR services:
; OR
(b) needed for other facility

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

This authorization expires six months from today's date.

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

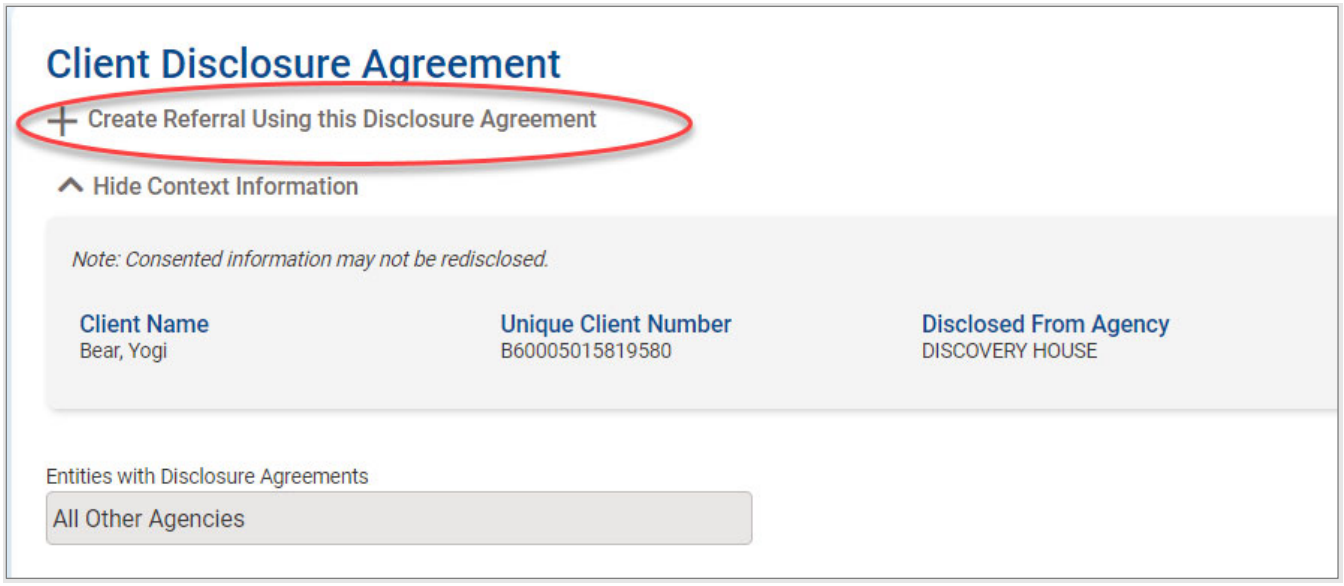


Figure 3-52: Create Referral Using this Disclosure Agreement link

Referrals

Create a Client Referral

Where: Client List > Activity List > Referrals

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

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

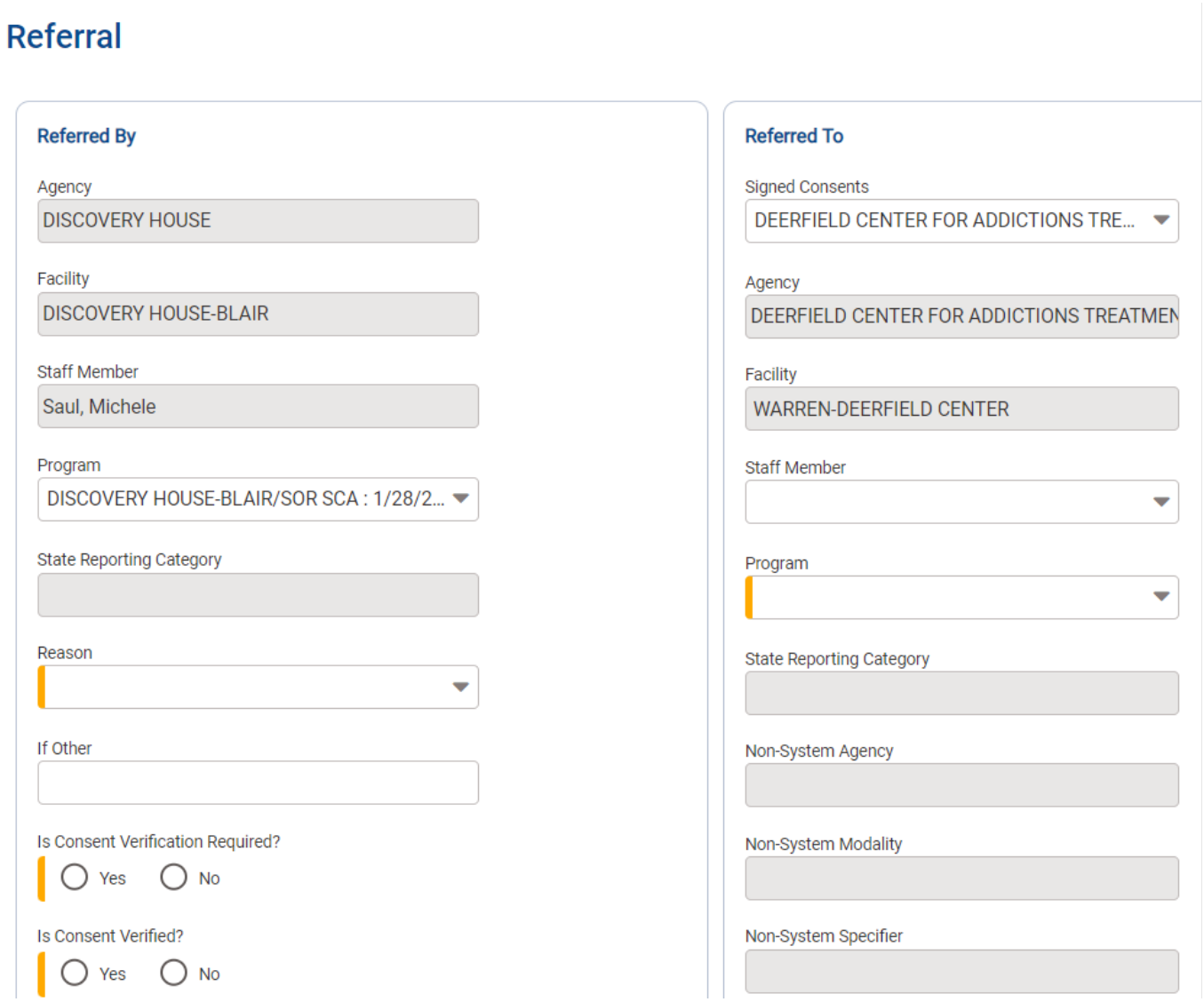


Figure 3-53: Referral screen

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

Table 3-15: Referred By fields

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

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

Table 3-16: Referred To fields

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

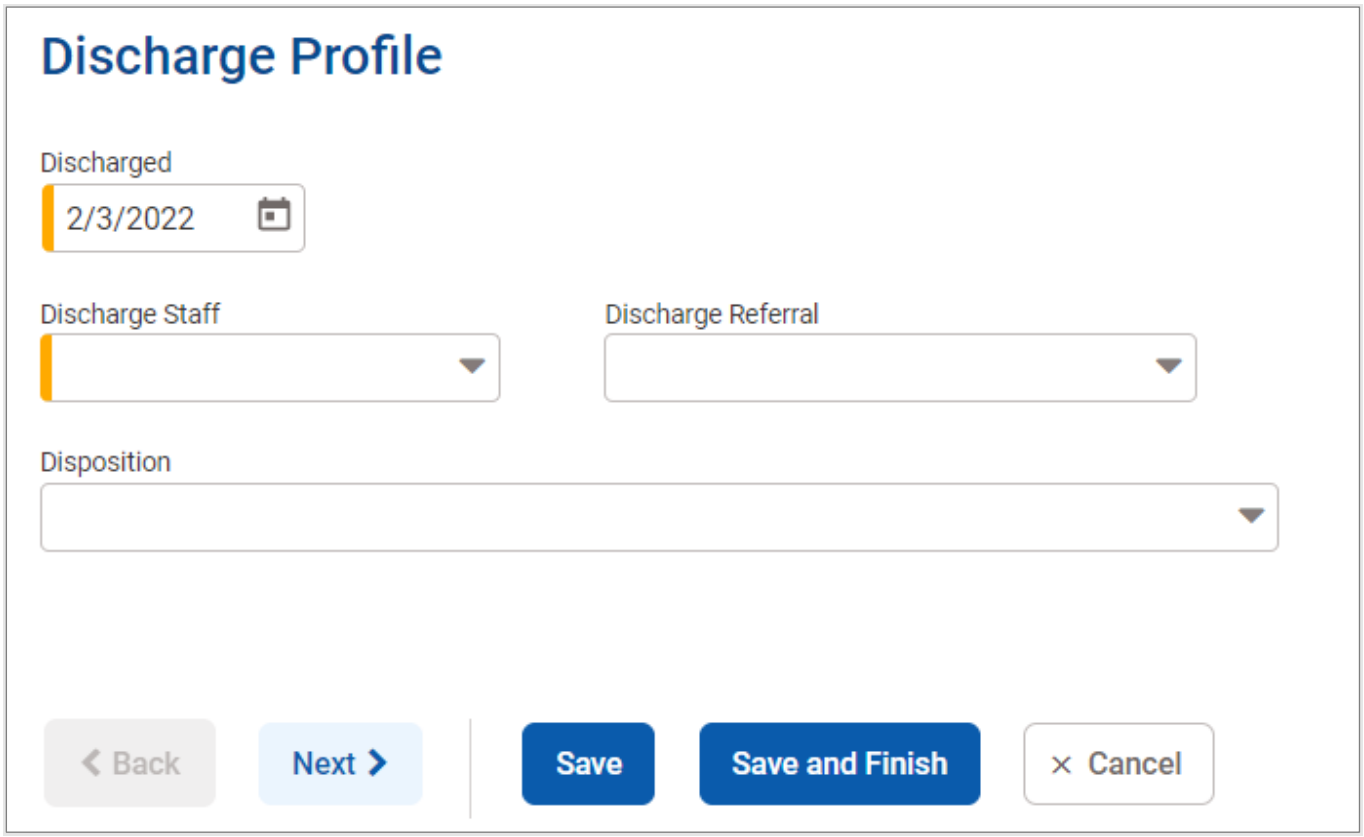
17. When complete, click **"Save and Finish"**.

Client Discharge

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

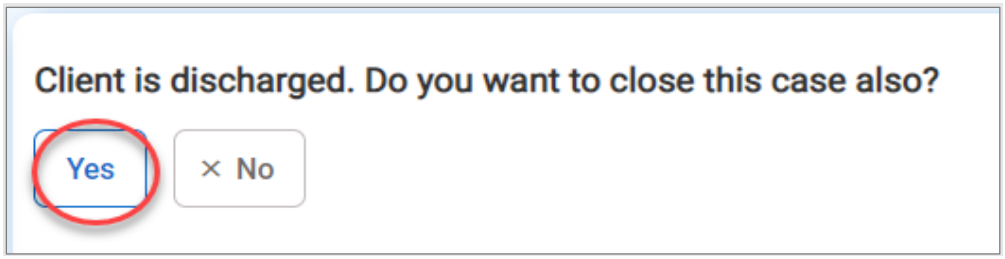
NOTE: You can **"ReOpen"** a case if your account permissions include the **"Case ReOpen"** role. Contact your **Staff Administrator** to have the role added to your account if necessary.

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

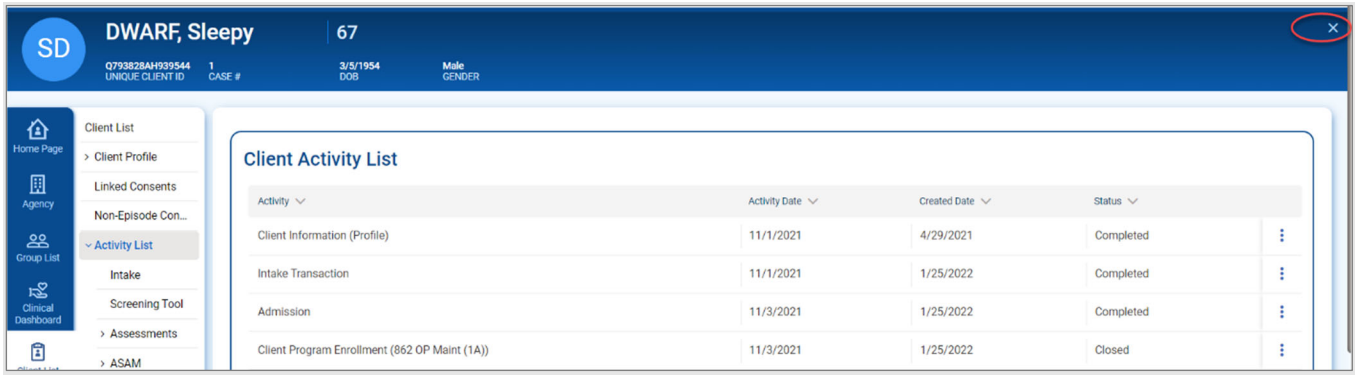


NOTE: There are additional screens that can be completed if the client is an adolescent. These screens are not required by DDAP but may be used if your agency chooses to.

5. A prompt message to close the case will appear. Click **"Yes".**



6. In the upper right corner of the blue client name banner, click on the small " **x** " to close the client profile.



Part 4: Case Management/Treatment Planning

Program Enroll (Case Management or Non-TEDS Program)

Where: Client List > Activity List > Program Enroll

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

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

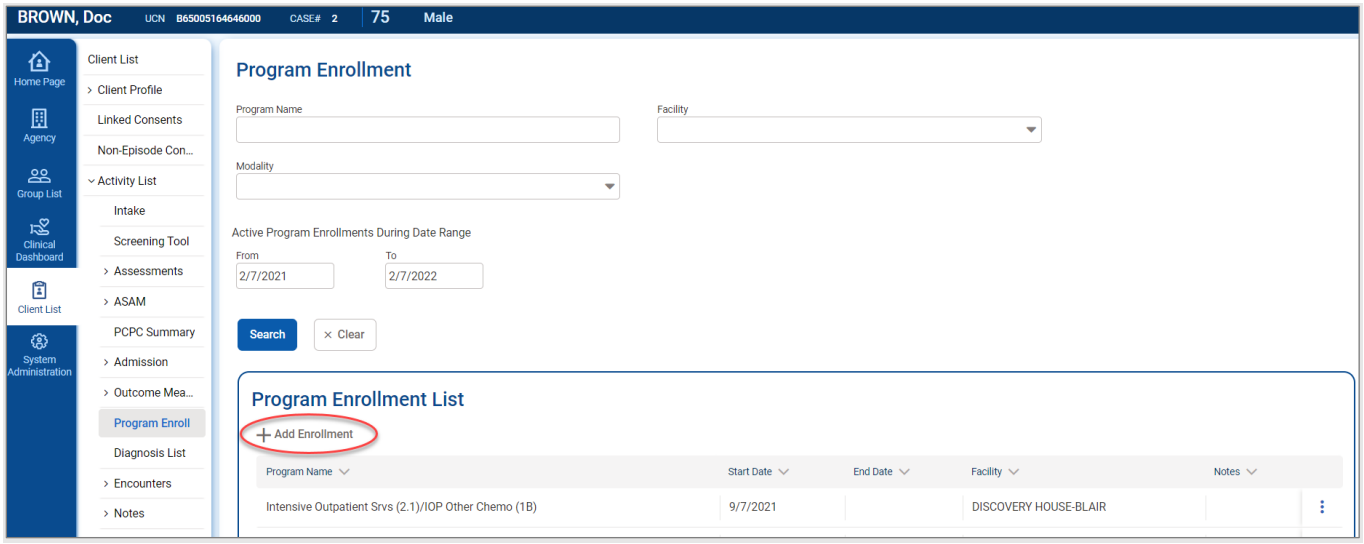


Figure 4-1: Program Enrollment screen

5. Complete fields on the **Program Enrollment Profile**.

Table 4-1: Program Enrollment Profile fields

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

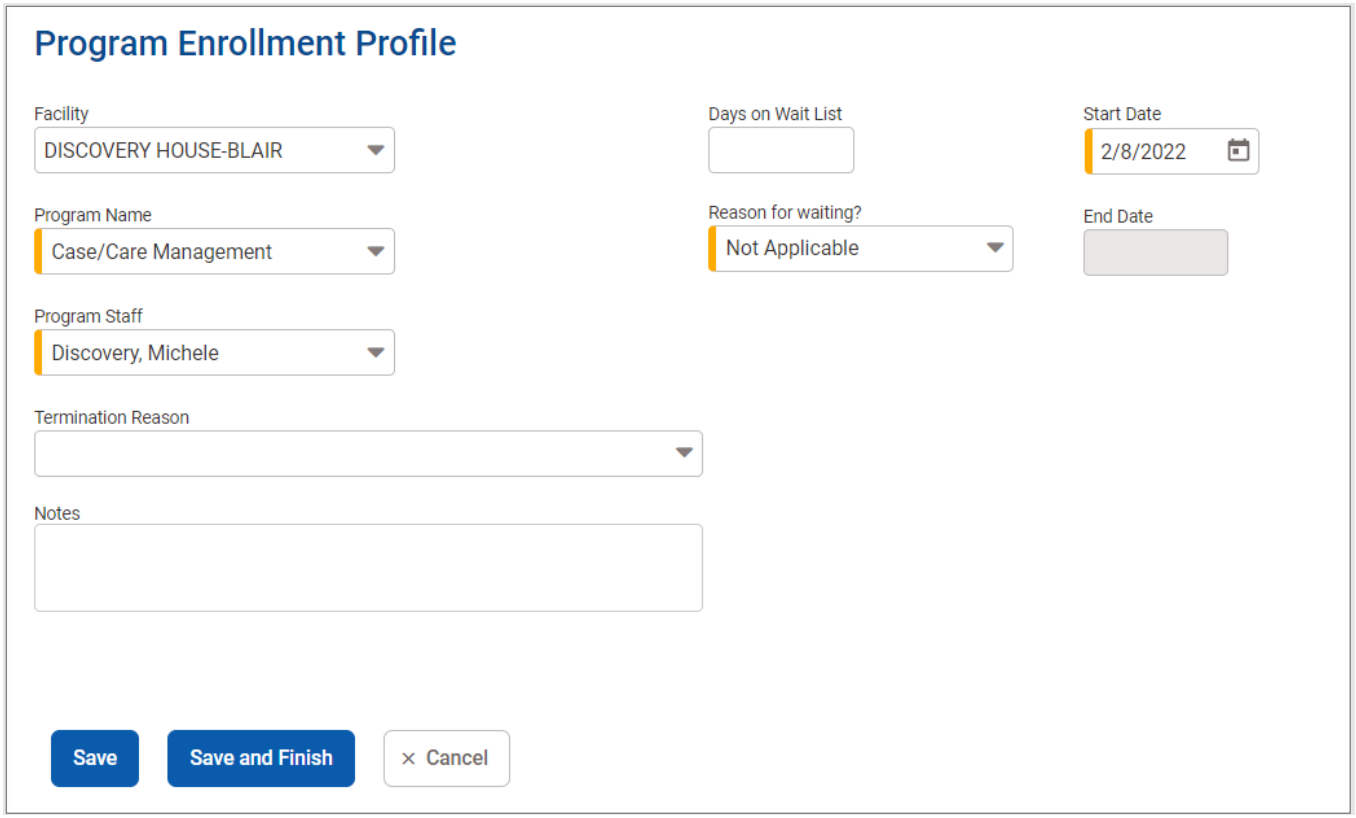
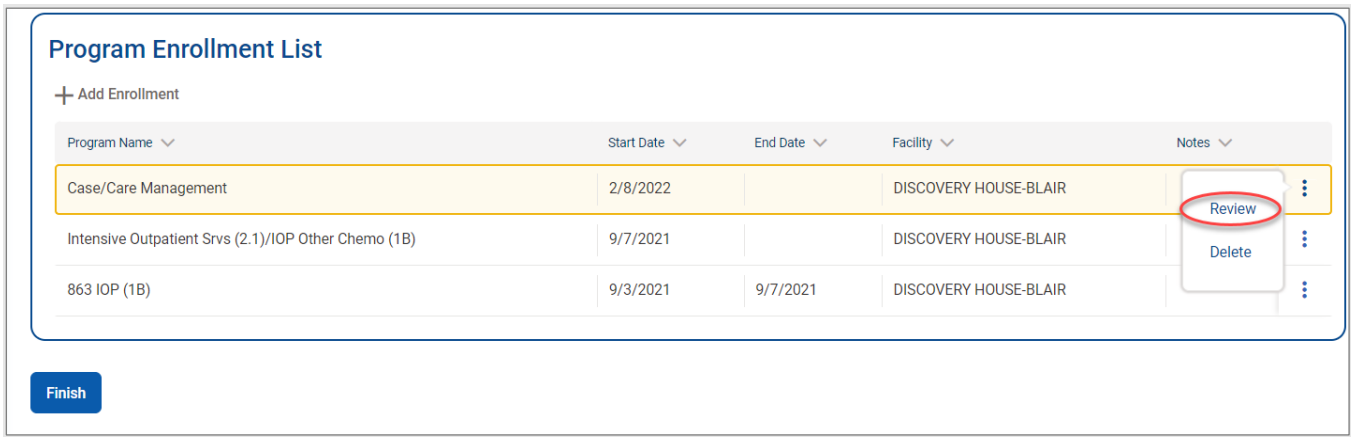


Figure 4-2: Program Enrollment Profile screen

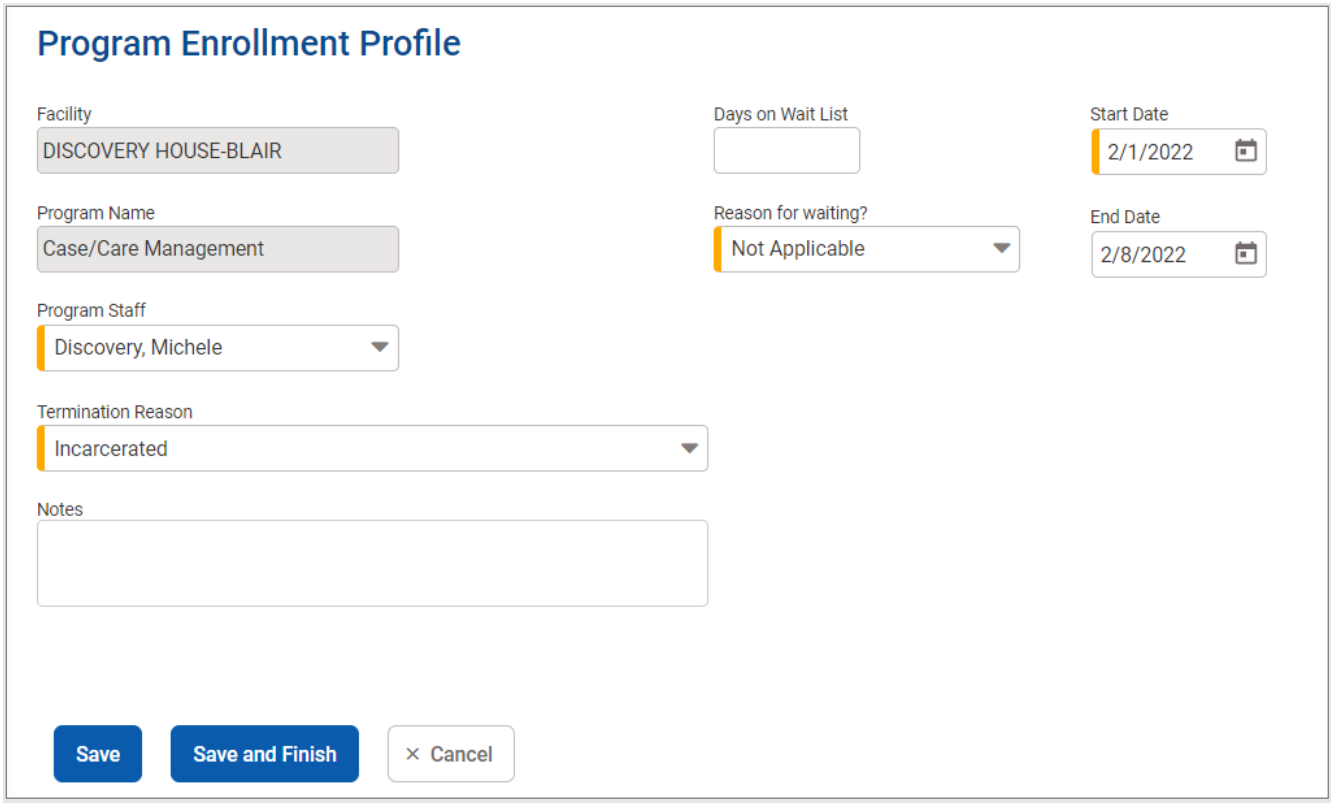
6. Click **"Save and Finish".**
7. On the Program Enrollment screen, click **"Finish".**

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

8. Hover over the ellipsis of the current program. Click **"Review".**



9. Enter the **End Date** (the date of discharge from the program) and the **Outcome Measure Date** that was entered on the **Client Status** screen. This date should not be confused with the **Date of Last Contact**.
10. Select the **"Termination Reason".**



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

Recovery Plan

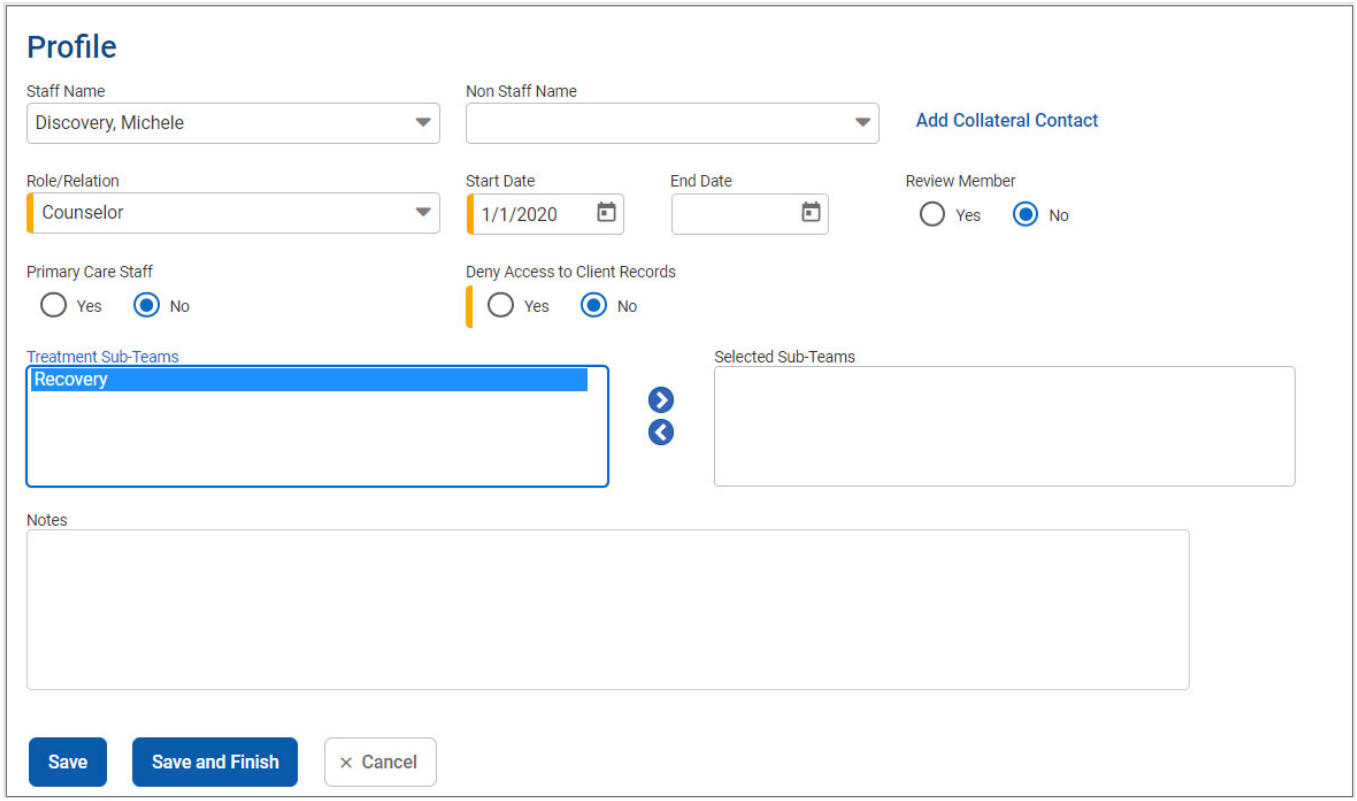
Where: Client List > Activity List > Recovery Plan

Role(s) Needed: **Recovery Plan (Full Access)** or **Recovery Plan (Read Only)** role

Add Recovery Team Members

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

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



4. Click **"Save and Finish".**

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

New Recovery Plan Profile

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

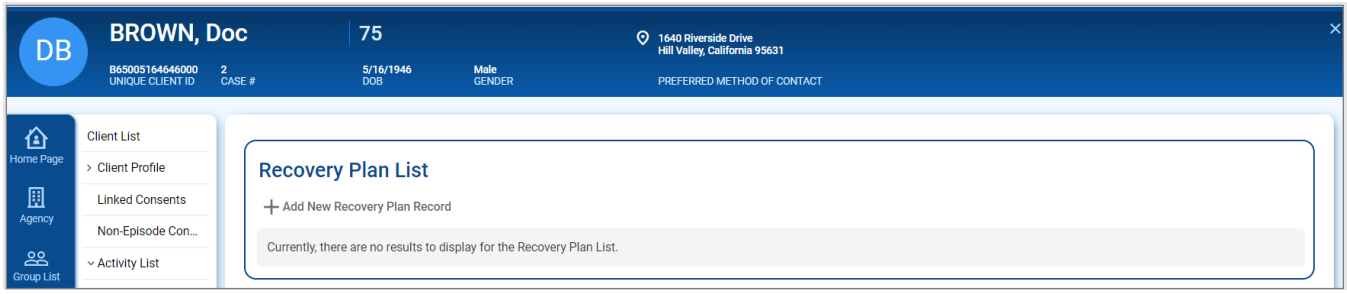
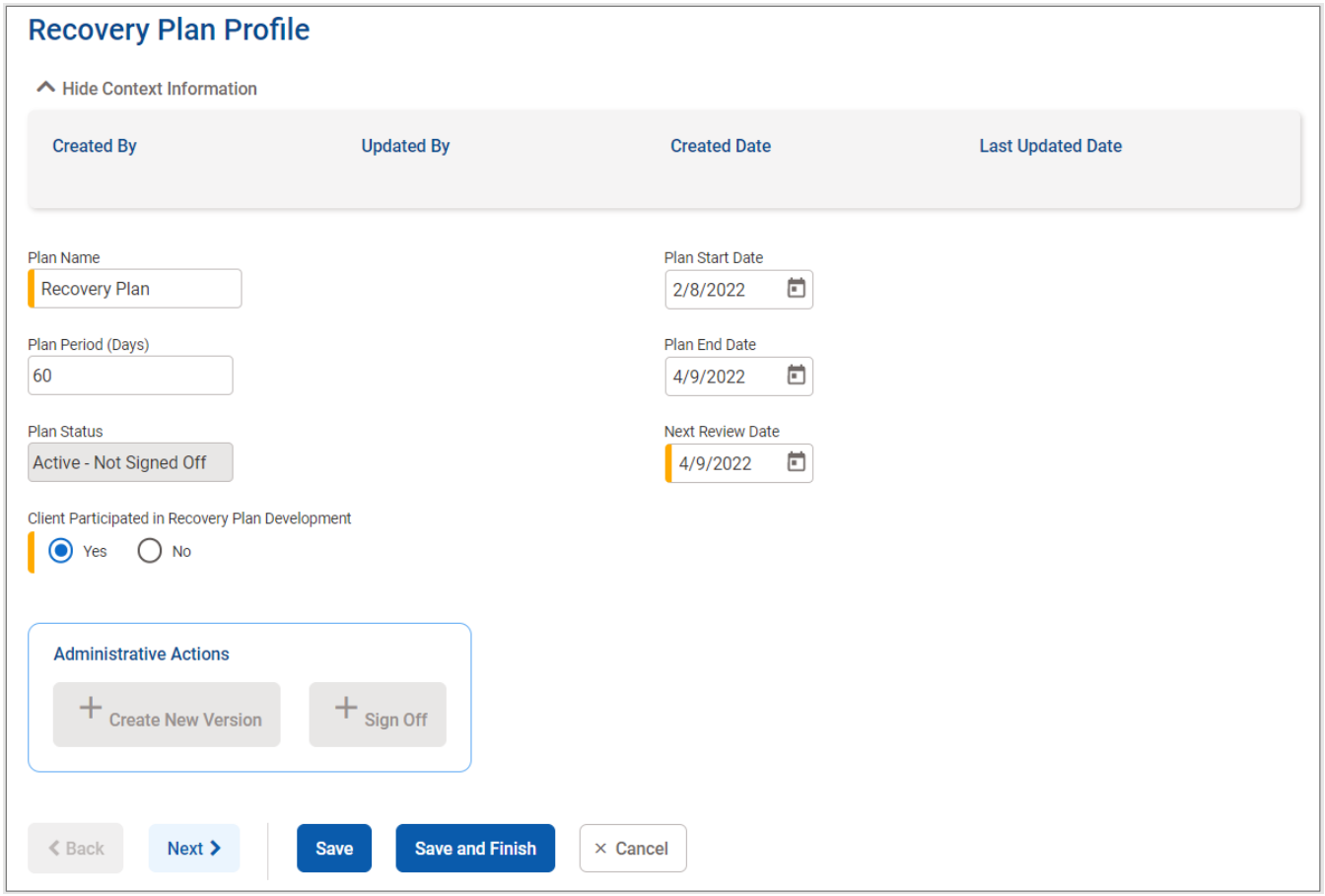


Figure 4-9: Recovery Plan List screen

5. Complete the **Recovery Plan Profile** fields.

Table 4-2: Recovery Plan Profile fields

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

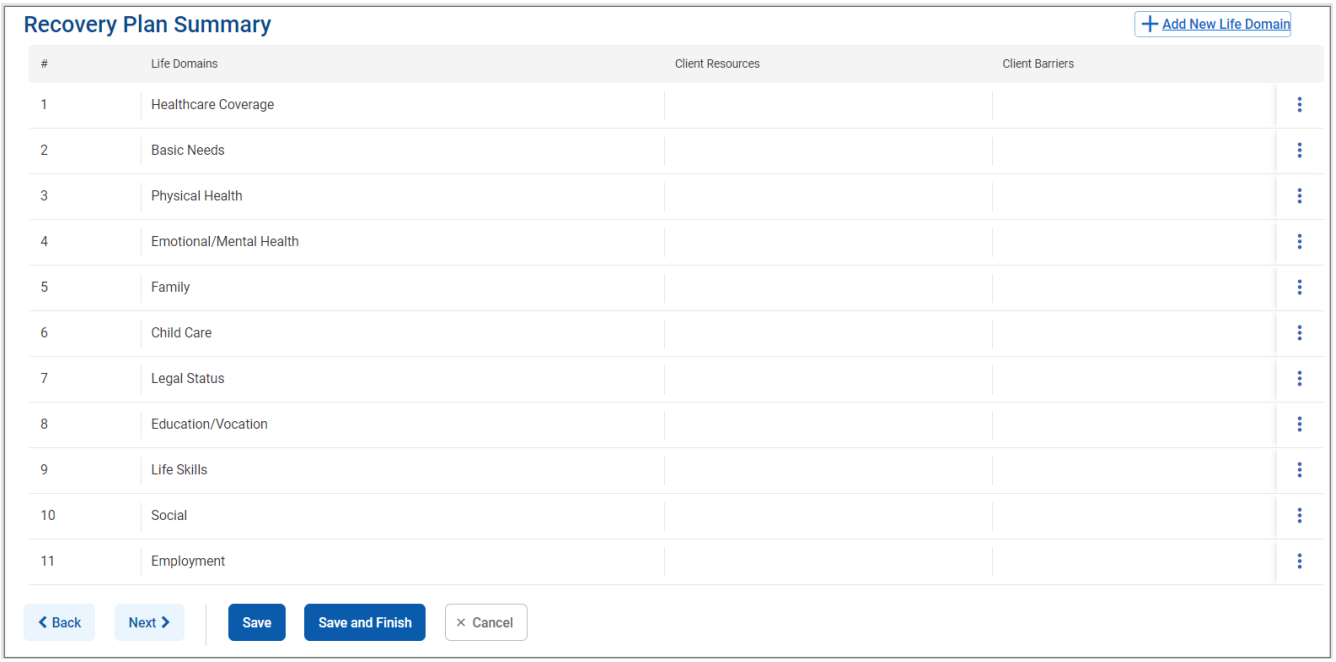


NOTE: If you change the **Start Date**, the remaining dates do not auto-calculate based on this change. You will need to manually change the **End Date** and **Next Review Date**, as well.

6. Click **"Save".**
7. Click the **"Next>"** button.

Life Domains/Goals

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



9. Hover over the ellipsis and click **"Review".**

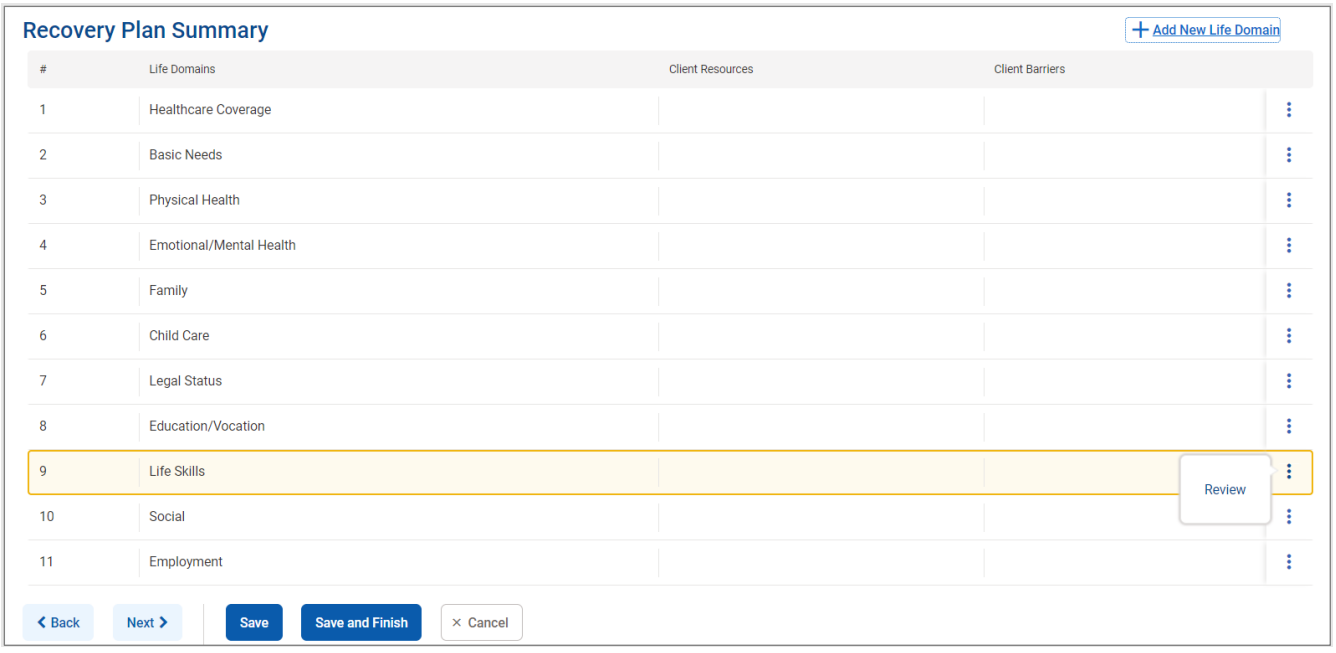


Figure 4-13: Recovery Plan Summary screen, Life Domains

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

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

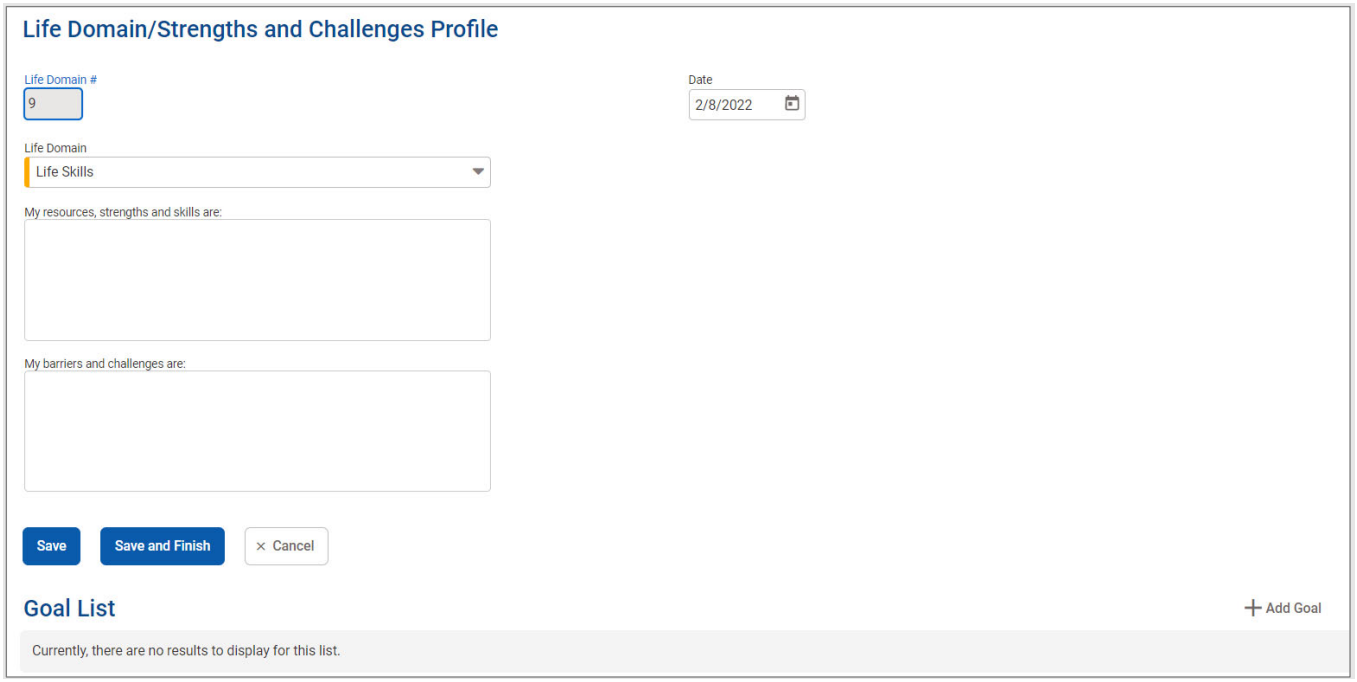


Figure 4-3: Life Domain/Strengths and Challenges Profile screen

11. Click **"Save".**

Add Goal

A **Goal** may have one or several **Objectives**.

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

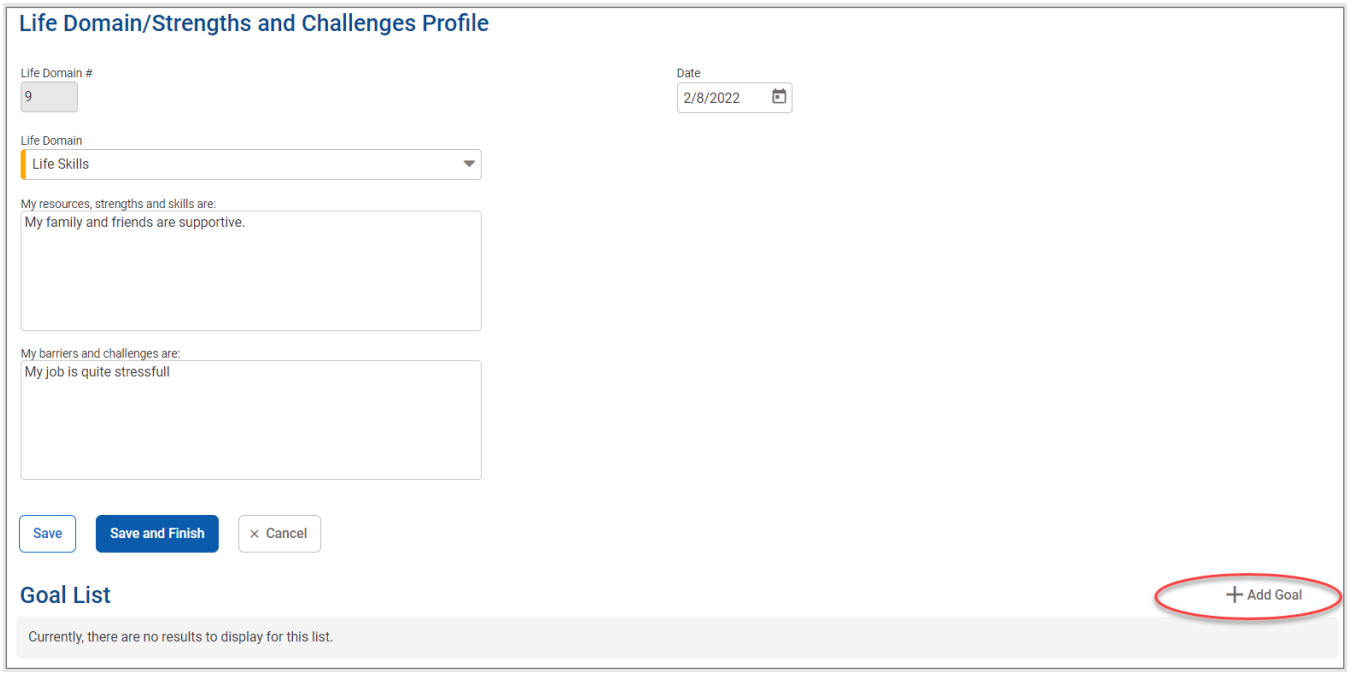
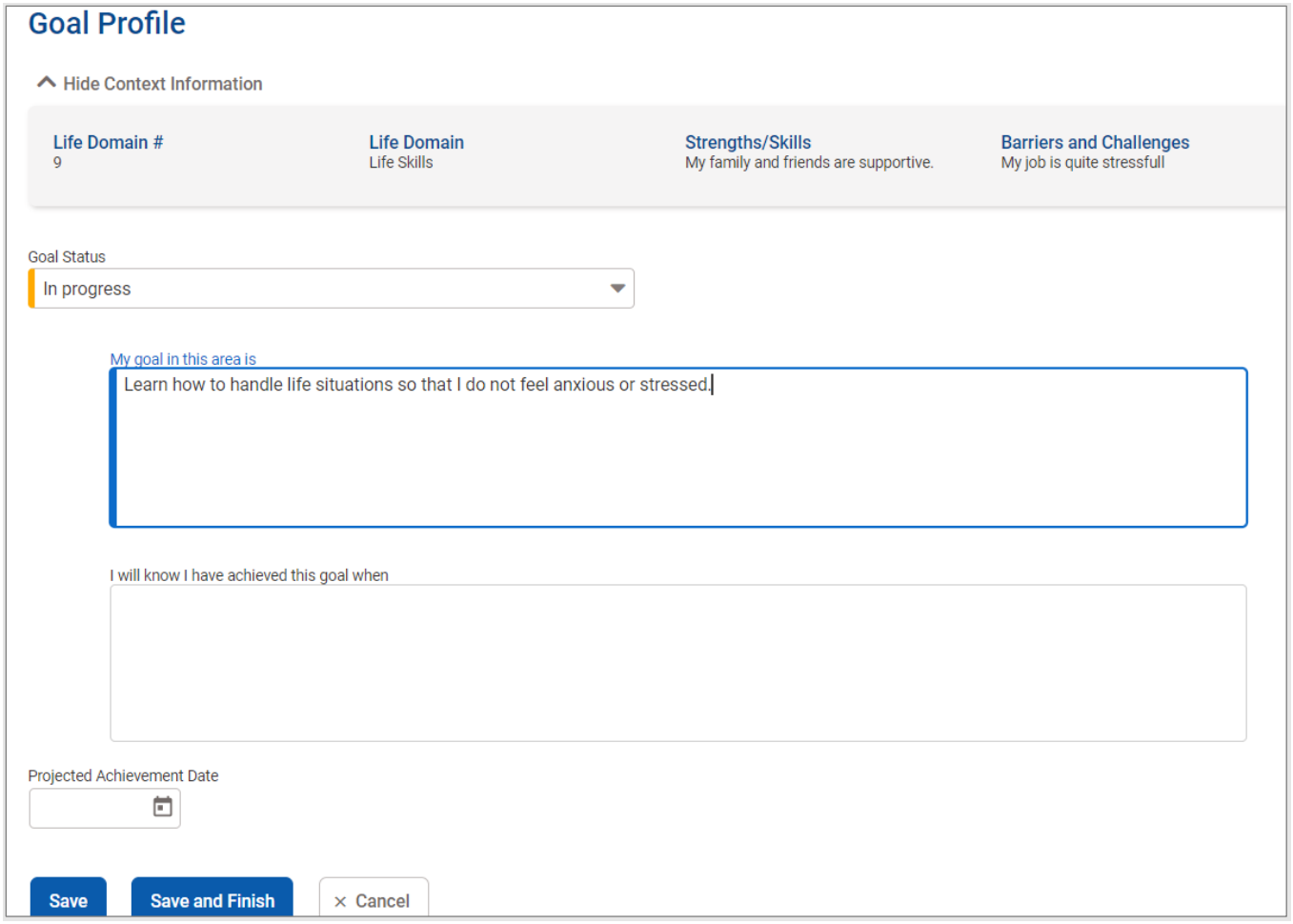


Figure 4-14: Life Domain/Strengths and Challenges Profile

13. Complete the fields on the **Goal Profile**.

Table 4-3: Goal Profile fields

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

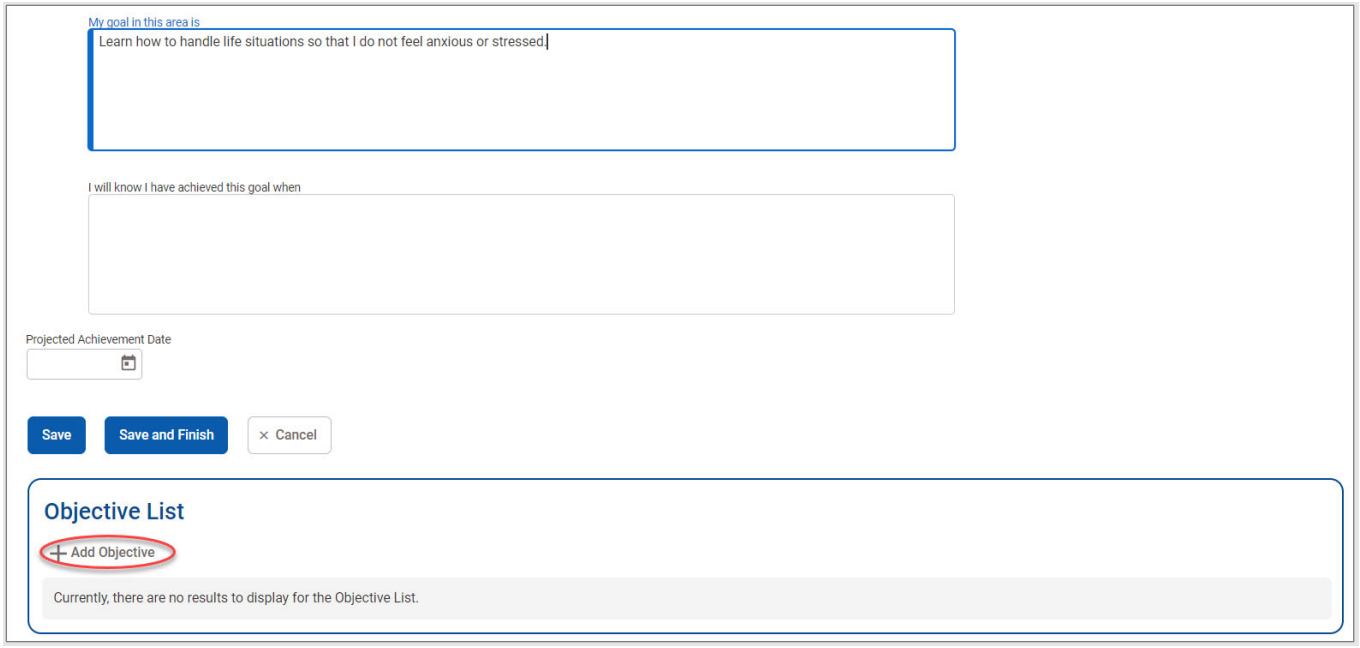


14. Click **"Save".**

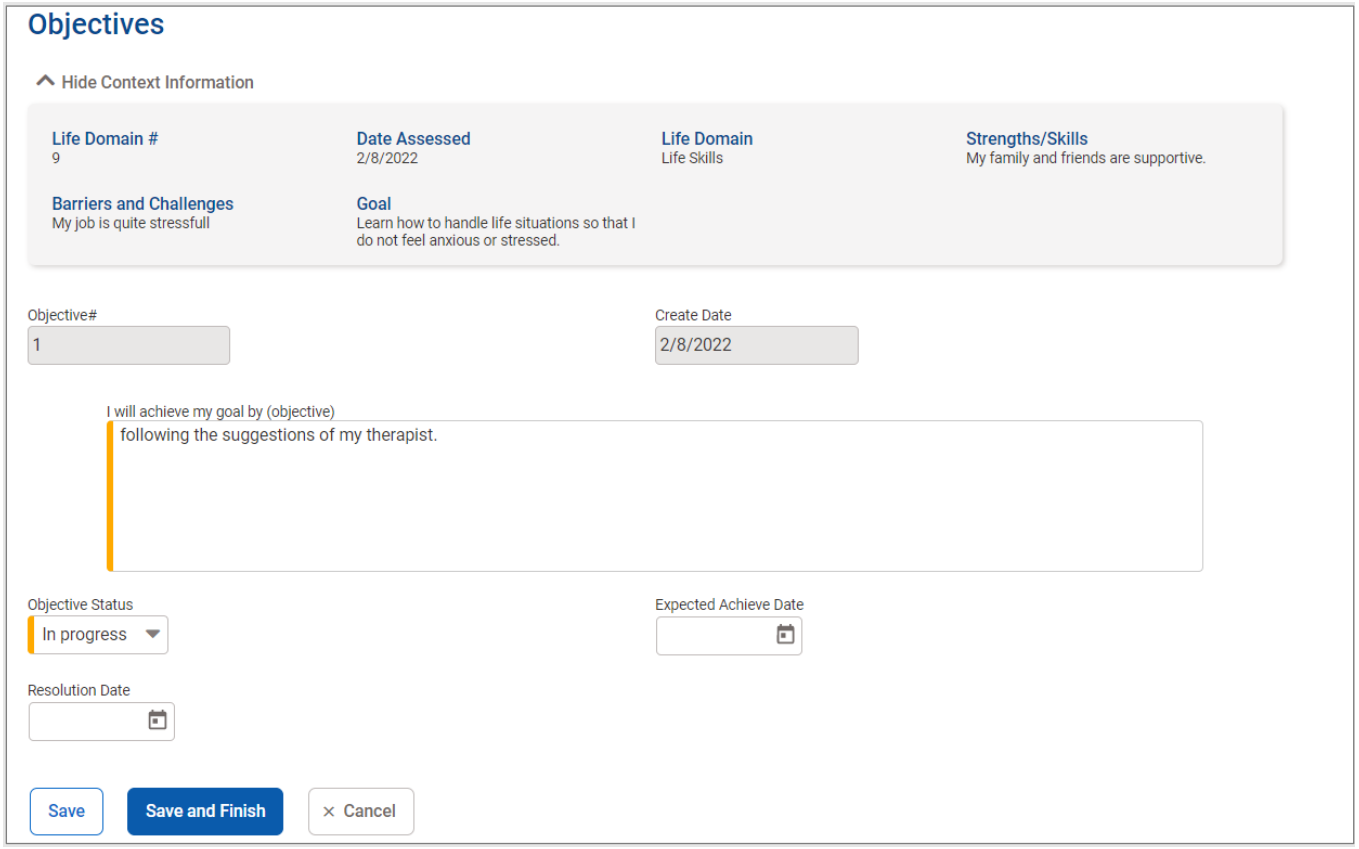
Add Objective

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

15. Click **"Add Objective".**



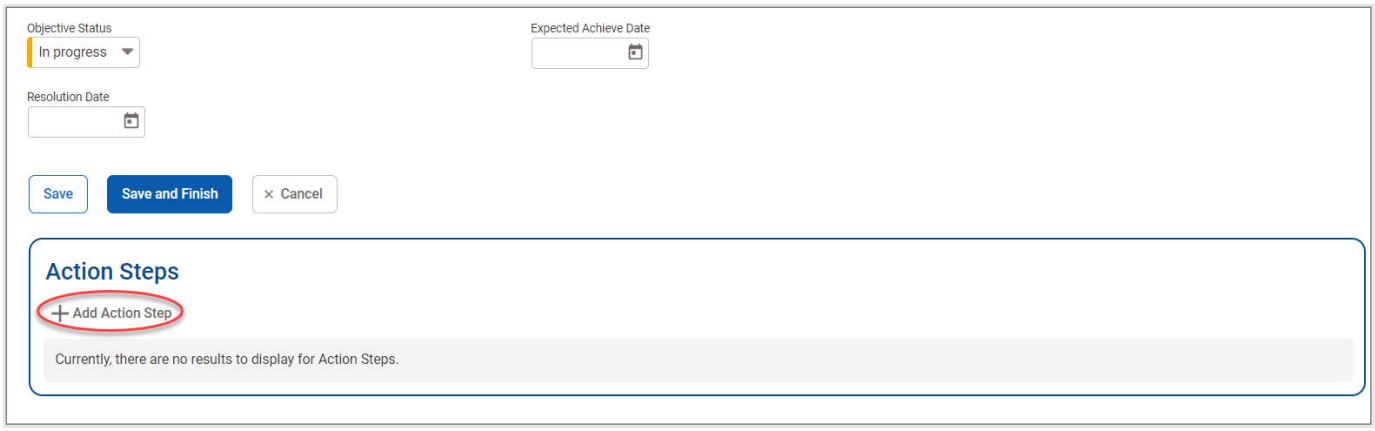
16. Complete the fields on the **Objectives** screen.



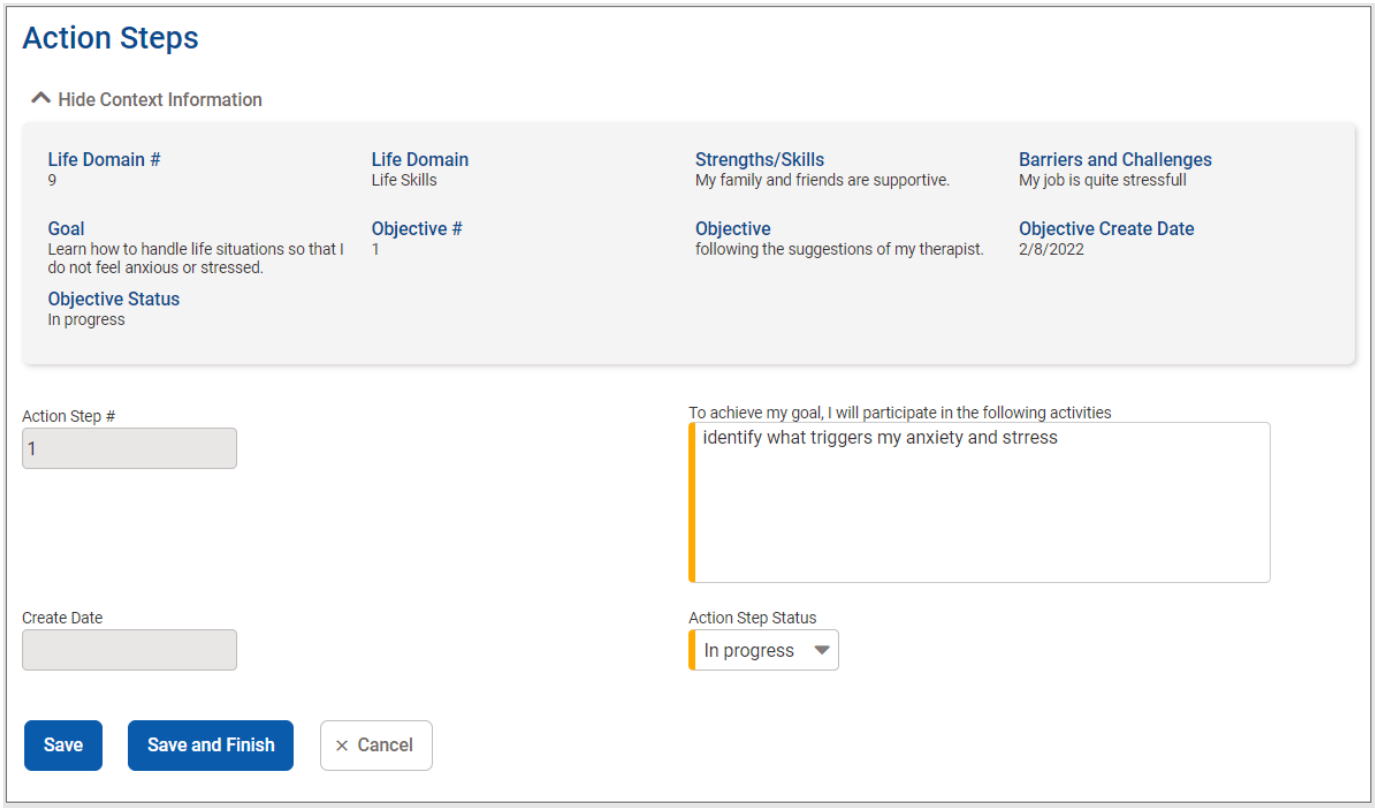
17. Click **"Save".**

Add Action Step

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

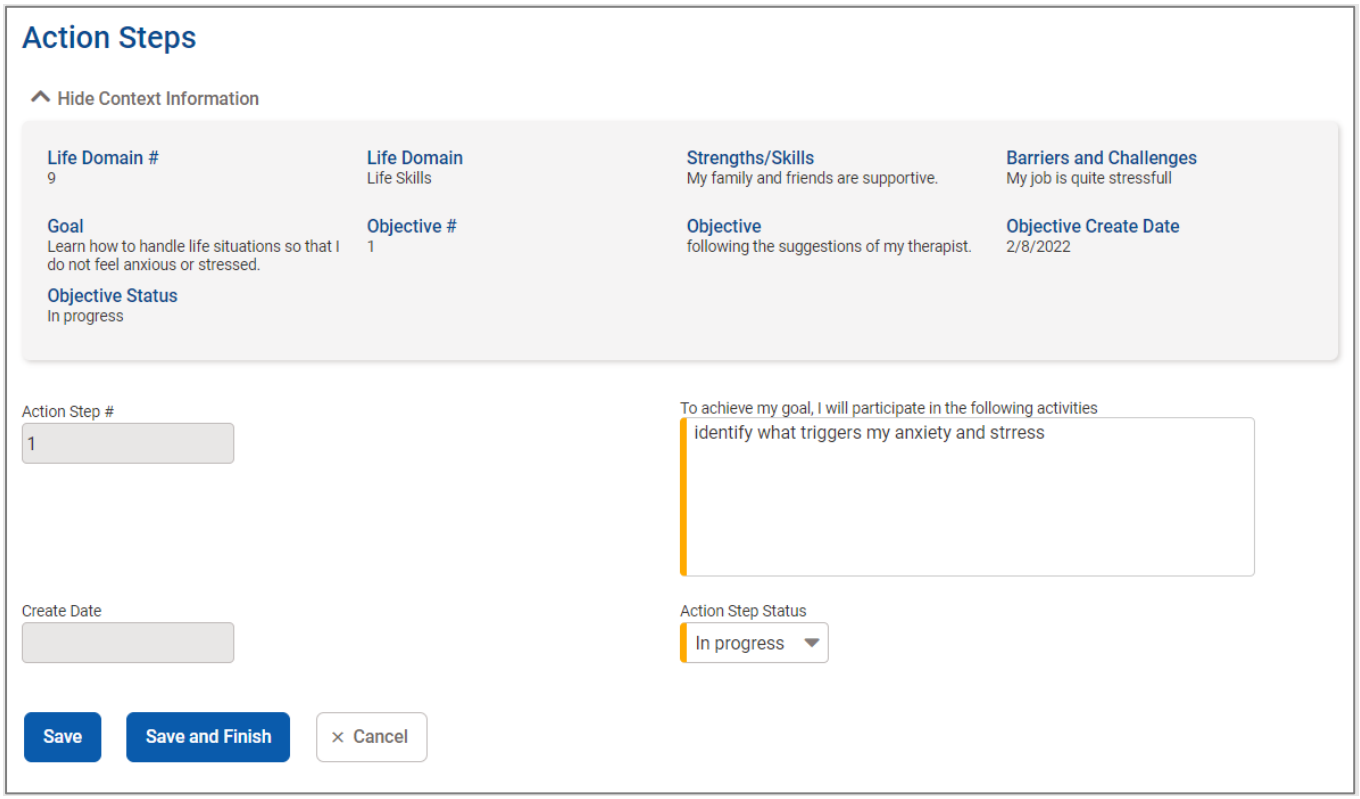


19. Complete the fields on the **Action Steps** screen.



20. Click **"Save and Finish".**

21. Add additional **Actions Steps** as needed.



22. Click **"Save and Finish".**

Plan Outline

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

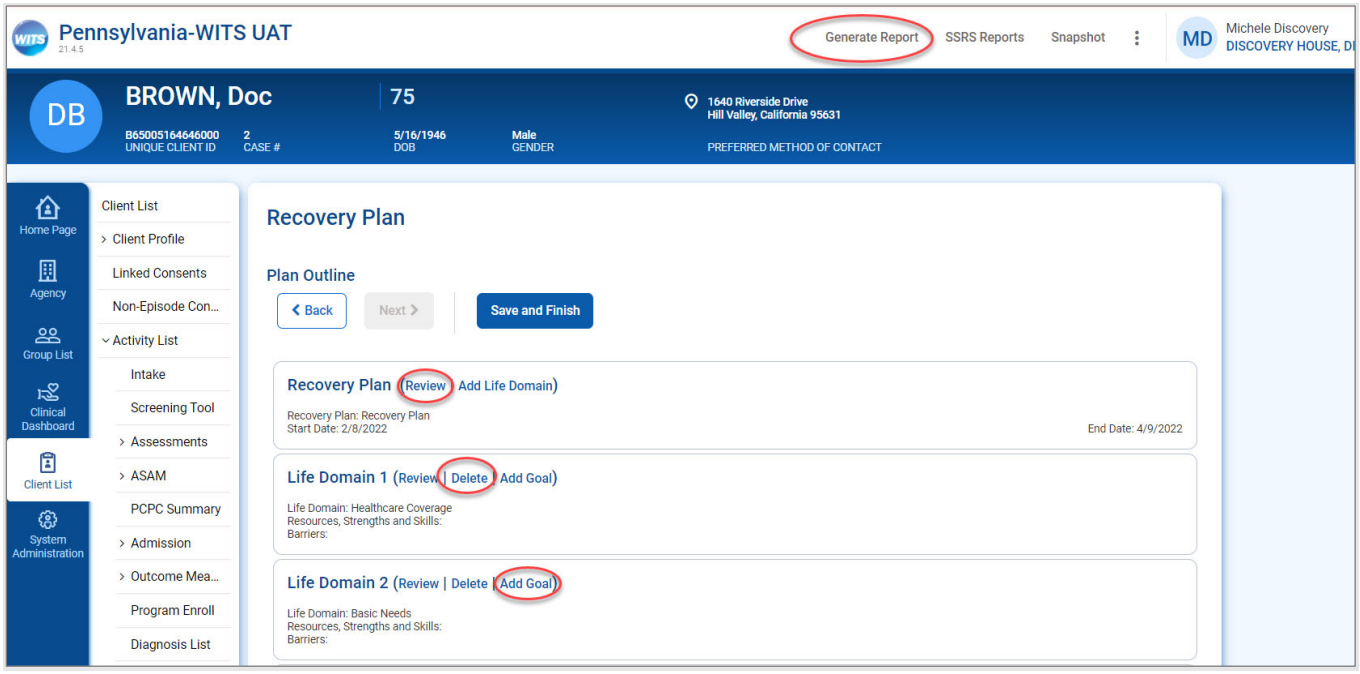
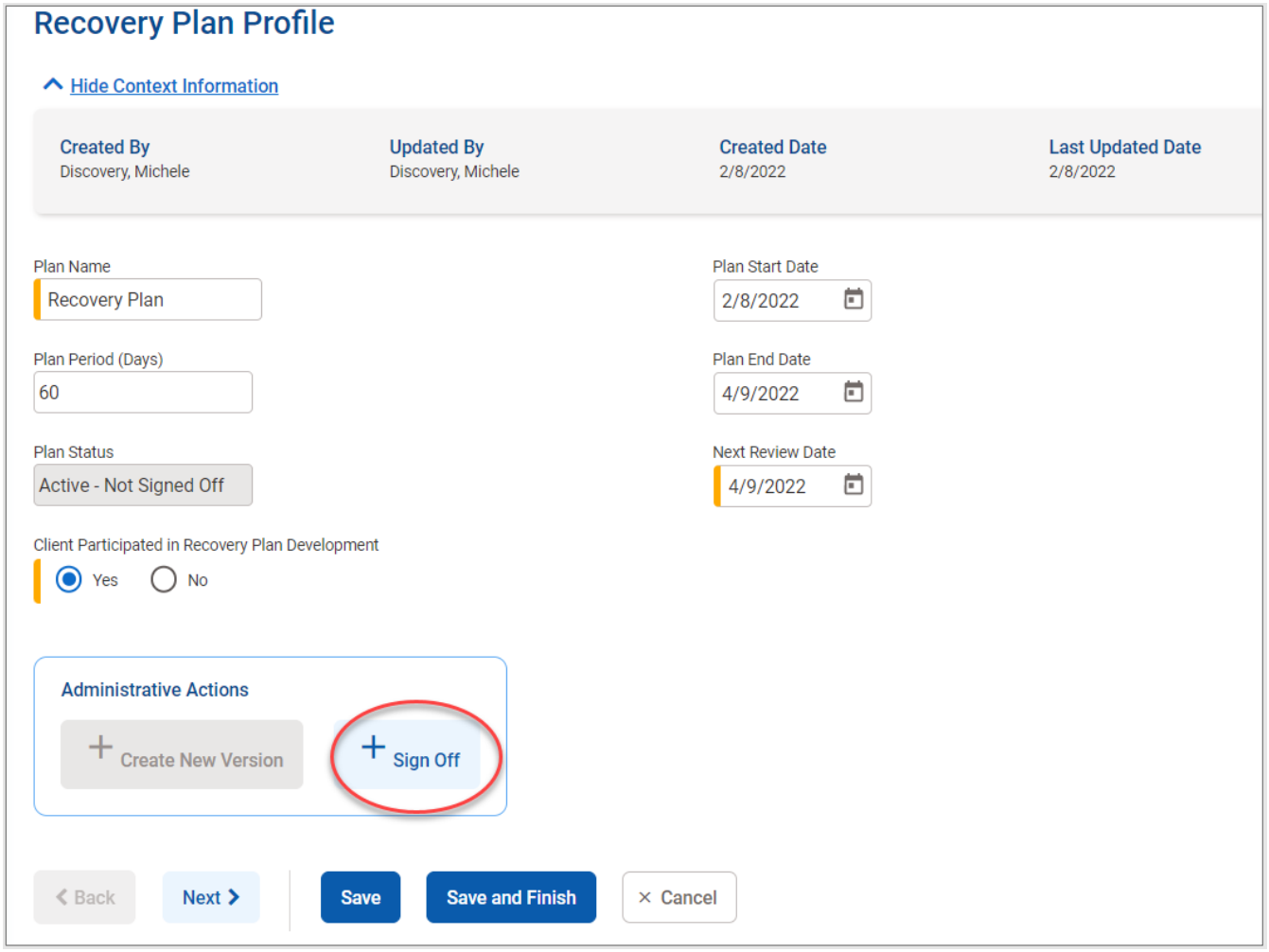


Figure 4-4: Plan Outline

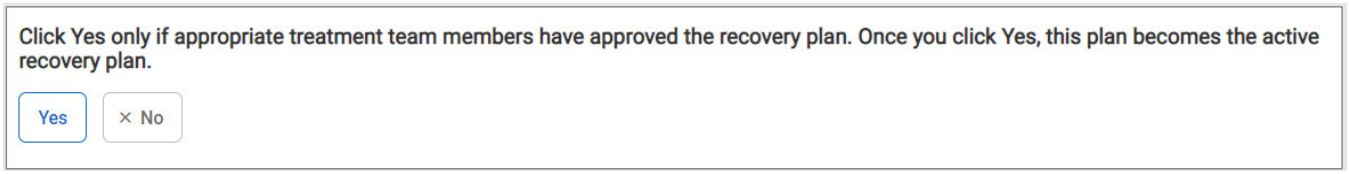
Sign Off

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

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

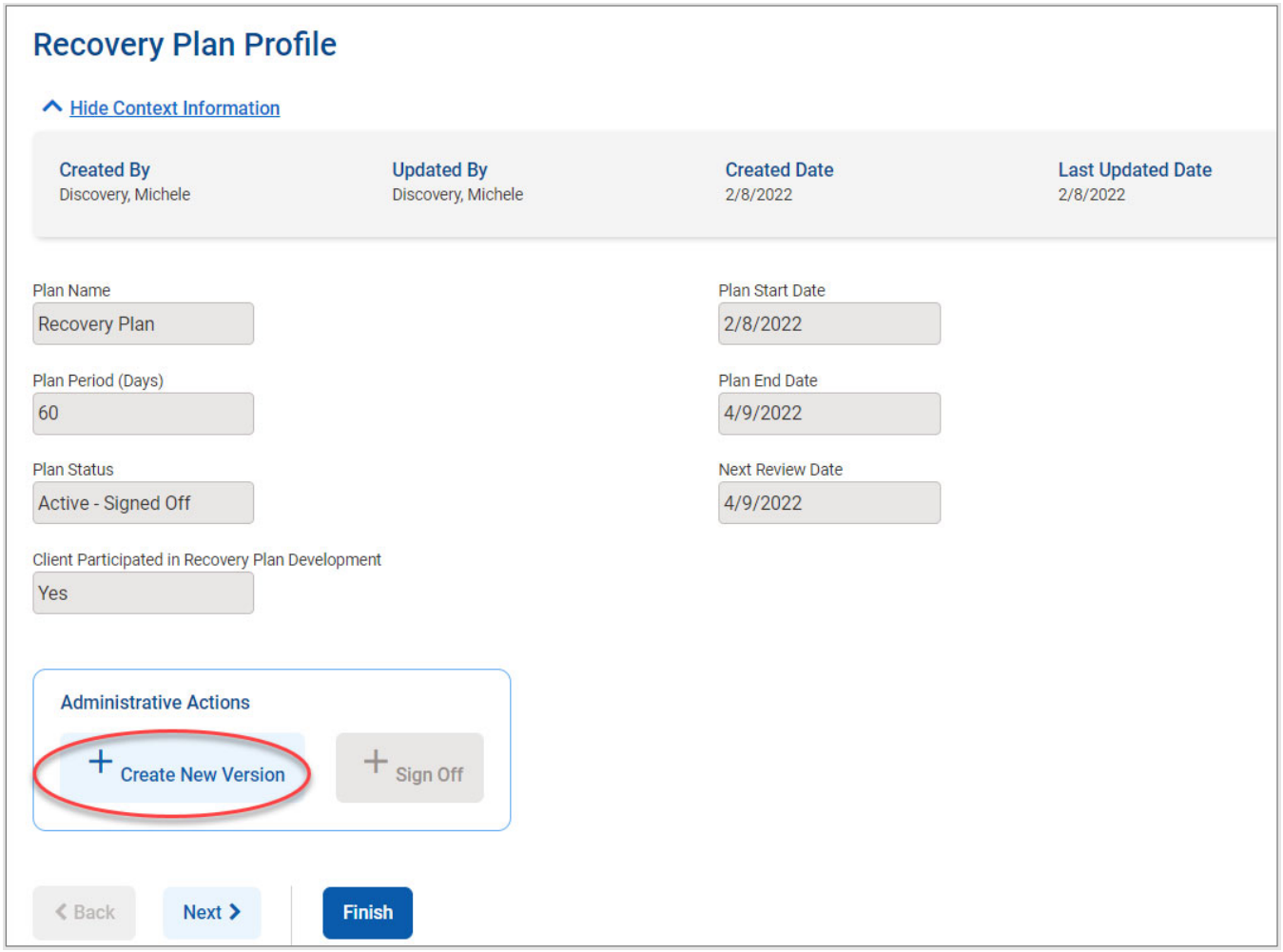


24. Click **"Yes"** only if appropriate treatment team members have approved the recovery plan. Once you click **"Yes"**, this plan becomes the active recovery plan.

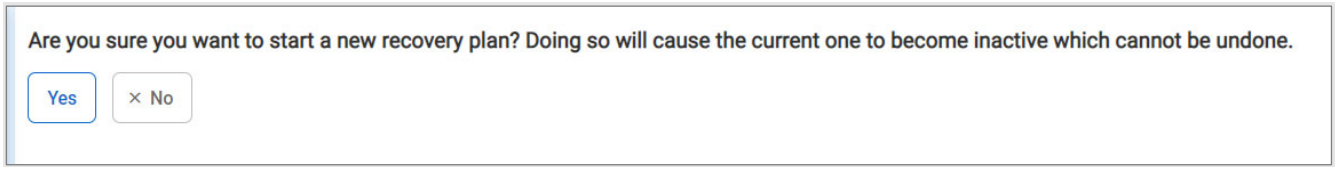


Create New Recovery Plan Version

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



25. Click "**Create New Version**" in the **Administrative Actions** box.
26. Answer **"Yes"** to the question *"Are you sure you want to start a new recovery plan? Doing so will cause the current one to become inactive which cannot be undone."*



27. Click the **"Next>"** button to move from the **Recovery Plan Profile** screen to the **Recovery Plan Summary** screen. You can now make any changes or updates to the client's recovery plan.

Diagnosis List

Where: Client List > Activity List > Diagnosis List

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

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

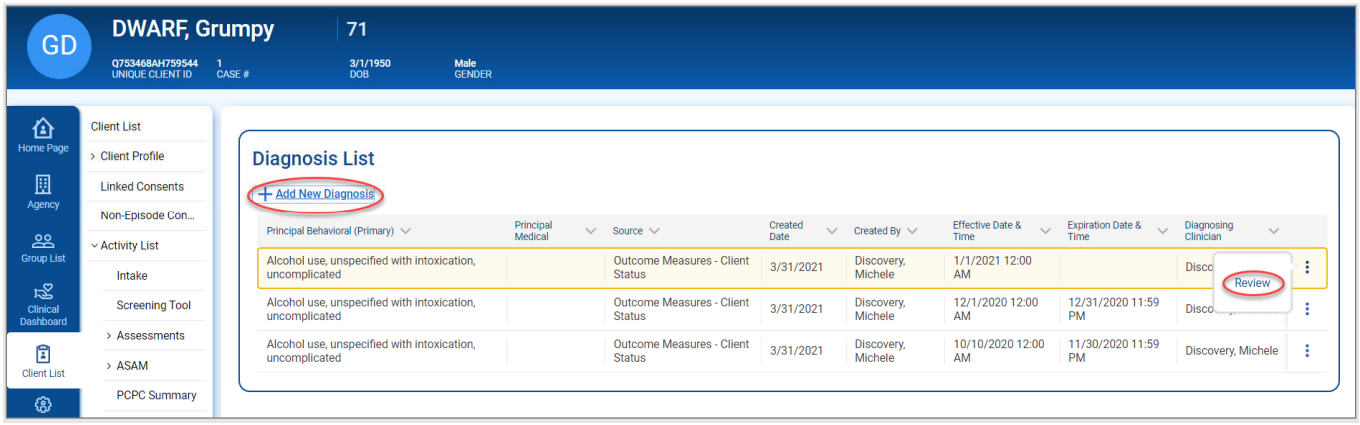


Figure 4-5: Diagnosis List, Review previously entered Diagnosis

Part 5: Notes

Notes

Where: Client List > Activity List > Notes

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

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

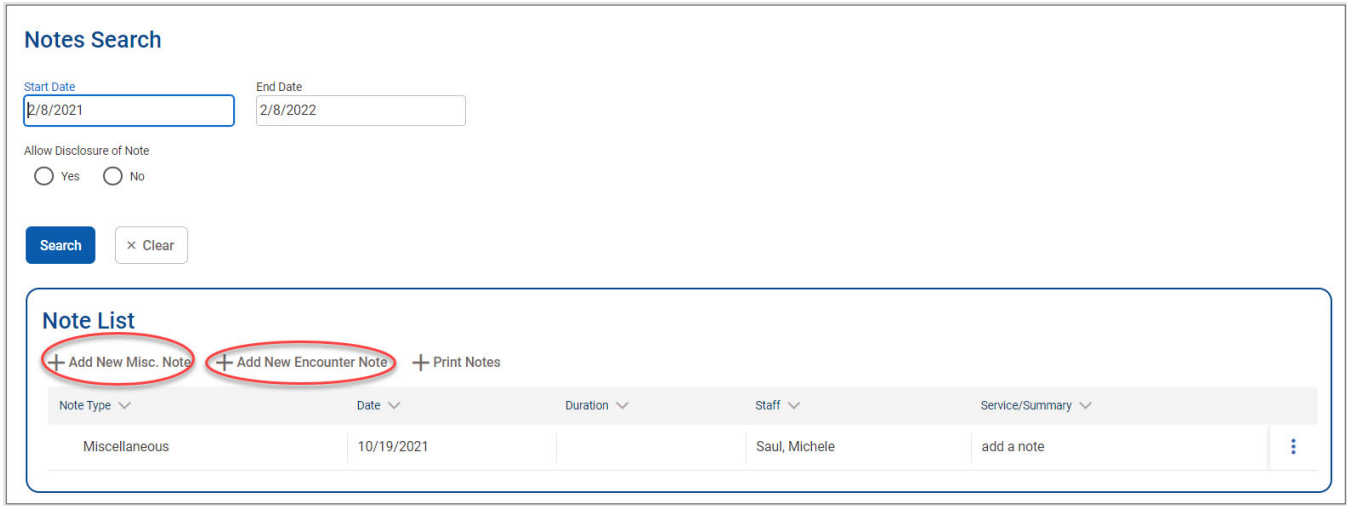


Figure 5-1: Notes screen, add new note

Encounter Notes

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

Create an Encounter Note

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

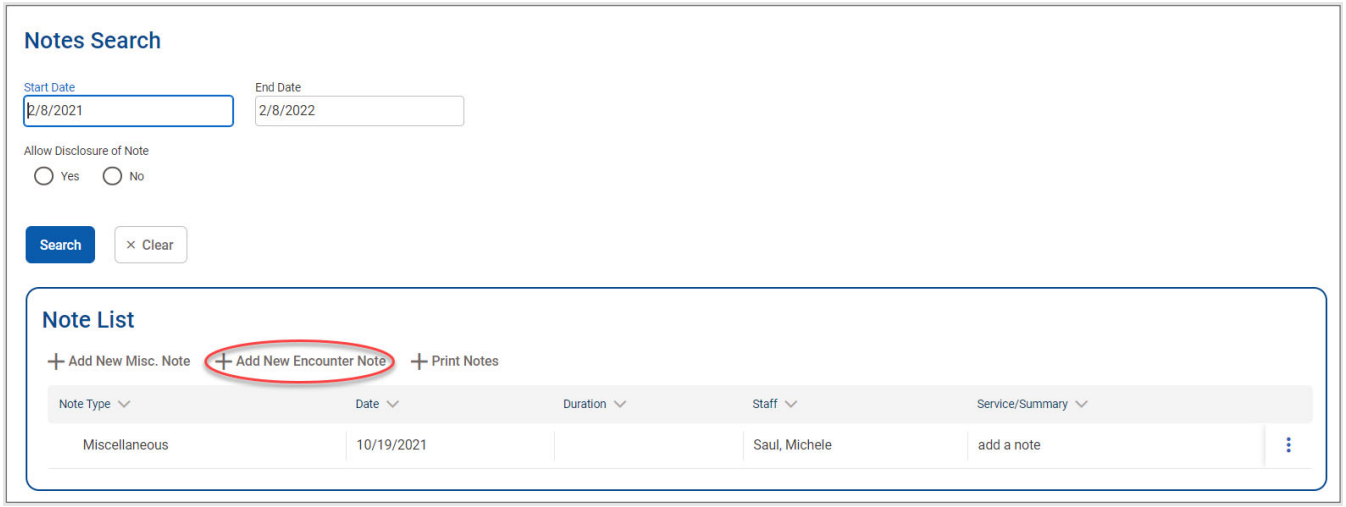


Figure 5-2: Notes screen, Add New Encounter Note link

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

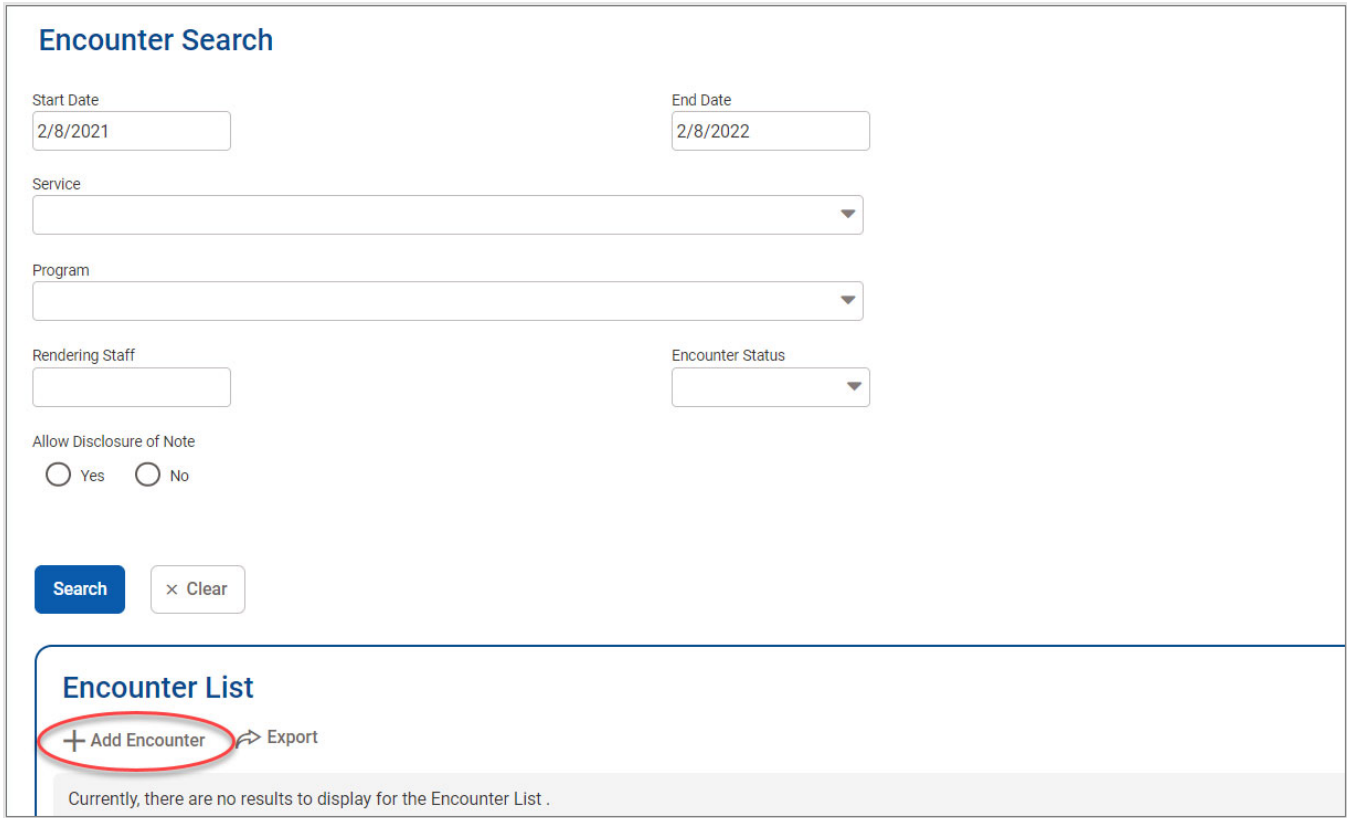


Figure 5-3: Encounter Search page

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

Table 5-1: Encounter Note fields

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

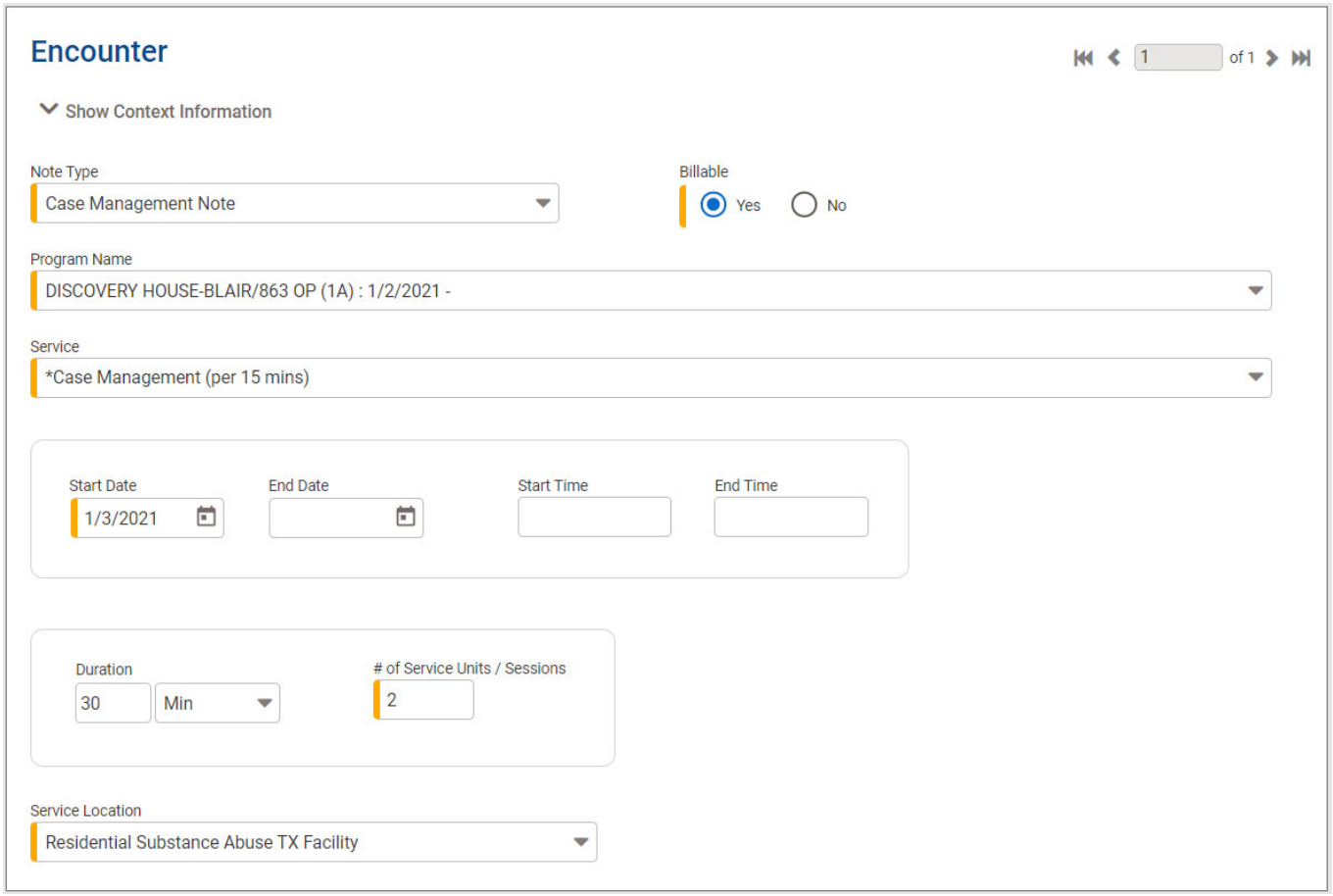


Figure 5-4: Encounter Note filled out

7. Click **"Save".**
8. Click the **"Next>"** button.

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

Prerequsite: **Active Signed-off Treatment Plan**

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

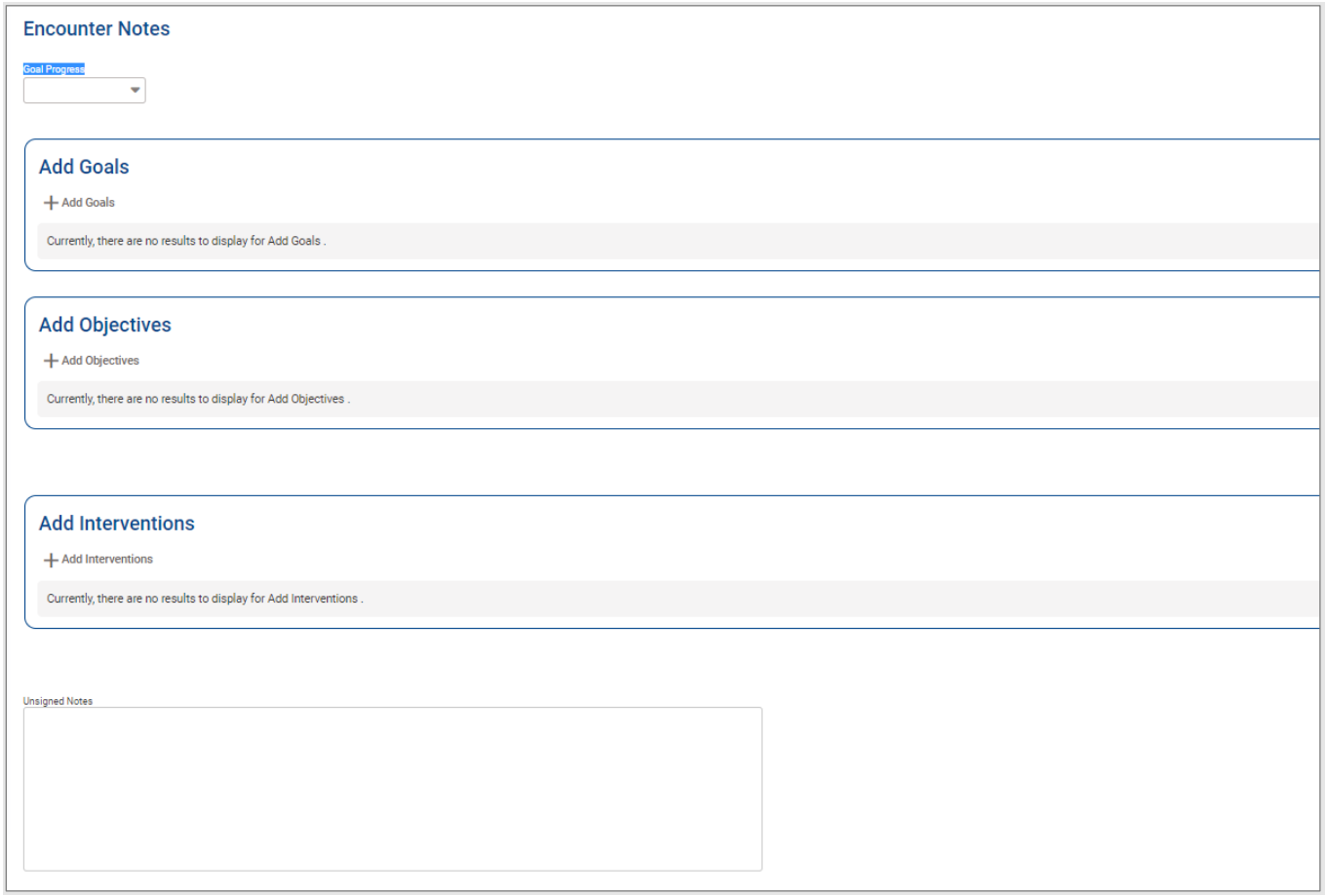


Figure 5-4: Encounter Note, Add Goals, Objectives, and Interventions

Miscellaneous Notes

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

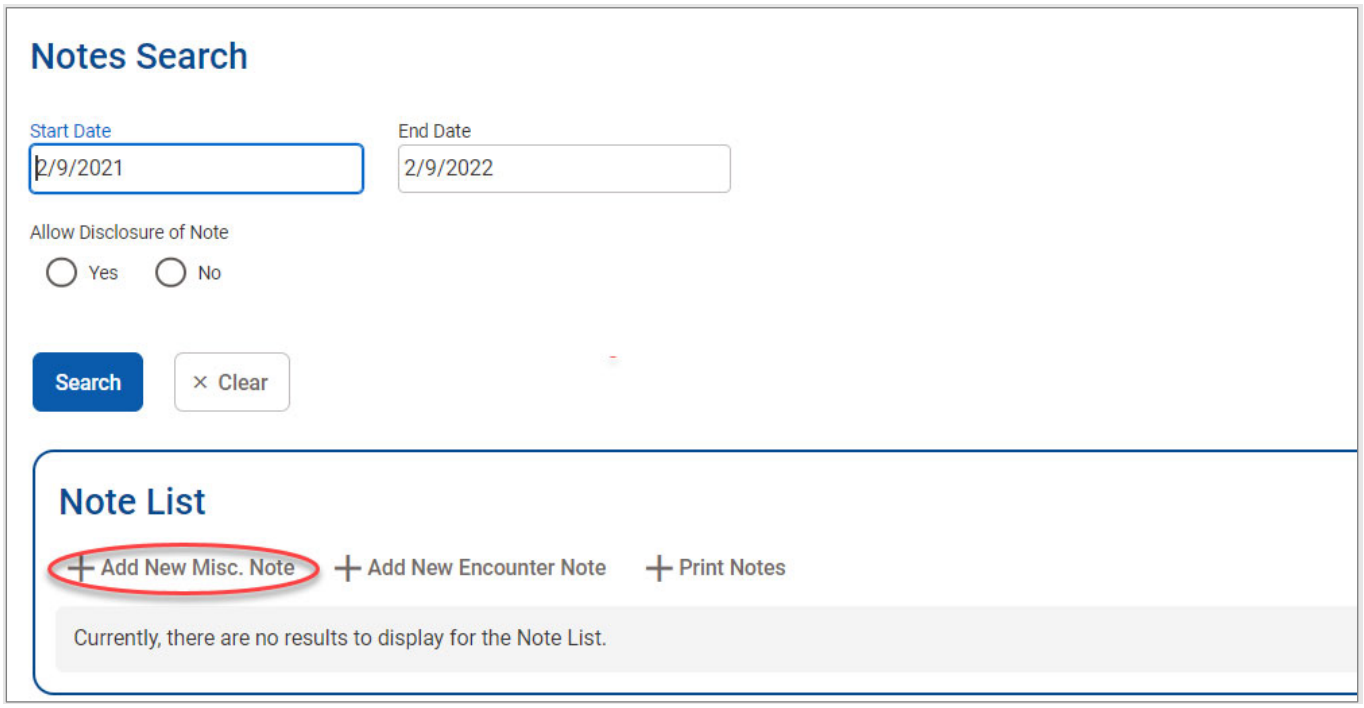


Figure 5-3: Notes screen, Add New Misc. Note link

2. Complete the following information:

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

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

NOTE: A separate **Note** record should be created for each **Note** that needs to be created.

Note Type: Case Management Note

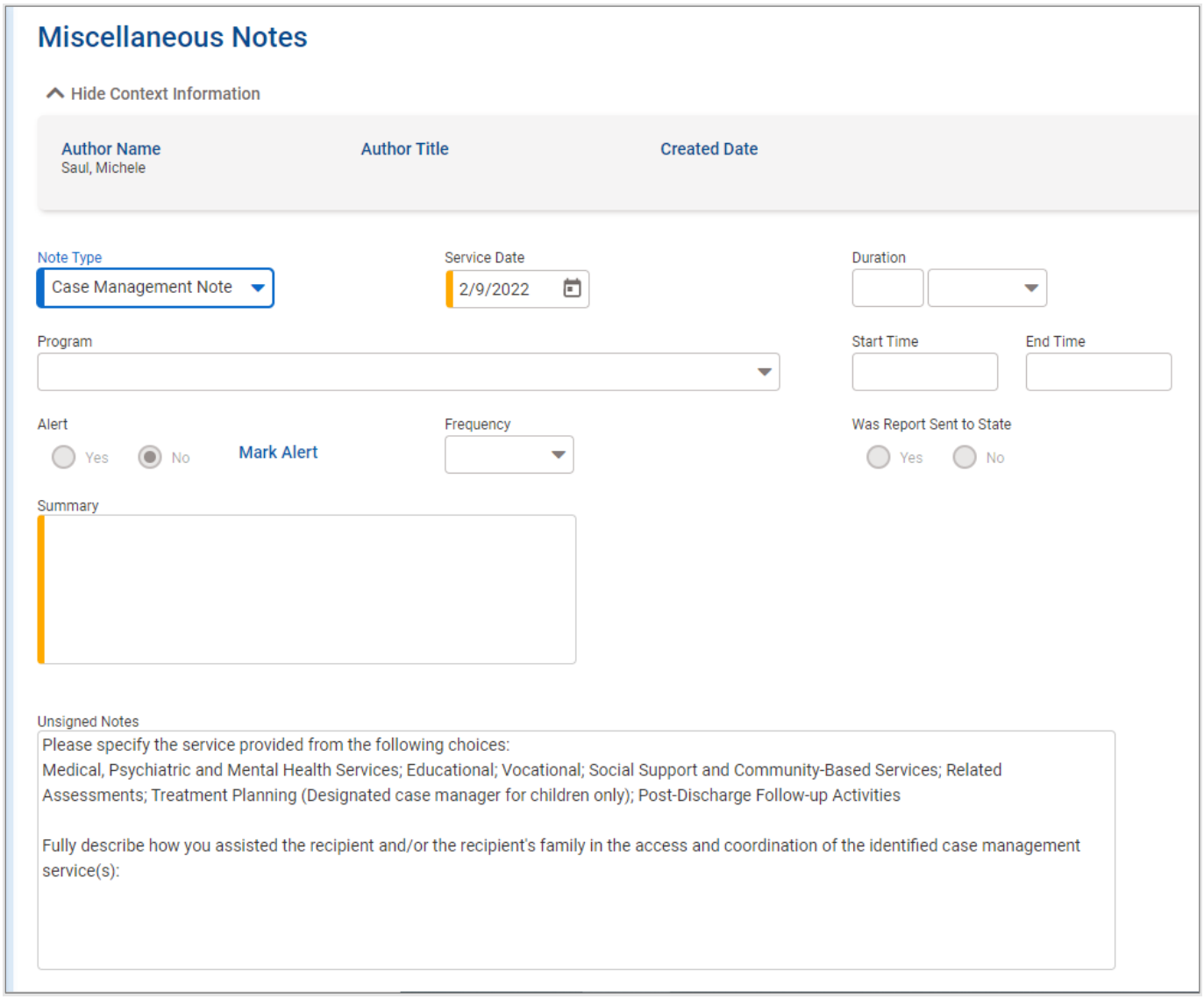


Figure 5-5: Miscellaneous Notes, Case Management Note Type

Note Text: Please specify the service provided from the following choices:

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

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

Note Type: Grievance and Appeal

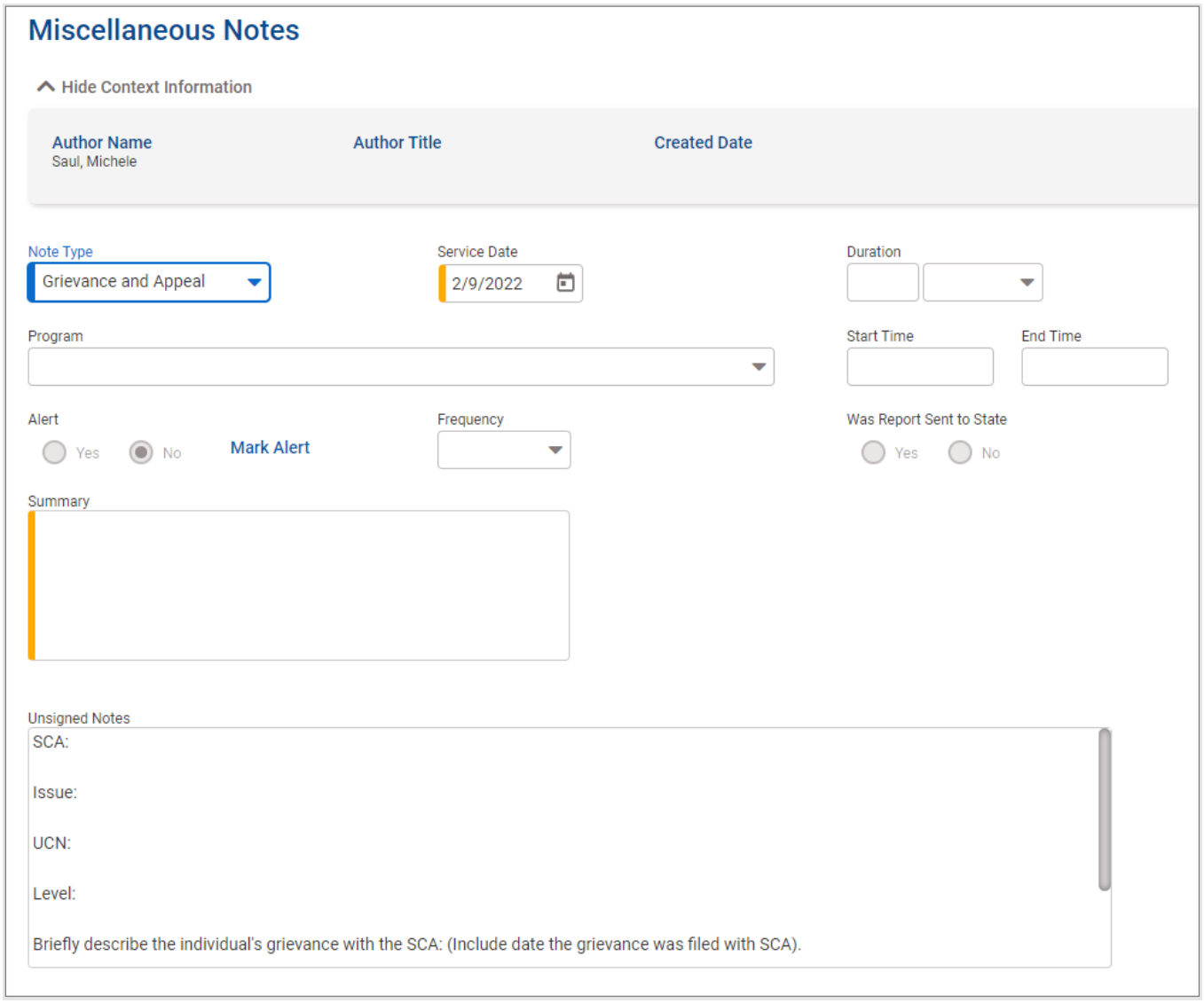


Figure 5-6: Miscellaneous Notes, Grievance and Appeal Note Type

Unsigned Note Text:

- SCA:
- Issue:
- UCN:
- Level:
- Briefly describe the individual's grievance with the SCA: (Include date the grievance was filed with SCA).
- Briefly describe the outcome of the grievance and the basis for the decision: (Include date of review).
- Grievance Resolved: Yes ( ) No ( )

Note Type: Gambling Screening

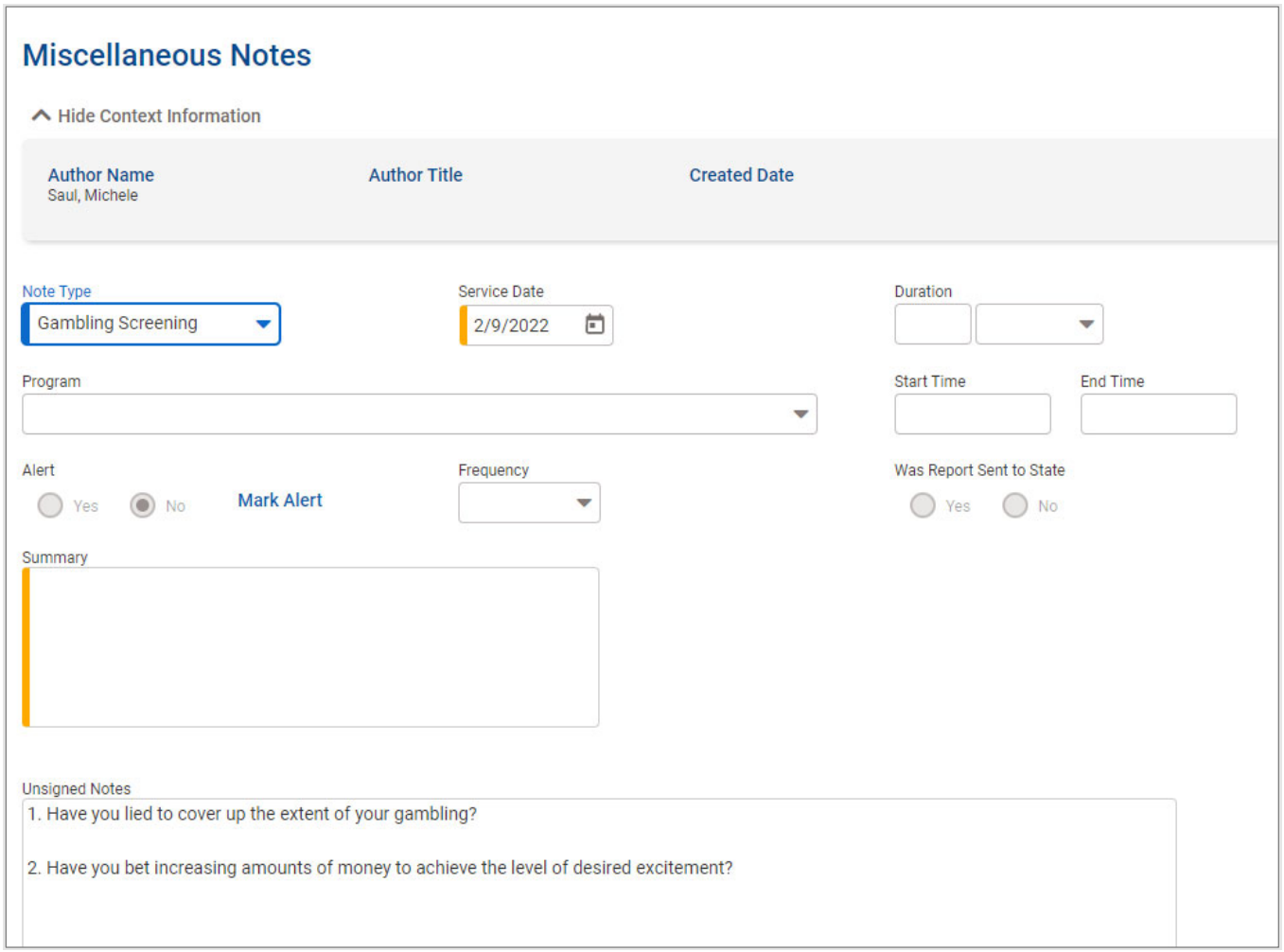


Figure 5-7: Miscellaneous Notes, Gambling Screening Note Type

Unsigned Note Text**:**

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

Note Type: TB Screening

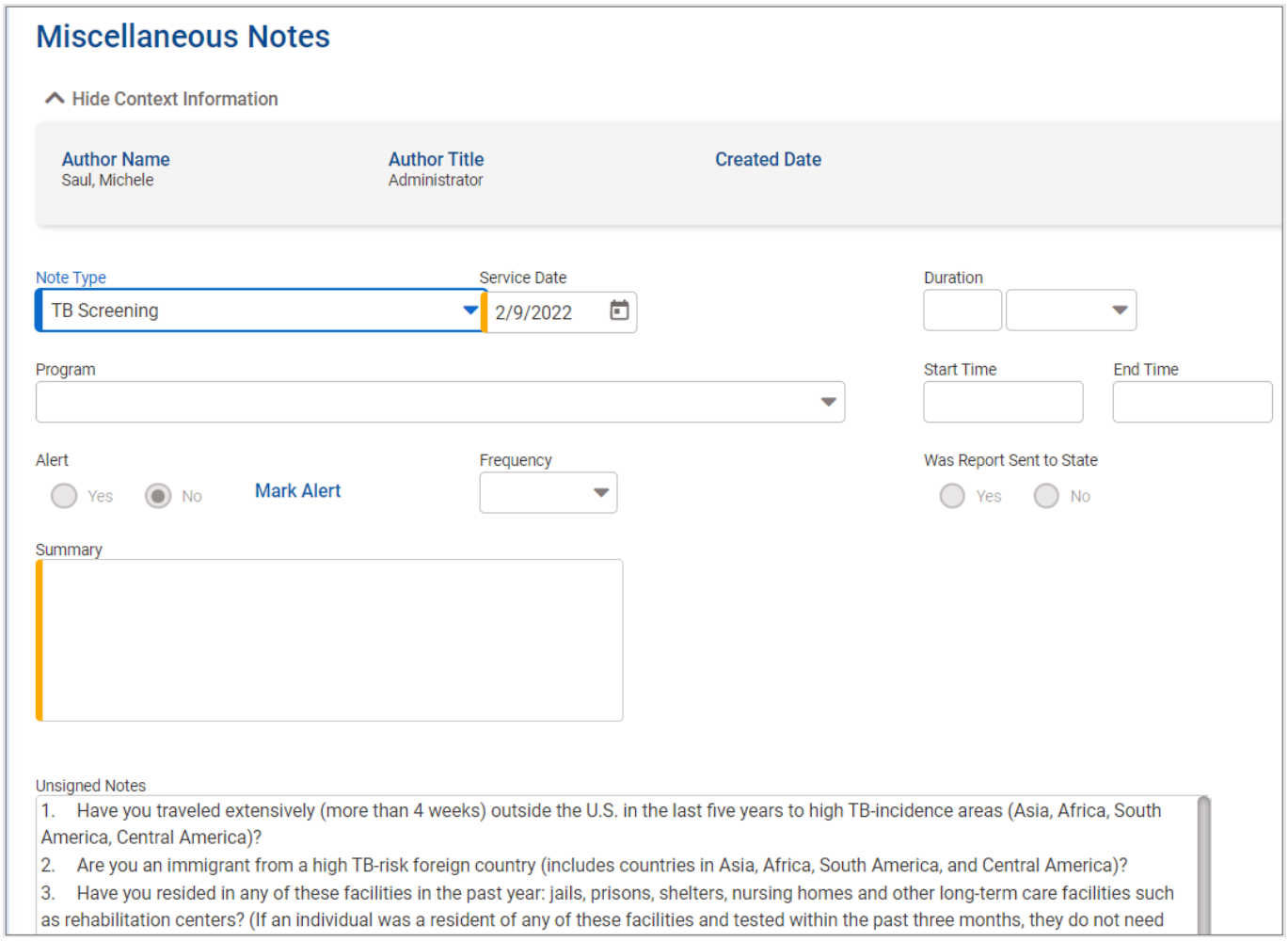


Figure 5-8: Miscellaneous Notes, TB Screening Note Type

Note Text:

- 1. Have you traveled extensively (more than 4 weeks) outside the U.S. in the last five years to high TB-incidence areas (Asia, Africa, South America, Central America)?
- 2. Are you an immigrant from a high TB-risk foreign country (includes countries in Asia, Africa, South America, and Central America)?
- 3. Have you resided in any of these facilities in the past year: jails, prisons, shelters, nursing homes and other long-term care facilities such as rehabilitation centers? (If an individual was a resident of any of these facilities and tested within the past three months, they don't need to be reassessed.)
- 4. Have you had any close contact with someone diagnosed with TB?
- 5. Have you been homeless within the past year?
- 6. Have you ever injected drugs?
- 7. Do you or anyone in your household, currently have the following symptoms, such as a sustained cough for two or more weeks, coughing up blood, fever/chills, loss of appetite, unexplained weight loss, fatigue, night sweats?
- 8. Do you currently have or anticipate having any condition that would decrease your immune system? (Examples: HIV infection, organ transplant recipient, treatment with TNF-alpha antagonist (e.g. infliximab, etanercept, others), steroids (equivalent dose of Prednisone 15mg/day for one month or longer) or any other immunosuppressive medications)