



SUBSTANCE USE DISORDER MIS ASSESSMENTS TRAINING



LIVE WELL
SAN DIEGO

**County of San Diego
Behavioral Health Services**



TABLE OF CONTENTS

TABLE OF CONTENTS	2
CONFIDENTIALITY	3
SANWITS SOFTWARE BASICS.....	4
LOGIN INFORMATION	5
Logging in to SanWITS.....	5
PASSWORD AND SECURITY QUESTION.....	6
Resetting Credentials.....	6
Changing Credentials (Security Question, Answer, and Password).....	6
HOME PAGE	7
Changing Facility.....	7
CLIENT SEARCH.....	9
CLIENT PROFILE	12
CLINICAL DASHBOARD	16
DASHBOARD (LPHA).....	18
ACTIVITY LIST	22
ASSESSMENTS.....	24
Viewing Assessments.....	24
Searching Assessments.....	26
Adding Assessments.....	29
Printing Assessments.....	31
Signatures.....	35
Adding Additional Assessments.....	37
AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)	39
TIMELINESS OF RECORDS	41
BHS SUD INSTRUCTIONS IN COMPLETING ASSESSMENTS.....	42
GLOSSARY.....	51
CONTACT INFORMATION.....	52

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



CONFIDENTIALITY

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

HIPAA regulations mandate that all client information be treated confidentially.

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

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

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

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

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

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

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

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





SANWITS SOFTWARE BASICS

- San Diego Web Infrastructure for Treatment Services (SanWITS) is accessed through: <https://sandiego.witsweb.org>
Save this to your favorites or create a shortcut for your desktop.
- NAVIGATE by using a function link, hand icon, pencil, arrow key, or button. The back arrow in the internet browser does not pull up the previous screen.
- FUNCTION LINKS are underlined links allowing certain actions to be completed. Function links are usually located on the section headers. A hand icon also functions as a link allowing a user to complete activities.
- SYSTEM REQUIRED FIELDS are in bright or light **yellow**. The bright yellow fields are system required to save the workspace. The light yellow fields are not system required but renders the activity unfinished (In Progress) if left blank.
- OPTIONAL FIELDS are in white. Some white fields may be yellow fields in other pages or screens.
- SYSTEM GENERATED FIELDS are in gray. Nothing can be changed or added in these fields.
- **GO** is the execute button. Click **GO** to change agency or facility, execute a command, load data, or pull up screens.
- **CANCEL** returns to the previous screen without saving the data entered.
- **SAVE** stores the information entered, and in certain screens adds multiple records of data.
- **FINISH** returns the user to the first workspace screen of the module or Activity List.
- **MENU** allows the user to return to the facility's homepage.

Reminder:

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

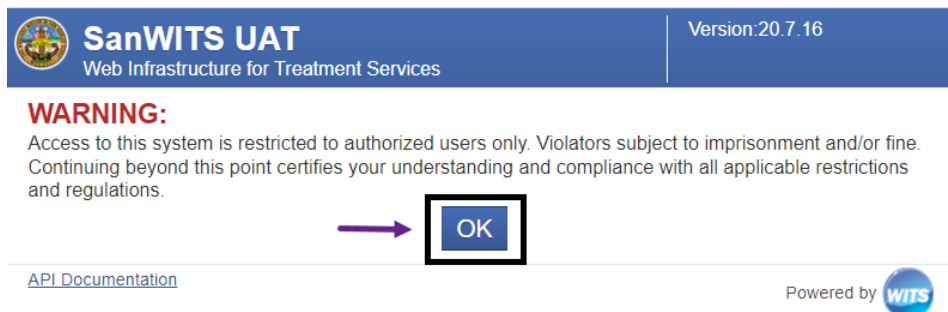


LOGIN INFORMATION

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

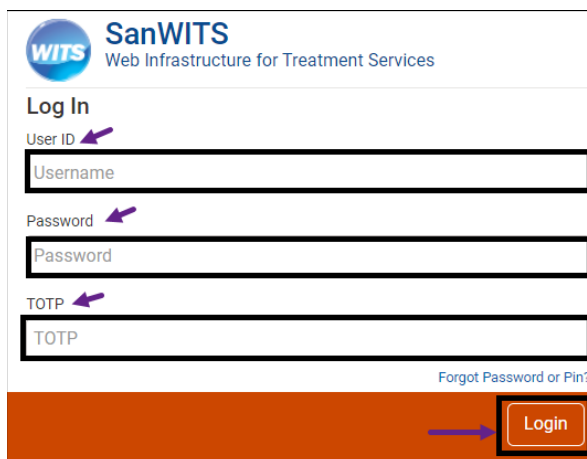
Logging in to SanWITS

The restrictions and penalty for abuse and noncompliance warning is the first screen users will see on their SanWITS window. Click **OK** to proceed with login.



The image shows the SanWITS UAT (User Acceptance Testing) warning screen. At the top, there is a blue header bar with the SanWITS logo on the left, the text "SanWITS UAT" and "Web Infrastructure for Treatment Services" in the center, and "Version: 20.7.16" on the right. Below the header, a red "WARNING:" label is followed by a paragraph of text stating that access is restricted to authorized users and that violators may be subject to imprisonment and/or fine. Below the text is a blue "OK" button with a purple arrow pointing to it. At the bottom left, there is a link for "API Documentation", and at the bottom right, it says "Powered by" followed by the WITS logo.

At the Login screen, enter the following: **User ID**, **Password**, and **TOTP**. Click **Login**.



The image shows the SanWITS login screen. It has a white background with the SanWITS logo and name at the top. Below the header, the text "Log In" is displayed. There are three input fields: "User ID" (with a purple arrow pointing to it), "Password" (with a purple arrow pointing to it), and "TOTP" (with a purple arrow pointing to it). Each field has a placeholder text: "Username", "Password", and "TOTP" respectively. Below the input fields, there is a link for "Forgot Password or Pin?". At the bottom right, there is an orange "Login" button with a purple arrow pointing to it.

If you are a first-time user, you will be directed to create a new password, set up your security question with a corresponding answer, and set up your Time-Based One-Time Password (TOTP).



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



PASSWORD AND SECURITY QUESTION

Resetting Credentials

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

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

To confirm credentials, click **Save**.

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

Changing Credentials (Security Question, Answer, and Password)

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



IMPORTANT: The security question and answer combination allow the user to use the **Forgot Password** link at the login screen to self-reset password.



HOME PAGE

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

Home Page	Home Announcements <table border="1"><thead><tr><th>Actions</th><th>Summary</th><th>Posted Date</th><th>Start Date</th><th>Priority</th></tr></thead><tbody><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td></tr></tbody></table> Alert List <table border="1"><thead><tr><th>Actions</th><th>Alert Type</th><th>Client Name; ID</th><th>Applies To Staff</th><th>Message</th><th>Facility</th><th>Date Due</th></tr></thead><tbody><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table>	Actions	Summary	Posted Date	Start Date	Priority																Actions	Alert Type	Client Name; ID	Applies To Staff	Message	Facility	Date Due																					
Actions		Summary	Posted Date	Start Date	Priority																																												
Actions		Alert Type	Client Name; ID	Applies To Staff	Message	Facility	Date Due																																										
► Capacity List																																																	
► Agency																																																	
► Group List																																																	
Residential Unit Dashboard																																																	
► Residential Unit Mgmt																																																	
Dashboard																																																	
Clinical Dashboard																																																	
► Client List																																																	
► System Administration																																																	
Reports																																																	

Changing Facility

Users who have access to multiple facilities must first select a facility before viewing the full Home Page. To select a facility:

Click the drop down arrow (▼) at the New Facility field. Select one from the list. Click **Go**.

Home Page	Change Facility Current Agency <input type="text"/> Current Facility <input type="text"/> New Agency <input type="text"/> New Facility <input type="text"/> <input type="button" value="Cancel"/> <input type="button" value="Go"/>
► Agency	
► Group List	
► Client List	
► System Administration	
Reports	



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



Home Page
▶ Capacity List
▶ Agency
▶ Group List
Residential Unit Dashboard
▶ Residential Unit Mgmt
Dashboard
Clinical Dashboard
▶ Client List
▶ System Administration
Reports

The Home Page navigation panel is located on the left side of the Home Page window.

Most actions are completed through the navigation panel.

The options vary depending on staff's roles.

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

Home

Announcements

Actions	Summary	Posted Date	Start Date	Priority

Alert List

[Search in Agency](#)

Actions		Alert Type	Client Name; ID	Applies To Staff	Message	Facility	Date Due

NOTES



IMPORTANT: Action links or execute buttons to search, add, or edit information are usually on the top right, middle right, or bottom right of the screen.



CLIENT SEARCH

A client should have only one client profile per agency. Conduct a careful and thorough search to determine whether or not the client has an existing profile in the agency.

Searching Clients:

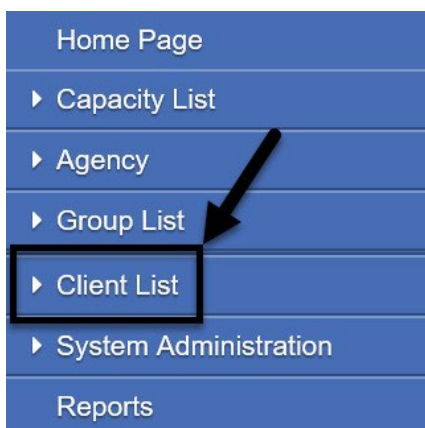
Typographical errors during client profile data entry may affect search results. Therefore, it is good practice to search several ways to open the client's existing profile.

Search the client's profile by using ~~the~~ basic identifiable information, such as:

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

For best results, add the wildcard or asterisk (*) after the first few characters of the client's name, SSN, or UCN. For example, enter **Jo*** for John and **Do*** for Doe.

Search by using the client's birth name, current name, and other alternate names (former names and aliases) the client may have used. To search a client from the navigation panel, click **Client List**.





On the Client Search workspace to the right of the navigation panel, enter part of the client's identifiable information and an asterisk (*). Click **Go**.

Client Search

Agency	San Diego County	Facility	<input type="text"/>
First Name	<input type="text" value="Fake"/>	Last Name	<input type="text" value="Cj*"/>
SSN	<input type="text"/>	DOB	<input type="text"/>
SanWITS UAT Client Id	<input type="text"/>	Provider Client ID	<input type="text"/>
Unique Client Number	<input type="text" value="FC*"/>	Primary Care Staff	<input type="text"/>
Treatment Staff	<input type="text"/>	Intake Staff	<input type="text"/>
Case Status	All Clients	Number Type	<input type="text"/>
Other Number	<input type="text"/>		
Include Only Active Consents	Yes		

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

Client Search

No results match your search criteria.

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



2. If a match is identified, the Client List will populate with the matching results. To open an existing client profile, hover over the pencil under the Actions column and select **Profile** or **Activity List**.

Client List (Export)			
Actions	Unique Client #	Full Name	DOB
Profile Activity List Linked Consents			



Additional Important Considerations in Searching Client's Records:

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

NOTES



CLIENT PROFILE

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

▼ Client List	Client Profile, Additional Information- CalOMS required screens
▼ Client Profile	
Alternate Names	Payor Group Enrollment, Contact Info- Medi-Cal billing required screens
Additional Information	
Contact Info	Alternate Names, Collateral Contacts, Other Numbers- Not system required
Collateral Contacts	
Other Numbers	History- Shows audit trails for viewing only
History	
Payor Group Enrollment	Allergies- Not currently in use
Allergies	

Client Profile: The Client Profile screen is the first screen in the Client Profile section. Many of the fields on the Client Profile workspace are also on the Client Search screen. The client's current name and birth name could be different, but the birth name should never change.

Client Profile			
Current First Name		State Client ID	
Middle Name		Provider Client ID	
Current Last Name		SSN	99902
Birth First Name		Driver's License	99902
Birth Last Name		Medicaid #	
Mother's First Name	Mother	Date of Death	
Sex	1-Male	Place of Birth	San Diego
Gender Identity		Consent on File for Future Contact	No
DOB			
No Readmit Until		Has Paper File	Yes
Record Created By		Created Date	11/13/2020
Last Updated By		Last Updated Date	11/13/2020



Alternate Names: The Alternate Names screen displays other names the client uses or has used in the past. The system is designed to search a client profile by alternate names.

Alternate Names				
Actions	Last Name	First Name	Middle Name	Client Alias Type

Additional Information: There are several fields in the Additional Information workspace that prepopulate in other screens. The preferred language prepopulates on the Encounter screen.

Additional Information

Ethnicity1-Not Hispanic

Primary Race/EthnicityWhite

Races

04-Alaskan Native
05-Asian Indian
06-Cambodian
07-Chinese
09-Guamanian

Selected Races

01-White
02-Black / African-American
03-American Indian
08-Filipino

Disabilities

2-Visual
3-Hearing
4-Speech
5-Mobility

Selected Disabilities

1-None

General Client Comments

Sexual Orientation

Religious Preference

Preferred LanguageEnglish

Interpreter Needed

Are you a Veteran?0-No

Finish

◀

▶



Contact Info: The client's address and telephone numbers are entered in the Contact Info workspace. The client's address is required to bill. If the client is homeless, the client's billing address will be the facility's address.

Contact Info					
Home Phone #	(555) 555-5555	Preferred Method of Contact	<div></div>		
Work Phone #	<div></div>				
Mobile #	<div></div>				
Other Phone #	<div></div>				
Fax #	<div></div>				
Email Address	<div></div>				

Addresses					Add Address
Actions	Address Type	Address	Confidential	Created	Updated
	Client Billing	3160 CAMINO DEL RIO S SAN DIEGO, CA 92108	No		

Collateral Contacts: The Collateral Contacts screen displays the client's collateral contacts, if available.

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

Other Numbers: The Other Numbers workspace documents the client's various court and petition numbers. Court numbers entered in this screen are searchable.

Other Numbers						
Actions	Number Type	#	Start	End	Contact Name	Status



Client History (Export)		
Date Changed	System Account	Description of Changes
7/20/2022 3:21 PM	LPHA, Eight	<ul style="list-style-type: none">Accessed DynamicQuestionnaires for Case: 1
7/20/2022 2:24 PM	LPHA, Eight	<ul style="list-style-type: none">Accessed AdultInitialLevelOfCare for Case: 1
7/20/2022 2:24 PM	LPHA, Eight	<ul style="list-style-type: none">Accessed Client Record: "1204, 1204, Client ID: 0000001204"
7/20/2022 2:01 PM	Counselor, Eight	<ul style="list-style-type: none">Accessed AdultInitialLevelOfCare for Case: 1
7/20/2022 2:01 PM	Counselor, Eight	<ul style="list-style-type: none">Accessed Client Record: "1204, 1204, Client ID: 0000001204"



The screenshot shows the 'Add New' dialog box with the 'Add New' button highlighted by a red rectangle. An arrow points to the button, indicating the next step in the process.

[illegible]



CLINICAL DASHBOARD

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



The Clinical Dashboard Search screen allows a staff to search using several parameters.

Clinical Dashboard Search

Intake Date Range From

To

Case Status

Modality

Available Staff

Selected Staff

Display Results For

Clinicians can access their own caseloads. Clinical supervisors may access the clinical dashboards of all clinicians within the facility.



The Case Status defaults to Clients with Open Cases. The Selected Staff defaults to the staff who is logged in. Display Results For defaults to Primary Staff. For best results, change to **Treatment Team** and click **Go**.

Clinical Dashboard Search

Intake Date Range From To

Case Status Modality

Available Staff
Counselor, Fifteen
Counselor, Five
Counselor, Forty
Counselor, Four

Selected Staff
Counselor, One

Display Results For

The search results can be sorted by Intake Date, Client Name, ASAM Date, Admission Date, or Primary Staff by clicking on the title. Click the client's name to view the client's electronic health record.

Actions	Intake date	Client Name	ASAM Date	Admission Date		Primary Staff
	2/1/2021	Client_Fake	2/1/2021	2/1/2021		Staff, Rendering

Make sure that all records are completed in a timely manner. The client is removed from the clinician's dashboard as soon as the episode is closed or when the clinician is removed from the client's treatment team.

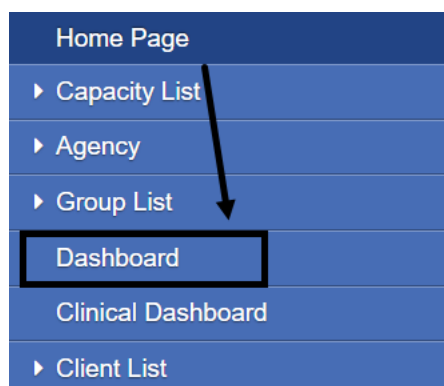
NOTES



DASHBOARD (LPHA)

The Dashboard screen in SanWITS is designed to hold several tiles that can be viewed based on a user's role. The Licensed Practitioners of the Healing Arts (LPHAs) who serve as clinical supervisors may use the Dashboard LPHA Workload tile to review and sign pending client activities.

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



The LPHA Dashboard launches, and the system hides the navigation pane. To show the navigation pane, on the upper left corner of the screen click **MENU**.

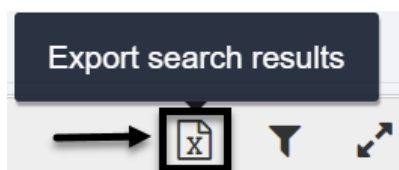


To search for a specific activity, enter the identifying information, and click **Search**.

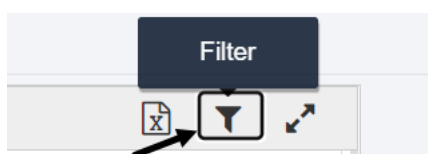




To convert the list to an Excel spreadsheet, click **Export Search Results**.



To change filters, click **Filter**.



Select **Finalized** and/or **Rejected** to add these assessments to the search criteria, and on the lower left corner of the screen click **Filter**. To display only the results for Rejected assessments, select **Rejected**, then click **x** to the right of Pending Finalization and Not Signed and click **Filter**.

To exit the Filter window, click **Cancel**.

LPHA Status:

<input type="text"/>	<input type="text"/>
Finalized	Pending Finalization
Rejected	Not Signed

Activity Type:

<input type="text"/>	<input type="text"/>
Parent/Guardian Initial Level of Care Assessment	Adolescent Initial Level of Care Assessment
Risk Assessment and Safety Plan	

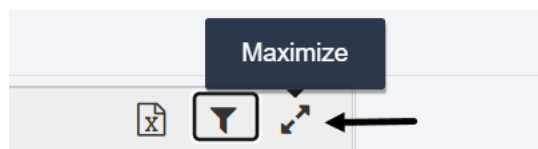
Finalized Date:

- ☒ Has end date

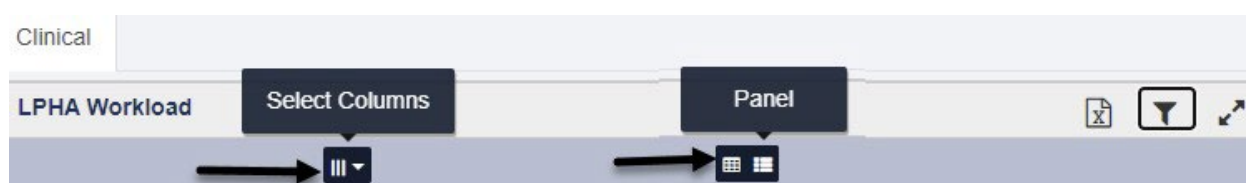
Filter Cancel



To view the Dashboard in full screen, click the two arrows facing out to maximize the window.



There are options to select or deselect columns to view, and the results can be displayed as a table or a panel.



The displayed items can be sorted by Client Name, Type, Activity Status, LPHA Status, or Activity Date. The first column does not show a title but is commonly called Actions.

LPHA Workload					
III ▾					
[Table Icon] [List Icon]					
	Client Name	Type	Activity Status	LPHA Status	Activity Date
		Adolescent Initial Level of Care Assessment	In Progress	Not Signed	07/26/2022
		Risk Assessment and Safety Plan	Finalized	Finalized	07/19/2022
		Risk Assessment and Safety Plan	Finalized	Finalized	07/18/2022

Hover over the pencil on the first column (also known as Actions), and click **View** to review, sign, and finalize the assessment. The LPHA Due Date turns red if the activity is not finalized within a certain number of days from the Activity Date. Follow your agency and the County policies on timelines of client records. The Timeliness of Records section in this training manual is not a comprehensive list of records but covers the initial forms that must be completed when a client is admitted to a facility.

	Client Name	Type
	1204, 1204	Risk Assessment and Safety Plan
	View	Risk Assessment and Safety Plan



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



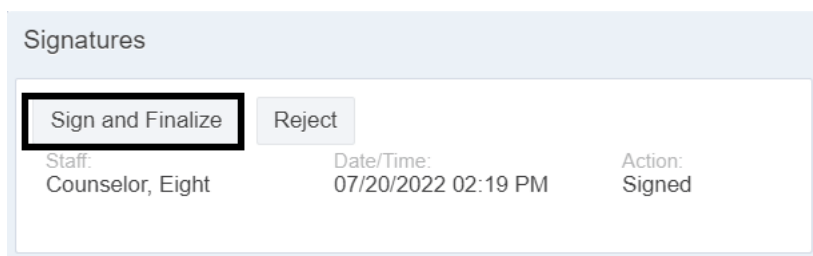
Once the assessment is launched, click **Edit** to review the assessment for accuracy.



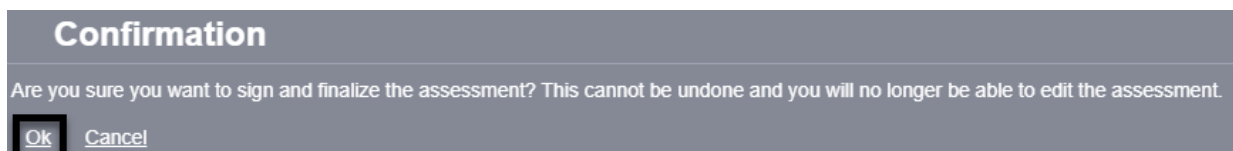
If the LPHA finds errors that the counselor should correct, click **Reject** at the Signatures section to return the assessment to the counselor.



If everything is accurate, complete the fields that an LPHA should complete and click **Sign and Finalize**.



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



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

After rejecting or finalizing a form, the system automatically returns to the LPHA Dashboard screen.

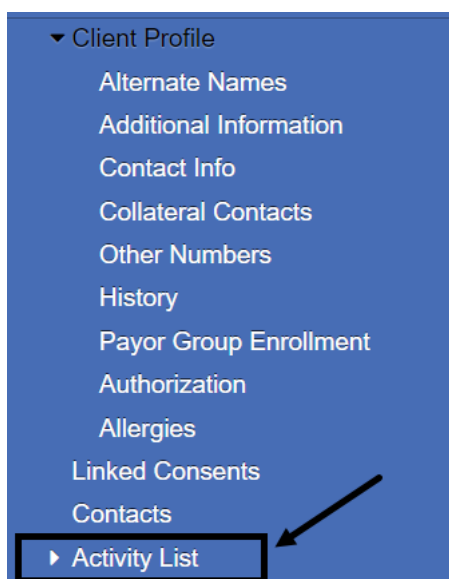


ACTIVITY LIST

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

To launch the Activity List first select the client from the Clinical Dashboard. Refer to the Clinical Dashboard section in this training manual for the path to access the Clinical Dashboard.

From the Navigation Pane, click **Activity List**.



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

Client Activity List				
Actions	Activity	Activity Date	Created Date▼	Status
	Adolescent Initial Level of Care	7/26/2022	7/27/2022	Finalized
	Additional Assessments Summary	7/26/2022	7/27/2022	Not Applicable



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

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

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

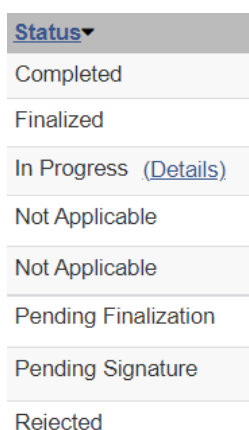
In Progress indicates an activity is pending completion.

Not Applicable indicates the activity has layers of activities within or is not required in SanWITS.

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

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

Rejected indicates an activity is being returned to the staff for corrections.



To view an activity, hover over the pencil in the Actions column and click **Review**.

Client Activity List				
Actions	Activity	Activity Date	Created Date	Status
	Additional Assessments Summary	7/19/2022	7/19/2022	Not Applicable
	Adolescent Initial Level of Care	7/26/2022	7/28/2022	Finalized

NOTES

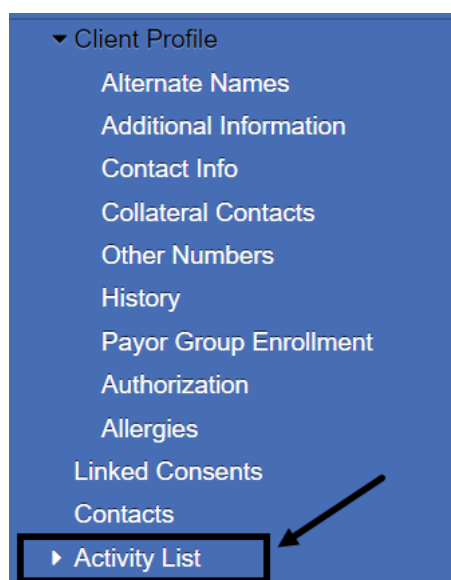


ASSESSMENTS

Clinical staff should enter the Initial Level of Care (ILOC) Assessment, Risk Assessment and Safety Plan, and Discharge Summary in SanWITS. These assessments are within the Activity List.

Viewing Assessments

To view an existing clinical assessment after launching the client profile from the navigation pane, click **Activity List**.





The Client Activity List launches displaying all actions performed for the client.

To view an existing assessment, select it by hovering over the pencil in Actions and click **Review**.



Client Activity List				
Actions	Activity	Activity Date	Created Date	Status
	Additional Assessments Summary	7/19/2022	7/19/2022	Not Applicable
	Adolescent Initial Level of Care	7/26/2022	7/28/2022	Finalized
	Review			



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

Client Activity List				
Actions	Activity	Activity Date	Created Date	Status
	Additional Assessments Summary	7/19/2022	7/19/2022	Not Applicable
	of Care	7/18/2022	7/18/2022	Finalized

On the Assessment screen, locate the assessment to be reviewed. Hover over the pencil and click **View** or, if applicable, **Edit**.

Type	Assessment Date	Interviewed By	Status
 Discharge Summary	07/19/2022	Counselor, Nine	Complete
 Risk Assessment and Safety Plan	07/19/2022	Counselor, Nine	Finalized

View

Previous

1

Next

The system opens the assessment selected.

Below is a sample of the upper portion of a finalized Adolescent ILOC assessment.

Adolescent Initial Level of Care

Status:
Finalized

Assessment Date:
07/26/2022

Interviewer:
Counselor, Eight

Created By:
Counselor, Eight

Created Timestamp:
07/27/2022 05:18 PM

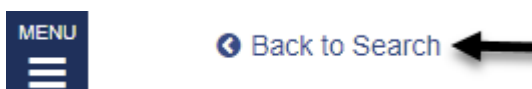
A counselor may edit a pending assessment as long as it is not signed. A signed assessment is locked to the counselor for editing. If the LPHA rejects the signed assessment, then the assessment becomes available to the counselor for editing. However, if the LPHA signs and finalizes the assessment, the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



To return to the homepage, on the upper left corner of the Assessment screen click **MENU**.



To return to the assessment search screen, on the upper left corner of the Assessment screen click **Back to Search**.

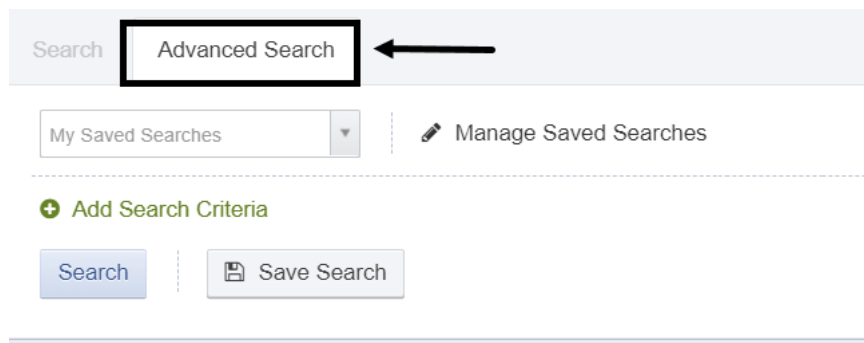


Searching Assessments

If there are several existing assessments created for the client and the list is long, the list can be narrowed down. To search for assessments that were previously entered, enter the search parameters in the Search field. The system automatically starts the search as soon as a character is entered. For best results, enter more characters.



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





Click **Add Search Criteria**.

Search Advanced Search

My Saved Searches Manage Saved Searches

+ Add Search Criteria

Search Save Search

Select the primary filter from the dropdown menu.

Select

Assessment Date

Interviewed By

Status

Type

Complete the remaining search specifications. If Assessment Date was selected as the primary filter, the next condition defaults to the value Equals. To change the default value, click the dropdown menu and select one from the list.

Assessment Date Equals

To add additional search criteria, repeat the above steps.

To remove the search criteria, click the **x** to the right of calendar.

Assessment Date Equals

x Remove Search Criteria

Click **Search**.

Search Save Search



The search criteria may also be saved for future use by clicking **Save Search**.



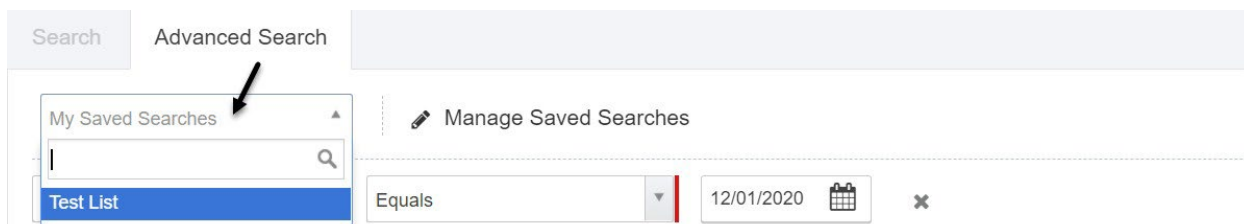
Enter the name of the search and click **Save**.

Save Your Search ×

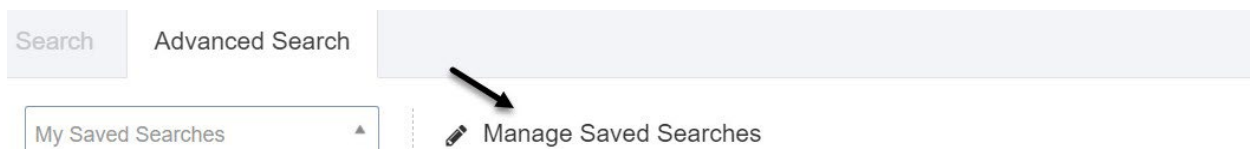
Name

Save Cancel

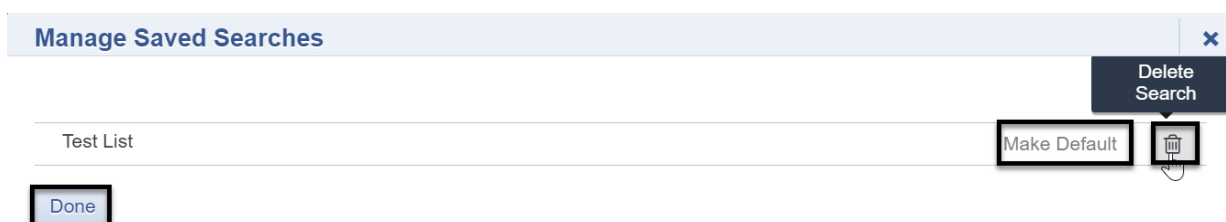
To search using a saved search, click **My Saved Searches** and select the saved search.



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



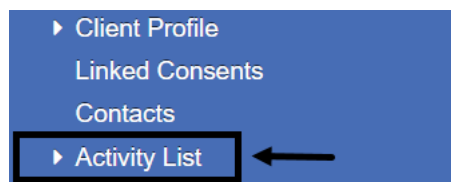
To make the saved search the default search, click **Make Default** and click **Done**.
To delete the saved search, click **Delete** and click **Done**.



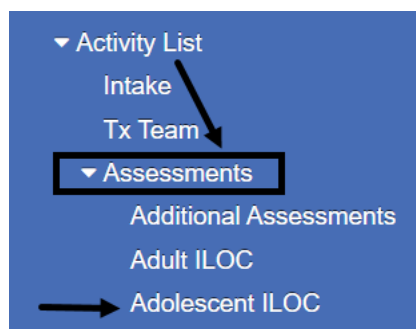


Adding Assessments

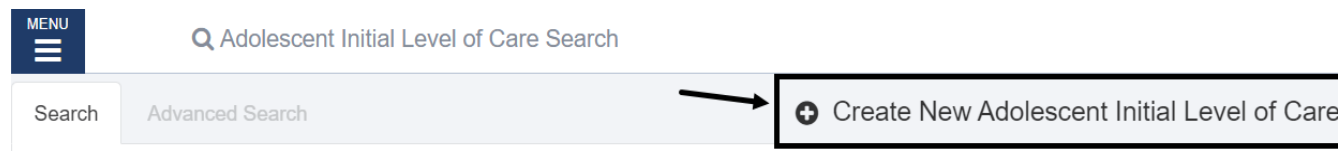
The standards in completing an assessment in SanWITS are the same as those shown on the assessment instructions posted on the Optum website. To add an Adolescent ILOC from the navigation pane, click **Activity List**.



Click **Assessments** → **Adolescent ILOC**



The Assessments screen launches displaying a section to search assessments and a button to create a new assessment. To continue, click **Create New Adolescent Initial Level of Care**.



On the next screen, select the staff who interviewed the client and the Assessment Date.

Interviewer:

Select 

Assessment Date:





Click **Save**.

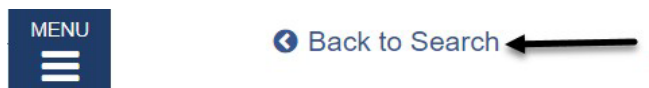


The assessment form launches and is ready for completion.

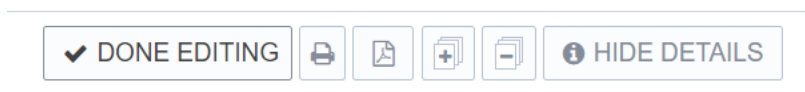
To return to the Homepage, on the upper left corner of the Assessment screen click **MENU**.



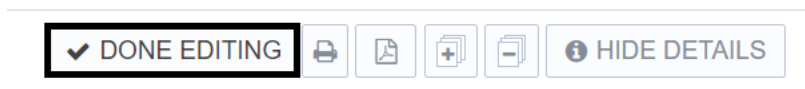
To return to the Assessment Search screen, on the upper left corner of the screen click **Back to Search**.



On the top right side of the assessment are several action buttons.



It is best practice to click **Done Editing** after completing an assessment even if the system automatically saves all responses.



The button name changes to Edit and locks the assessment from being edited. Click **Edit** to enable editing of the assessment.





Printing Assessments

To print the assessment, click **Generate Report** to convert the assessment to an Acrobat Adobe document before printing it.



The **plus (+)** sign expands all the details, and the **minus (-) sign** collapses or hides all details. The **Hide Details** hides the section and question help texts.



Both the left and right sides of the screen can be used to navigate the Adolescent ILOC. The right side also serves as a validation for completion requirements. The middle column is the actual assessment form.

To change the Assessment Date or Interviewer, hover anywhere on the top part of the assessment and click **Edit**.



The initial screen re-opens. Update the assessment date and/or interviewer and click **Save**.

Status:
In Progress

Assessment Date:
07/26/2022

Interviewer:
Counselor, Eight

Created By:
Counselor, Eighteen

Created Timestamp:
07/27/2022 05:18 PM

Save Cancel

The double right arrow on the navigation pane indicates which question or section is active.

Adolescent Initial Level of Care

Profile

Personal Information

Alcohol and/or Other Drug Use

Alcohol and/or Other Drug Use

To collapse a section, click the down arrow on the right side of the section title.

Signatures

To expand a section, click the left arrow on the right side of the section title.

Signatures




The status bar located at the bottom of each section shows the total number of required questions, required questions completed, and percentage completed. It is good practice to confirm that the questions answered equal the total required questions before moving on to the next section.

# Total Required Questions: 5	# Required Questions Completed: 5	% Complete: 100
-------------------------------	-----------------------------------	-----------------

The Completion Requirements panel on the right side of the assessment can also be used to navigate to each section by clicking on each tile. When all the required questions in that section have been answered, the tile will disappear from the Completion Requirements.

Completion Requirements

+ Personal Information	?
+ Alcohol and/or Other Drug Use	?
+ Alcohol and/or Other Drug Treatment History	?
+ ASAM Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential	?



Completion Requirements

+ Personal Information	?
+ Alcohol and/or Other Drug Use	?
+ ASAM Dimension 1: Substance Use, Acute Intoxication and/or Withdrawal Potential	?

NOTES



The questions may be answered by entering a free-flowing text, selecting from a dropdown menu, choosing from the radio button selections, or selecting a date when required. The following are examples of questions:

1.) Place of Interview:

10.) Primary Drug:

5.) Are you Pregnant?

Required

☒ Yes
☐ No
☐ Not Applicable
☐ Client Declined to State
☐ Unknown

6.) Due Date:

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

10.) Do you have Health Insurance?

Required

☐ Yes
☒ No

11.) Insurance Company:
Not Applicable

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

1.) Are you currently taking prescription medication for any medical conditions?

Required

☐ Yes
☒ No

2.) Please describe:



Signatures

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

The screenshot shows a light blue header bar with the word "Signatures" in orange on the left and a downward arrow on the right. Below the header is a white rectangular box containing a black arrow pointing to the left.

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

The screenshot shows the same "Signatures" header bar. Below it, the white box now contains a button with the text "Sign". The button is highlighted with a black rectangular border.

Click **OK** to confirm.

The screenshot shows a dark gray dialog box with the title "Confirmation" in white. Below the title, the text reads: "Are you sure you want to sign the assessment? This cannot be undone and you will no longer be able to edit the assessment." At the bottom left, there are two buttons: "OK" and "Cancel". The "OK" button is highlighted with a black rectangular border.

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

The screenshot shows the "Signatures" header bar. Below it, the white box contains a table with the following information:

Staff:	Date/Time:	Action:
Counselor, Eight	07/28/2022 03:37 PM	Signed

If the LPHA created the form and is also finalizing the assessment, go back to the Signature section and click **Sign and Finalize**.

The screenshot shows the "Signatures" header bar. Below it, the white box contains two buttons: "Sign and Finalize" and "Reject". The "Sign and Finalize" button is highlighted with a black rectangular border.



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

Confirmation

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

If the LPHA completed, signed, and then finalized the assessment, the Signatures section will display the LPHA's staff name twice.

Signatures

Staff: LPHA, One	Date/Time: 07/28/2022 04:08 PM	Action: Signed
Staff: LPHA, One	Date/Time: 07/28/2022 04:08 PM	Action: Finalized

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

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

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

NOTES

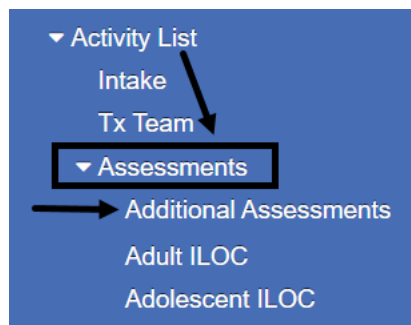


Note: A finalized Adolescent ILOC assessment will generate a finalized ASAM Assessment. Do not manually enter an ASAM (American Society of Addiction Medicine) assessment.

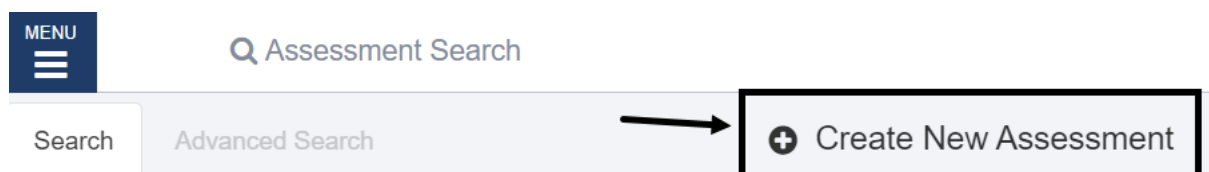


Adding Additional Assessments

To add a Parent/Guardian ILOC, Discharge Summary, or Risk Assessment and Safety Plan from the navigation pane, click **Activity List** to expand it. Click **Assessments** and then **Additional Assessments**.




The Additional Assessments screen launches displaying a section to search a specific assessment, a list of previously entered assessments, and a button to create a new assessment. To add a new assessment, click **Create New Assessment**.



Complete the three required fields on the Add Assessment screen to continue.

Add Assessment

Assessment:

Assessment Date:


Interviewer:



After selecting the assessment, assessment date and interviewer, click **Save**.



The assessment form launches and is ready for completion.

Risk Assessment and Safety Plan			
Status: In Progress			
Assessment Date: 07/19/2022	Interviewer: Counselor, Eight	Created By: LPHA, Eight	Created Timestamp: 07/20/2022 06:22 PM

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

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

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

Another difference is if the Parent/Guardian ILOC is completed by an LPHA, the Sign button is hidden but the LPHA can Sign and Finalize right away. A finalized Parent/Guardian ILOC cannot be edited. If there are errors that need to be corrected, add another one.

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

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

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



AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

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

The system generates a read-only ASAM from a finalized Adolescent ILOC.

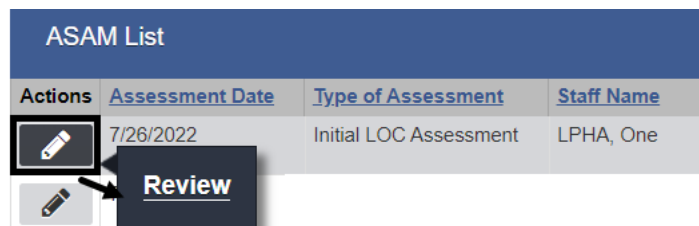
To access the ASAM from the navigation pane, click the **Activity List** to expand it. Then click **ASAM**.



The ASAM List screen includes a button to add an ASAM and shows all existing ASAM records. It displays the Assessment Date, Type of Assessment, Staff Name, Recommended Level of Care, Status, and Updated Date. The Adolescent ILOC is populated to Initial LOC Assessment.

ASAM List							Add ASAM
Actions	Assessment Date	Type of Assessment	Staff Name	Recommended Level of Care	Status	Updated Date	
	7/26/2022	Initial LOC Assessment	LPHA, One	1 Outpatient	Completed	7/28/2022	

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





The ASAM launches.

ASAM

Type of Assessment		Initial LOC Assessment	
1 - Acute Intoxication and/or Withdrawal Potential	Level of Risk	2 ⓘ	Level of Care
	Comments	nothing at this time	
2 - Biomedical Conditions and Complications	Level of Risk	0 ⓘ	Level of Care
	Comments	nothing to add at this time	
3 - Emotional, Behavioral, or Cognitive Conditions and Complications	Level of Risk	1 ⓘ	Level of Care
	Comments	possible seeking outside therapy is an option	

Everything is grayed out including the assessment date and finalized date/time information.

Assessment Date	7/20/2022	Program	
-----------------	-----------	---------	--

Administrative Actions

Signed by:	Counselor, Eight	Signed on:	7/20/2022 2:19 PM
Finalized by:	LPHA, Eight	Finalized on:	7/20/2022 2:26 PM

To return to the previous screen, in the right lower corner of the ASAM click **Cancel**.



Note: ASAM scores must be manually entered in SanWITS if ASAM Assessment was completed in paper.



TIMELINESS OF RECORDS

Document	Level Of Care (LOC)	Timeframe for Completion
Adolescent Initial Level of Care Assessment	Withdrawal Management	Within 24 hours of admission
	Residential	Day of admission (no more than 24 hours after admission)
	Outpatient (OS/IOS)	Within 7 days of admission
Risk Assessment and Safety Plan	Withdrawal Management	Within 24 hours of admission
	Residential	Completed, reviewed, and signed by LPHA within 24 hours of admission
	Outpatient (OS/IOS)	Completed, reviewed, and signed by LPHA within 7 days of admission
Discharge Summary	All programs	Within 30 days of last face-to-face or telephone contact

NOTES

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



BHS SUD INSTRUCTIONS IN COMPLETING ASSESSMENTS

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

Adolescent Initial Level of Care Assessment Instructions

REQUIRED FORM: This form is required within the client file

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

Timelines:

- **Outpatient programs** – To be completed within **30 calendar days** from day of admit or within 60 calendar days if under the age of 21 or experiencing homelessness.
- **Residential programs** – To be completed with **10 calendar days** from day of admit

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

REQUIRED ELEMENTS:

- **Client Name:** Enter "Client Name". If using the form-fill, hit tab to get to "Client ID #", *once you hit tab again to go to the next field, the client name and ID will populate on the rest of the pages*
- **Client ID#:** Client ID number by entering the client's SanWITS' Unique Client Number (UCN).
- **Staff Completing the Form:** Name of staff completing the assessment/intake.
- **Place of Interview/assessment:** Location of assessment (jail, program, etc.)
- **Date of assessment/interview:** Date of assessment/interview.
- **Referral source:** Referral source name (Probation, CWS, Parole, etc.) and contact information (contact person, phone number, address, etc.).
- **If referral is being made but admission is expected to be DELAYED, reason:** (Must select one of the reasons below, if applicable)
 - Waiting for level of care availability
 - Hospitalized
 - Waiting for ADA accommodation
 - Waiting for language-specific services
 - Incarcerated
 - Other: (if selected, must explain): _____
 - Waiting for other special population-specific svcs
 - Patient preference



PERSONAL INFORMATION

- **Name:** Client's first name, middle initial and last name (obtain copy of legal ID, if available).
- **Age:** Client's age.
- **Social Security Number:** Client's social security number (obtain a copy of card, if available). If client does not have a social security number, follow your agency guidelines.
- **Birth Date:** Client's month/day/year of birth.
- **Phone Number:** Client's phone number/email address. Check if permitted to leave a message.
- **Preferred language:** Client's preferred language.
- **Address:** Client's current, physical address. If client is homeless, document "homeless" and address issue on ASAM Dimension 6: Recovery Environment.
- **What are the main reasons you are seeking help here today?** Write in client's own words, ask the client to prioritize in importance to him/her.
- **Gender Identity:** Check appropriate box. If "Other", write in client's own words specifics.
- **Sexual Orientation:** Check appropriate box. If "Other", write in client's own words specifics.
- **Pregnant /Due date:** Client's pregnancy status, check Yes or No.
 - If yes, complete due date. (Inform client they may be asked to provide documentation such as proof of pregnancy).
- **Number of Children:** Complete client's number of children.
- **Medi-Cal:** Check Yes or No.
 - If yes, complete Medi-Cal card number. (Inform client they may be required to provide proof of Medi-Cal eligibility. Follow agency guidelines for Medi-Cal eligibility).
- **Health Insurance:** Check Yes or No.
 - If yes, complete Insurance Company's name. (Inform client they may be required to provide proof of insurance. Follow agency guidelines for health insurance eligibility).
- **Have you ever been arrested/charged/convicted/registered for arson?** Check Yes or No.
- **Have you ever been arrested/charged/convicted/registered for a sex crime(s)?** Check Yes or No.
- **Emergency Contact:** Name, relationship, and contact number of designated emergency contact.
- **Parent/Guardian Information:** Name, relationship, and contact number of person designated parent/guardian.

THE FOLLOWING SECTIONS ARE TO BE COMPLETED BY THE ADOLESCENT AND THERPST/COUNSELOR TOGETHER

ASAM DIMENSION 1: SUBSTANCE USE, ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

- **In the past year how many times have you used?:** Mark an (X) as Never, Once or Twice, Monthly, Weekly, for all the following: Alcohol, Marijuana, Illegal Drugs, Prescription drugs not prescribed to client, Overuse of your prescription drugs, Inhalants, Herbs or synthetic drugs, Other. If "Other" is checked, enter details on the line provided.
- **Complete ALL boxes as appropriate for:** Primary Drug, Secondary Drug, and Tertiary Drug. If any of the boxes do not apply, enter N/A. This is based upon the client's *current* self-report of use.
- **Have you used needles in the past 12 months?** Check Yes, No, or Declined to State.
 - If yes, enter date last used.



- Date you last used any drugs including alcohol: Enter date.
- Number of days in a row you have been using: Enter number.
- Alcohol and/or other drug treatment history
- Have you received treatment for alcohol and/or other drugs in the past? Check Yes or No.
 - If yes, provide details, and follow prompts in the boxes: Type of Recovery Treatment, Name of Treatment Facility, Dates of Treatment, Treatment Completed or Not.
- **Severity Rating – Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.
- **Nicotine or Tobacco:** # of days used in the past 30 days, Route of Admission, Age at first use and Date Last Used.
 - If Nicotine or Tobacco Use is identified indicate if it is cigarette or vaping.
- Alcohol and Other Drug Treatment, if yes, document details for type of treatment, treatment facility and dates of treatment and treatment completed.

ASAM DIMENSION 2: BIOMEDICAL CONDITIONS/COMPLICATIONS

(LPHA/Counselor will review the Client Health Questionnaire and TB Screening as part of this Dimension).

- Are you currently taking prescription medication for any medical conditions? Check Yes or No.
 - If yes, describe in detail.
- **Severity Rating – Dimension 2 (Biomedical Conditions and Complications):** Follow the prompts; check the current, assessed level of risk. Include information from the Parent/Guardian Form as well as the client health questionnaire and TB screening when determining risk rating.
- For residential programs: if risk rating in this dimension is greater than "zero" (0), submit completed Health Screening Questionnaire along with Initial Assessment/Intake Form to assist with obtaining initial authorization.

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

(LPHA/Counselor to review the Risk Assessment and Co-Occurring Conditions Screening Forms for historical information relevant to this dimension. Include as part of your assessment of severity below).

- Do you have any current thoughts of hurting yourself or others? Check Yes or No.
 - If yes, continue questions per your agency policy and procedure to include additional screens, and assessment if client has a plan or means to harm self or others. Document client responses and respond accordingly per your agency policy and procedure.
- Are you currently seeing a therapist/Counselor, (or sought help in the past), for a mental health or behavioral need? Check Yes or No.
 - If yes, describe in detail to include therapist name, address, how long, successful discharge, what was client being seen for, did the client feel treatment helped or not.
 - If yes to above, are you currently prescribed medications for mental health/behavioral health conditions described above? Check Yes or No.
 - If yes, describe; name, dosage, frequency, prescribed by whom. Did client take as directed?
- Have you ever had trouble controlling your anger? Check Yes or No.
 - If yes, describe with additional detail; how often, when was the last time, what does it look like, what helps to calm you, what's the worst that happened when you had trouble



controlling your anger?

- **Over the past (2) weeks, how often have you been bothered by any of the following problems?** Ask *all* six prompts, check the appropriate box: Not at all, Several Days, More Than Half the Days, Nearly Every Day. ***DO NOT LEAVE BLANK.***
- **Severity Rating – Dimension 3 (Emotional, Behavioral or Cognitive (EBC) Conditions or Complications):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form as well as the risk assessment and co-occurring screening forms when determining the risk rating.

ASAM DIMENSION 4: READINESS TO CHANGE

- **On a scale of 0 (not ready) to 4 (very ready) how important is it you to stop drinking or using other drugs:** Check the appropriate box. Add additional comments as appropriate. Use the client's own words as much as possible.
- **Do you intend to reduce or quit drinking alcohol or using other drugs in the next 2 weeks:** Check the appropriate box.
- **Does your family or friends ever tell you that you should cut down on your drinking or drug user:** Check the appropriate box.
 - If yes, provide additional information.
- **Severity Rating – Dimension 4 (Readiness to Change):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

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

- **Do you ever use alcohol or other drugs while you are by yourself or alone?** Check Yes or No.
- **Do you ever use alcohol or other drugs to relax feel better about yourself, or fit in?** Check Yes or No.
- **How often do you want to or feel like using or drinking?** Document in client's own words.
- **What's the longest time you have gone without using alcohol and/or other drugs?** Document in client's own words; try to obtain specific timeframes, what helped him/her to achieve this.
- **Severity Rating – Dimension 5 (Relapse, Continued Use, or Continued Problem Potential):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

ASAM DIMENSION 6: RECOVERY ENVIRONMENT

- **Have you ever gotten into trouble while you were using alcohol or other drugs?** Check Yes or No.
 - If yes, describe in detail; timeframes, whom involved, consequences, how many times, times when client avoided getting into trouble and how did he/she achieve that?
- **Vocational/Educational Achievements (Highest grade level completed, any training or technical education, etc.):** Enter vocational/educational school or training.
- **Do you feel supported in your current living environment?** Check Yes or No.
- **Are you homeless or at risk?** Check Yes or No.
 - If yes, obtain additional information: how long, do you have a caseworker? Is the client interested in a housing referral and/or linkage? Could this be a barrier to service?



- **Where do you live/who do you live with?** Enter client self-report. How many times has the client moved within the last 18 months and why? How often do the people whom the client lives with change?
- **Does anyone else at home drink alcohol or use other drugs?** Check Yes or No.
 - If yes describe with as much detail as possible. Has Child Welfare ever come to your home or school?
- **Do your close friends drink alcohol or use other drugs?** Check Yes or No.
 - If yes, describe to include if any are currently in treatment.
- **Severity Rating – Dimension 6 (Recovery/Living Environment):** Follow the prompts and check the current, assessed level of risk. Include information from Parent/Guardian Form when determining risk rating.

YOUTH "AT" RISK :

- **Youth is at-risk for SUD and does not have a SUD diagnosis:** Check Yes or No.
 - If yes, refer to appropriate community resource.

LEVEL OF CARE DETERMINATION

(Read Level of Care Determination Instructions provided on the Screen/Intake Form carefully).

- **Recommended Level of Care:** Enter the ASAM Level of Care that offers the most appropriate treatment setting given client's current severity and functioning.
- **Acute Level of Care:** If a level of care other than the determination is provided, enter the next appropriate level of care.
- **Reason for Discrepancy:** Check the reason(s) for a discrepancy in the recommended level of care vs. acute level of care if appropriate. Provide a written explanation of the discrepancy on the line provided.
- **Designated Treatment Provider Name/Location:** Complete this information if services are NOT going to be provided by program completing this assessment and they are referring the client to another program.
- **Counselor Name:** If applicable, print name, signature, credentials, and date.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY AN LPHA

PROVISIONAL DIAGNOSIS

NOTE: All programs must provide a provisional diagnosis

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

- **Enter Provisional DSM-5 Diagnosis & ICD-10 Code(s):** Ensure to utilize correct DSM-5 diagnostic label and ICD-10 code; a diagnosis of Substance Use will be the primary and listed first. There can be additional DSM-5 Diagnostic Labels and ICD-10 codes listed as well, but will need to follow the SUD label if appropriate.
- **A Face to Face interaction occurred between both counselor and LPHA to validate medical necessity:** Enter the date of the face to face interaction, if applicable.
Note: If a LPHA does not conduct the assessment, a face-to-face interaction must take place, at a minimum, between the counselor who has completed the assessment for the client and the medical director, licensed physician, or LPHA. The medical director, licensed physician, or LPHA must document the date when the face-to-face interaction took place and then sign and date the assessment form.
- **Provisional Diagnosis Narrative:** Explain basis for provisional diagnosis here
- **LPHA* Name:** Print name, signature, credentials, and date.

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



Risk Assessment and Safety Management Plan Instructions

REQUIRED FORM:

This form is a required document in the client file.

WHEN:

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

COMPLETED BY:

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

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

REQUIRED ELEMENTS:

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



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

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

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

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

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

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



Discharge Summary Instructions

REQUIRED FORM:

This form is a required document in client file

WHEN:

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

COMPLETED BY:

An SUD Counselor or LPHA from the program

REQUIRED ELEMENTS:

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



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



GLOSSARY

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



CONTACT INFORMATION

SanWITS System and End User Support

SUDEHRSupport.HHSA@sdcounty.ca.gov
Phone: 619-584-5040 (for password resets)
Fax: 1-855-975-4724

Clinical Processes and Documentation

QIMatters.HHSA@sdcounty.ca.gov

BHS SUD Instructions, Manuals, and Forms

www.optumsandiego.com

SanWITS Training Registration

<https://www.regpack.com/reg/dmc-ods>
1-800-834-3792 x3

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

