SUBSTANCE USE DISORDER MIS

TREATMENT PLAN TRAINING

Live Well San Diego

County of San Diego

Behavioral Health Services

TABLE OF CONTENTS

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 Systems (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!

TREATMENT PLANS IN SANWITS

Important: *Prior to completing treatment plans in the Live environment, review the Substance Use Disorder (SUD) Quality Management (QM) guidelines, SUD Provider Operations Handbook (SUDPOH), and SUD Uniform Record Manual (SUDURM) instructions for each treatment plan.*

Overview of Treatment Plans

Treatment plans are completed as part of the clinical workflow of the client's electronic health record. The standards in completing treatment plans in paper and electronically (in SanWITS) are the same.

Follow the SUDURM treatment plan instructions in completing a treatment plan. The instructions provided in this manual are more technical in nature and apply to system requirements needed to complete treatment plans in SanWITS. These do not replace the guidelines provided at clinical documentation training classes and other workshops facilitated by SUD QM. It is ***strongly recommended*** that staff complete the QM Clinical Documentation Training before attending the SanWITS Treatment Plan Training.

After the client profile and contact records are completed and medical necessity has been determined through the initial level of care (ILOC) and diagnosis determination note (DDN), the client is admitted, assigned to a treatment team, and enrolled in a treatment program. The CalOMS (California Outcome Measurement System) admission record must also be completed.

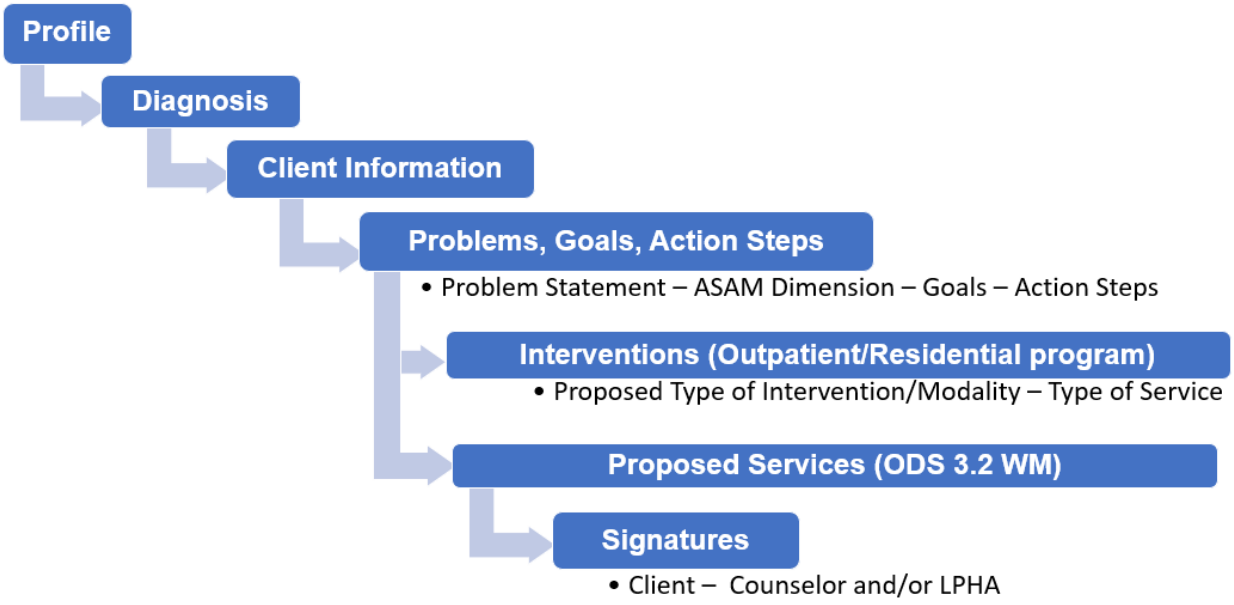
With the exceptions of special circumstances, for example ***courtesy dosing***, a client must have a program enrollment in order to enter a treatment plan in SanWITS. Below is a basic workflow that must be followed in creating a treatment plan.

The **SUD QM resources**, such as SUDPOH, SUDURM, tip sheets, and important announcements for detailed instructions in completing a treatment plan, can be accessed through the Drug Medi-Cal Organized Delivery System (DMC-ODS) page of the Optum website at www.optumsandiego.com, Questions can also be sent to QIMatters.HHSA@sdcounty.ca.gov.

Design of the Treatment Plans

After a client is enrolled in a program, a counselor or an LPHA (Licensed Practitioner of the Healing Arts), in collaboration with the client, prepares the treatment plan. A diagnosis must be added based on the clinical standards outlined in the SUDPOH.

The following illustrates the treatment plan design in SanWITS. Some data prepopulate from other parts of the client's SanWITS record.



A treatment plan goes through different stages as it is developed in SanWITS. The signature buttons are hidden when the plan is *In Progress*. After the plan is completed and the client signature is collected, the plan is *Pending Signature* if completed by a counselor or *Pending Finalization* if prepared by an LPHA. If the completed plan was signed by a counselor, the system then sends it to the LPHA for review and finalization. After the plan is reviewed and signed by the LPHA, it is in a *Finalized* stage.

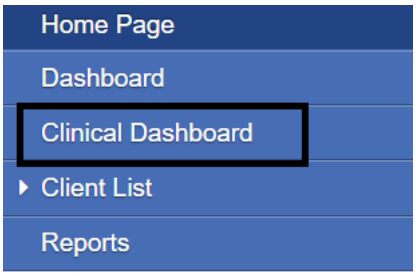
- **In Progress**: Created in SanWITS but incomplete
- **Pending Signature**: Signed by the client but pending counselor signature
- **Pending Finalization**: Pending LPHA review and signature
- **Finalized**: Signed and finalized by the LPHA

CREATING TREATMENT PLANS

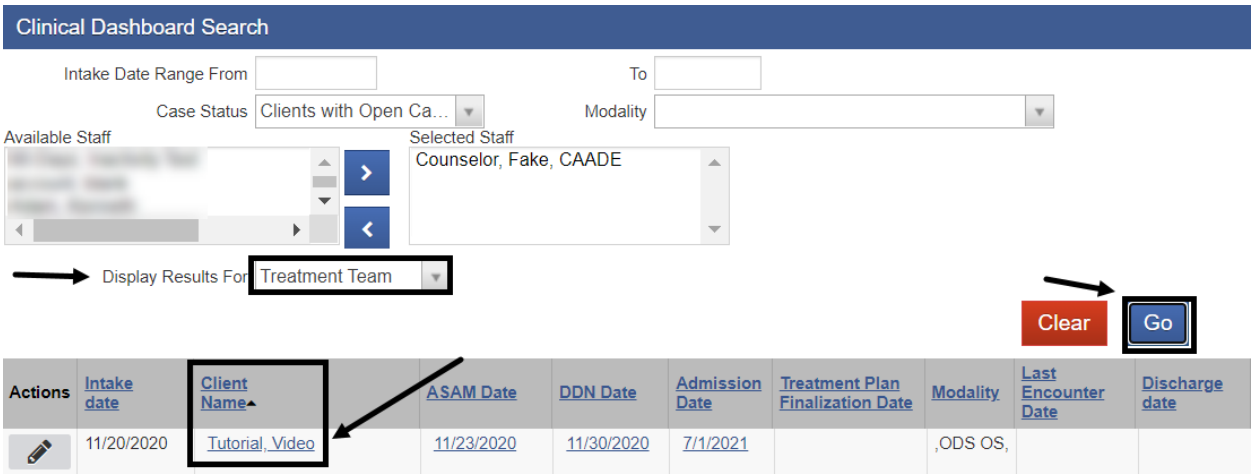
Follow the SUDURM instructions in completing a treatment plan. The standards in completing a treatment plan in SanWITS are the same as in paper and are shown on the SUDURM treatment plan instructions posted on the Optum website.

Initial Treatment Plans

An initial treatment plan is completed for a client admitted to Outpatient and Residential Programs. To create an initial treatment plan from the Home Page navigation pane, click **Clinical Dashboard.**

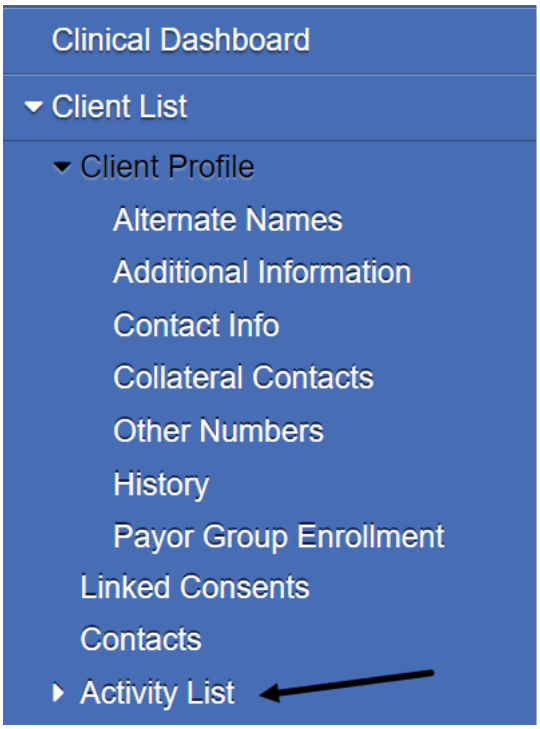


In the Clinical Dashboard Search screen, display the results for Treatment Team, and in the Client Name column click the **client's name** to pull up the client record.

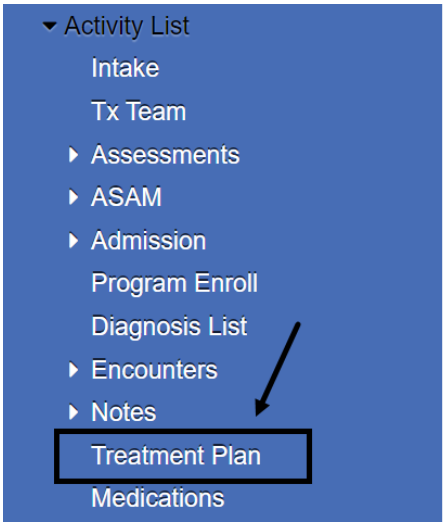


Note: *Prior to completing treatment plans in the Live environment, review the SUD QM guidelines, SUDPOH, and SUDURM instructions for each treatment plan.*

When the Client Profile is launched, from the navigation menu scroll down and click **Activity List**.



Under Activity List, click **Treatment Plan**.

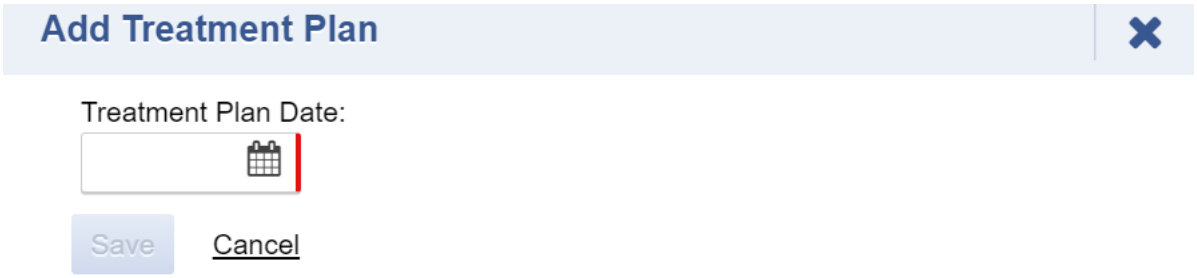


The Treatment Plan screen launches, allowing the user to search and view finalized treatment plans, or edit treatment plans that have not been finalized. Searching, viewing, and editing treatment plans are covered in a separate section of this manual.

Create New Treatment Plan

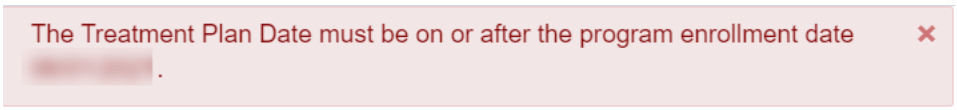
To continue creating the initial treatment plan, to the right of the screen click **Create New Treatment Plan**.

The Add Treatment Plan window opens. The Cancel button closes the window and returns to the Treatment Plan Search screen.



To continue adding a treatment plan, enter the **Treatment Plan Date**. The date should be on or after the client's program enrollment. It cannot not be earlier than the program enrollment and cannot be a future date.

An error message appears on the screen if a date prior to program enrollment date is entered.



An error message also appears on the screen if a future date is entered.

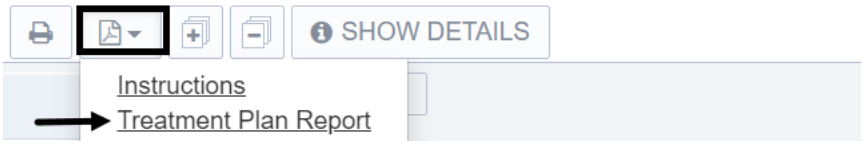
Click **Save**.

The Treatment Plan workspace launches. To return to the main navigation pane, click **Menu**. To go back to the Treatment Plan screen, click **Back**.

To inactivate editing, click **Done Editing**.

Printing a Treatment Plan

The standard print button opens the standard print window. However, it is best to click the **Generate Report** button, then select **Treatment Plan Report** and preview the record before printing it.

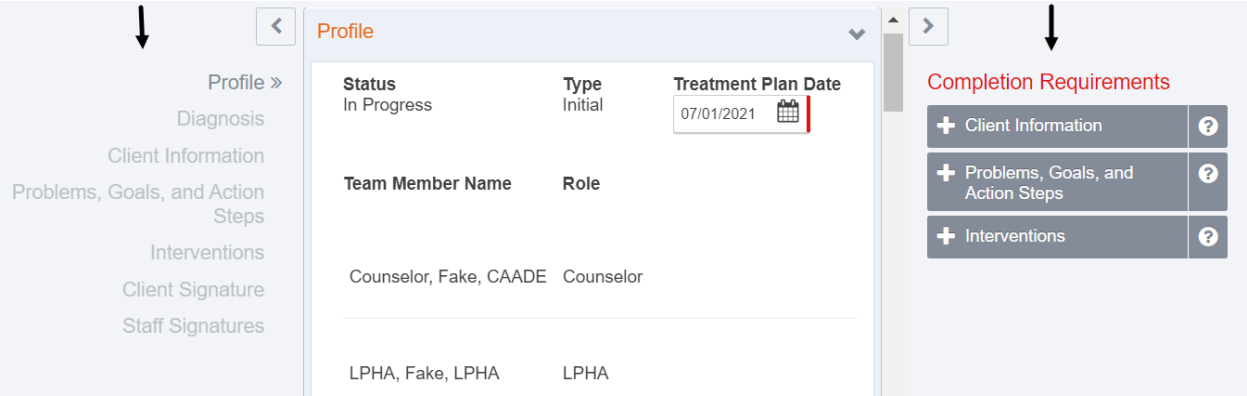


To expand all panels, click the **Expand All (+)** button. To collapse all panels, click the **Collapse All (-)** button.

***Note**: To print a Treatment Plan, select the **Generate Report** button instead of the standard print option for best results.*

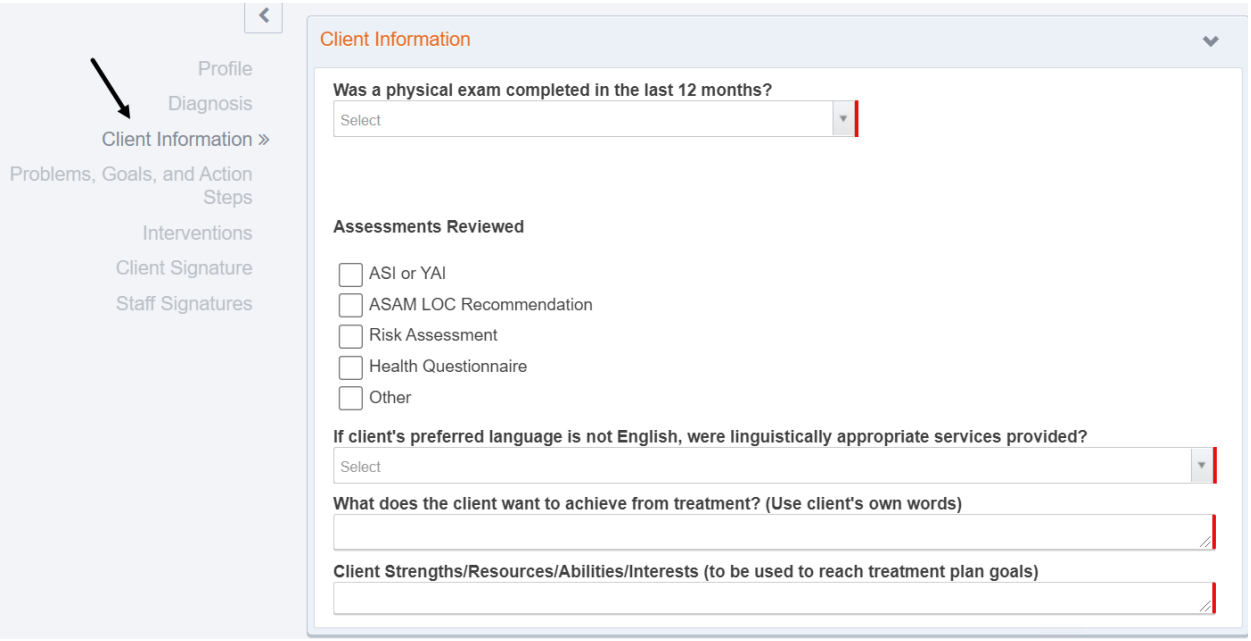
The Treatment Plan is divided into 3 sections.

In the left section is the list of panels. The panels are in the middle section, and the Completion Requirements are listed on the right.



Panels

Select a panel title to jump to a particular panel.

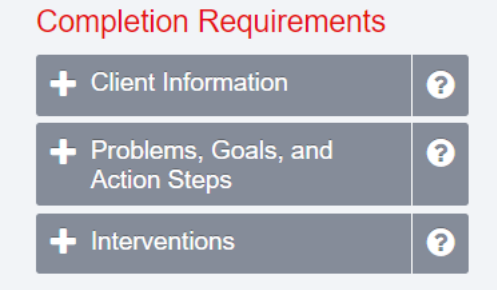


Completion Requirements

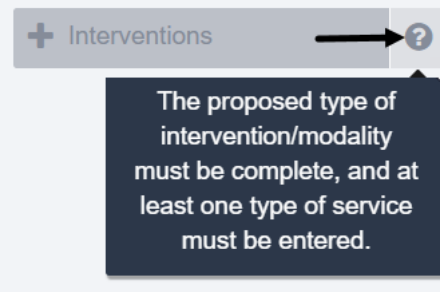
The completion requirements section validates the proper completion of the treatment plan.

This section also alerts the counselors and LPHAs which panels are incomplete. When a panel is completely filled in, it is cleared from this section.

The client and staff signatures are inactive while there are panels listed in the completion requirements.



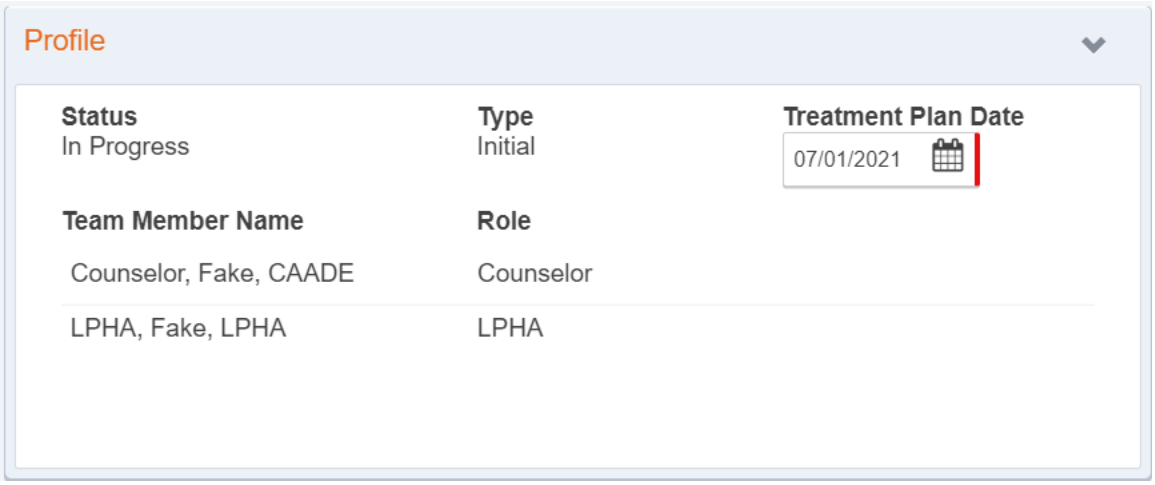
The panels have Help text for additional information. To view Help text, to the right of the listed requirement, hover over the **Question Mark (?)**.



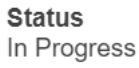
NOTES

Profile Panel

The Profile panel displays the status, type, treatment plan date, and treatment team members of the client.

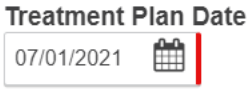


Status- The status default value is In Progress and will remain in this status until the plan is signed by the client.



Type- The type is Initial for the first plan created.

Treatment Plan Date- The treatment plan date is captured from the Add Treatment Plan window. It can be changed as long as the plan has not been signed by the client. This date should be on or after the program enrollment date up to the current date, but not a future date.



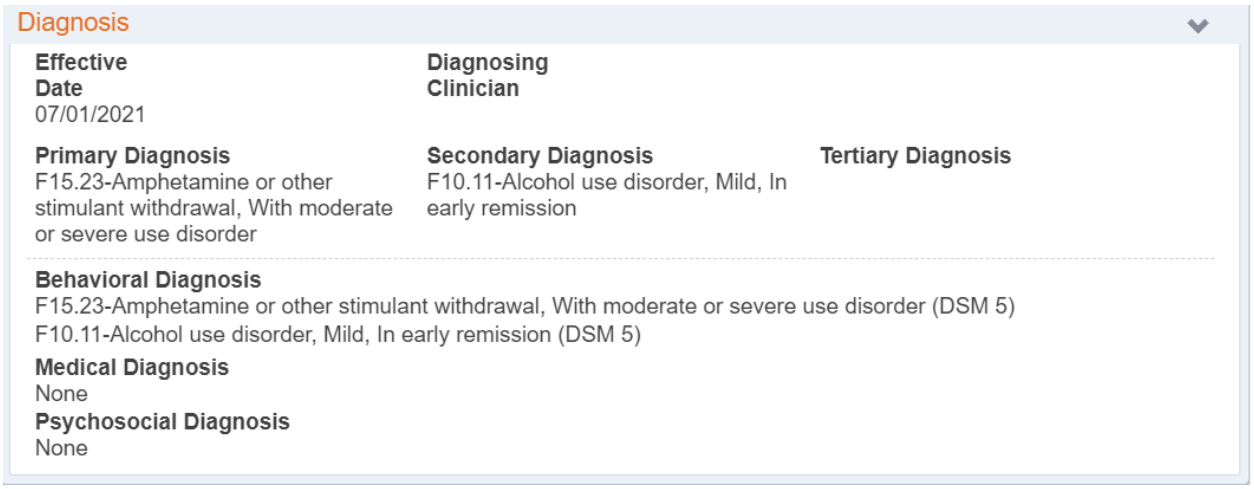
Note: *The Type is **Updated** for subsequent plans. However, for ODS 3.2 WM (Withdrawal Management) client program enrollment, **Withdrawal Management** always prepopulates as the Type.*

Team Member Names- A Treatment Team must include, at a minimum, a counselor (or an LPHA) and must be entered before creating a treatment plan because the team member names are pulled from the Treatment Team screen and cannot be changed in the treatment plan. To add or remove a team member, a staff with full access to the Treatment Team screen will make the changes in the Treatment Team screen. If the *pending* treatment plan is open, close and then re-open it to refresh the team member names. Changes to the Treatment Team screen do not pull forward into a *finalized* treatment plan. Refer to the SUDPOH for more information.

Team Member Name	Role
Staff, Rendering	Counselor
Lead, DMC, LMFT	Case Manager

Diagnosis Panel

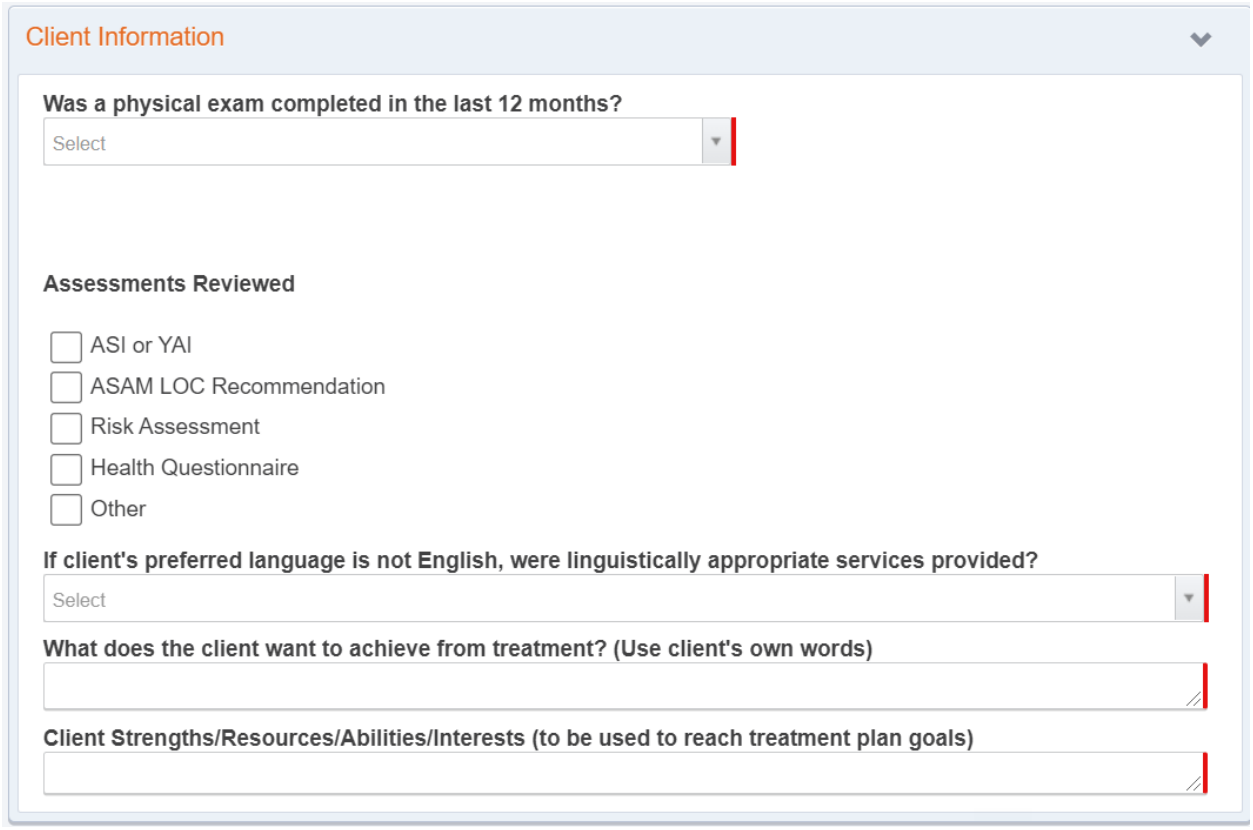
The Diagnosis panel is read only and prepopulates with all active diagnoses identified on a finalized Diagnosis Determination Note (DDN).



A diagnosis is required but cannot be added within the treatment plan. To add or change a diagnosis while the treatment plan is pending, create a new DDN. The DDN must be finalized before finalizing the treatment plan. If the *pending* treatment plan is open, close it and then re-open it to refresh and capture the diagnosis from the finalized DDN. If there are any updates made to the diagnosis record through the DDN, the updates will not pull forward to the finalized treatment plan. Once the treatment plan is finalized, the diagnoses that prepopulated are locked.

Client Information Panel

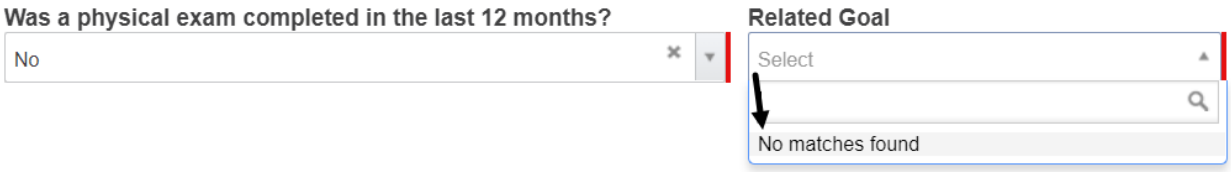
A client's physical examination in the last 12 months, assessments reviewed, preferred language, what the client wants to achieve from treatment, and the client's strengths are stored in the Client Information panel. All these fields must be completed, with at least one selection in the Assessments Reviewed section.



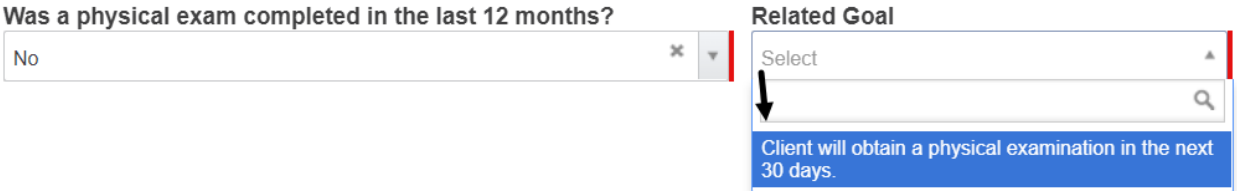
Was a physical exam completed in the last 12 months?- If a physical examination has been completed within the last 12 months, select Yes.

If a physical examination has not been completed in the last 12 months, select No. The Related Goal drop down menu is then activated and must be completed.

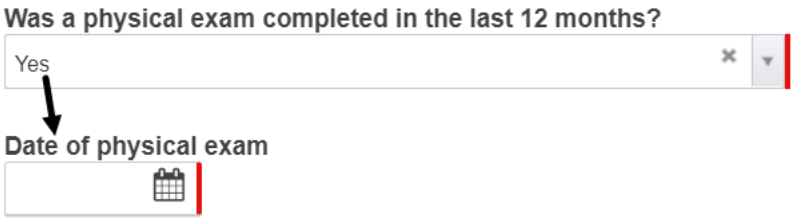
The Related Goal field starts out blank, displaying the error message 'No matches found'.



A goal to obtain a physical examination under the Biomedical Conditions and Complications ASAM 2 Dimension must be added. *Refer to the Problems, Goals, and Action Steps Panel section for the steps to adding a goal.* After an ASAM 2 goal is entered, return to this field to select it.

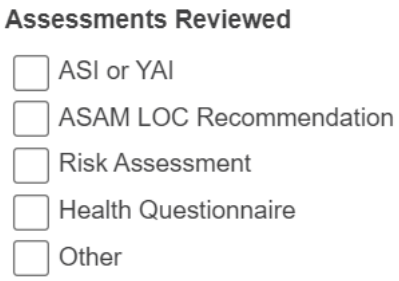


If there was a physical examination completed in the last 12 months, enter the **Date of physical exam**.

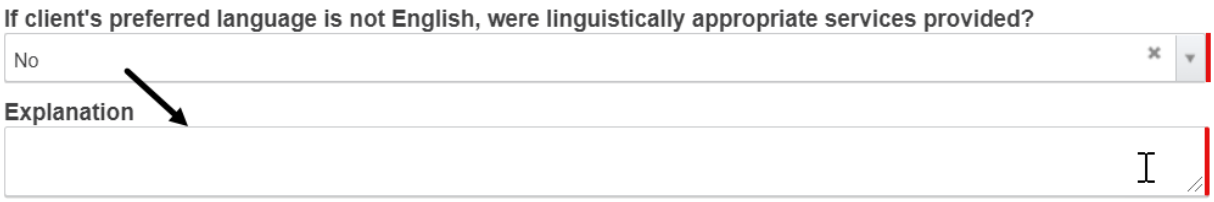


If the client has completed a physical examination but has not provided a copy of the examination results, a goal to obtain a physical examination must remain in the treatment plan and selected as a related goal.

Assessments Reviewed- Select all the assessments that were reviewed. At least one assessment must be selected.

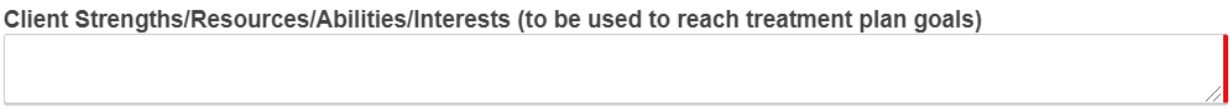


If client's preferred language is not English, were linguistically appropriate services provided?- There are three selections for the linguistically appropriate service question. Selecting 'Yes' or 'Not Applicable' does not require justification but 'No' does. Enter the reason in the Explanation field if the language used in service is not English and a translator was not provided.



What does the client want to achieve from treatment? (Use client's own words)- Client's own words may be used in documenting the client's hopes and goals regarding treatment services provided at the program.

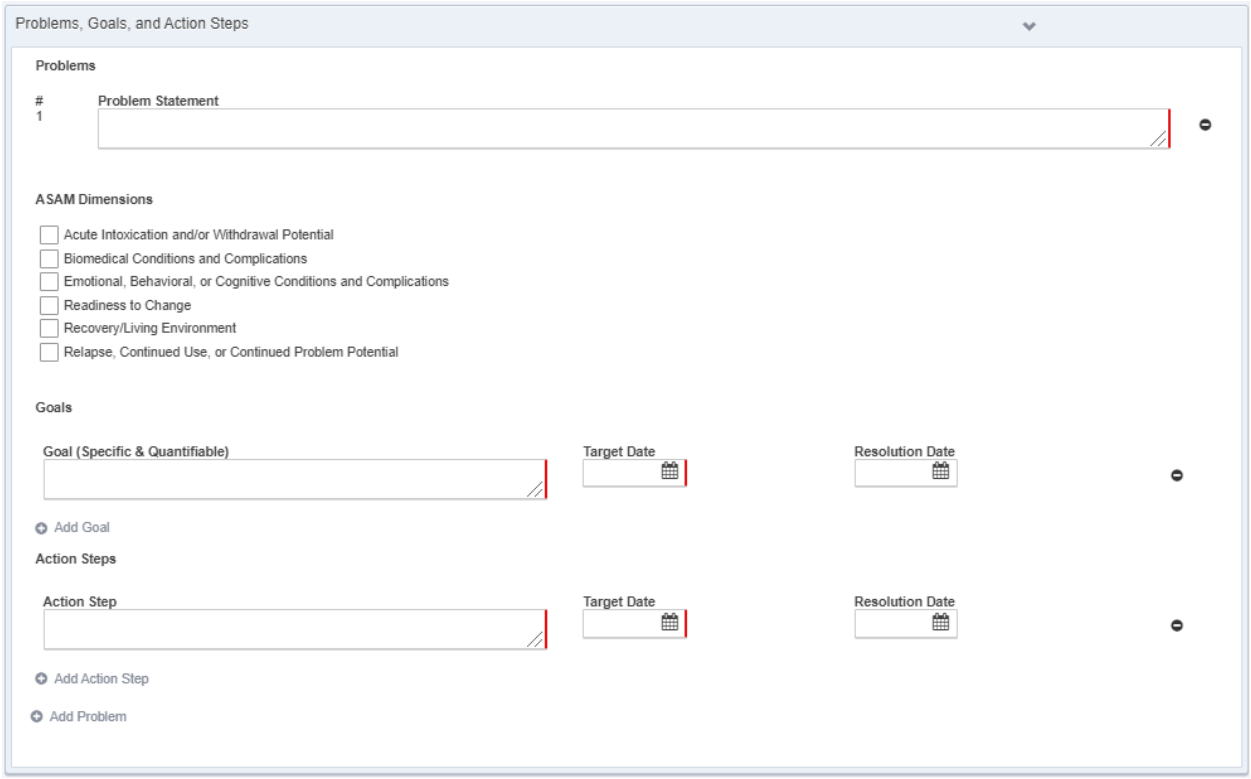
Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals)- Enter the strengths of the client that were collected during the motivational interview.



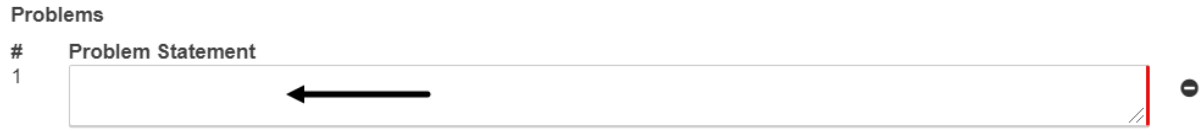
When the panel is fully completed, the Client Information panel title is automatically removed from the Completion Requirements.

Problems, Goals, and Action Steps Panel

The Problems, Goals, and Action Steps panel is used to document the client's problems, goals, and action steps. The treatment plan must contain at least one problem that is associated to at least one ASAM dimension and must have one goal and one action step.



Problems- Enter the problem unique to the client. Multiple related problems may be combined into one problem statement if the problems fall under the same ASAM dimension. Problem statement numbering starts at number 1.

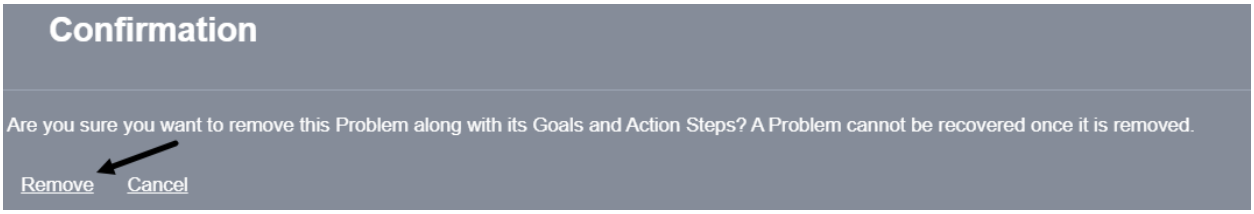


To add an additional problem statement, click **Add Problem** on the lower left corner of the panel.

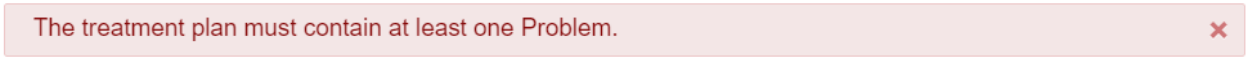
Each additional problem will also contain the same set of fields- a problem statement, at least one ASAM Dimension, a specific and quantifiable goal with a target date, and an action step with a target date. Additional problem numbers are automatically generated in increments of 1.

To remove a problem, click **Remove (-)** to the right of the problem statement to be removed.

On the Confirmation message, click **Remove** to delete the problem along with its goals and action steps. To keep the problem and its goals and action steps in the plan, select Cancel.



The treatment plan must contain at least one problem. If there is only one problem and the Remove (-) button is selected, an error message appears on the screen and the problem is not removed from the plan. Click **x** on the right of the message to manually close the error message.

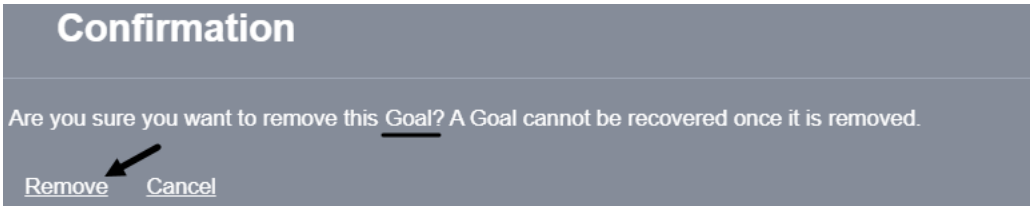


Goals- To add a goal, enter a specific and quantifiable goal in the **Goal** field. Enter the target date for the goal in the **Target Date** field. The target date can be a future date but cannot be prior to the treatment plan date.

If there are multiple goals identified in addressing the client's problem, click the **Add Goal** button below the Goal field, then enter the additional goal and its target date. Repeat the step for additional goals.

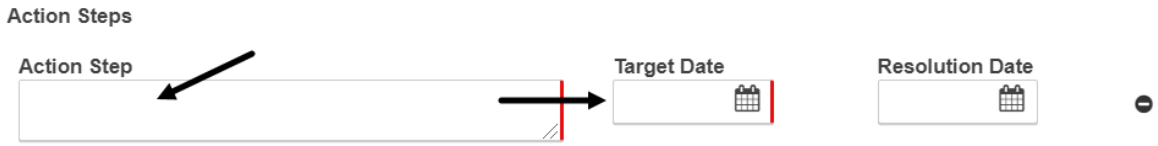
To remove a goal, click the **Remove (-)** button to the right of the Goal field.

On the Confirmation message, click **Remove** to delete the goal. Removing a goal cannot be undone. If the goal was removed in error, manually add it back. Click Cancel to keep the goal in the plan.



The problem statement must contain at least one goal. If there is only one goal and the Remove (-) button is clicked, an error message appears on the screen and the goal is not removed from the problem. Click **x** on the right of the message to manually close the error message.

Action Steps- To add an action step, enter a specific action step in **the Action Step** field. Enter the target date for the action step in the **Target Date** field,. The target date can be in the future but cannot be prior to the treatment plan date.



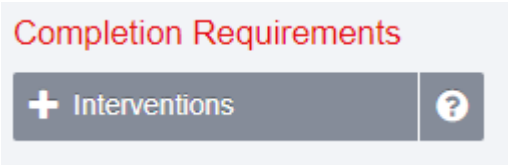
If there are multiple action steps identified to meet a goal, click the **Add Action Step** button below the Action Step field and enter the action step and its target date. Repeat the steps for additional action steps.

To remove an action step, click the **Remove (-)** button to the right of the Action Step field.

At the Confirmation message window, select **Remove**. Removing an action step cannot be undone. If the action step was removed in error, manually add it back. Click Cancel to keep the action step.

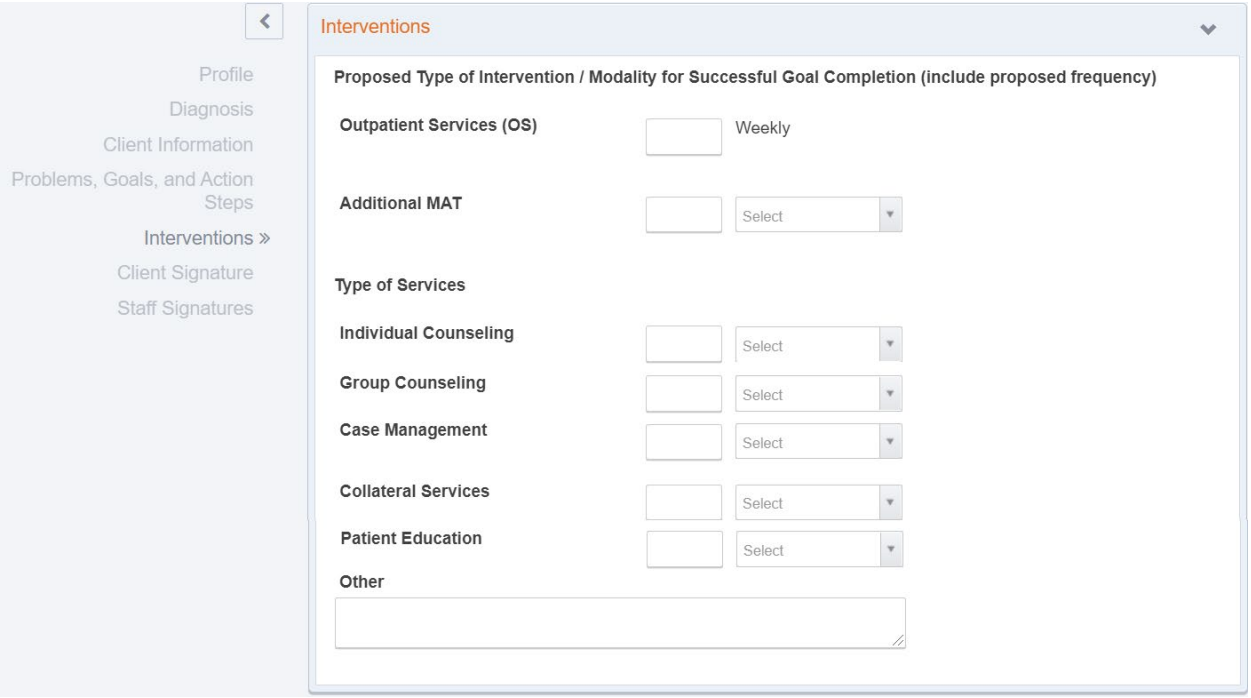
The rules in removing a goal also apply to action steps. The problem must contain at least one action step. If there is only one action step, an error message similar to the goal error message appears on the screen and the action step is not removed from the problem. Click the **x** on the right to manually close the error message.

When the panel is completed, the Problems, Goals, and Action Steps panel title is cleared from the Completion Requirements.



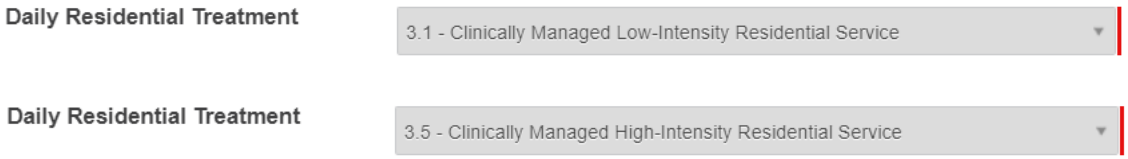
Interventions Panel

The Interventions panel displays the proposed modality, type, and frequency of services that will be provided to the client. Refer to the treatment plan instructions and SUDPOH for more information on interventions.



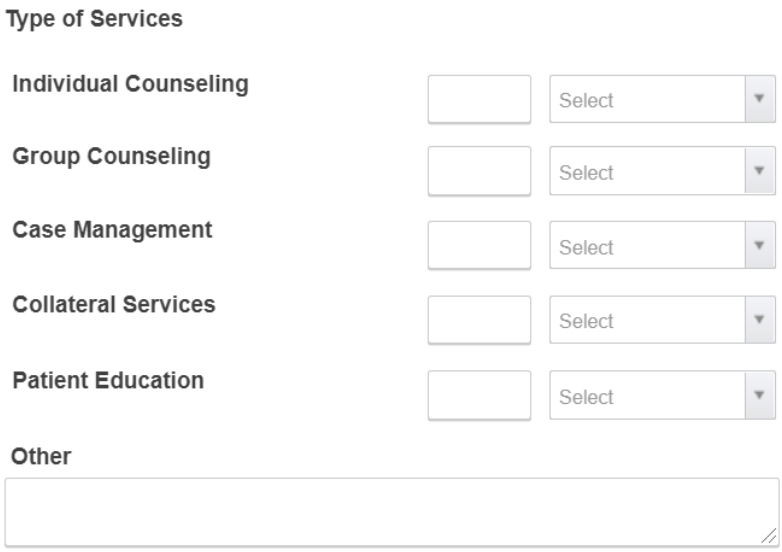
Type of Modality- Enter the frequency of services if the Client Program Enrollment (CPE) is Outpatient Services (**OS**) or Intensive Outpatient Services (**IOS**).

For residential clients, the CPE will prepopulate in the Daily Residential Treatment field.



For OS or IOS client, enter the additional MAT services, if any.

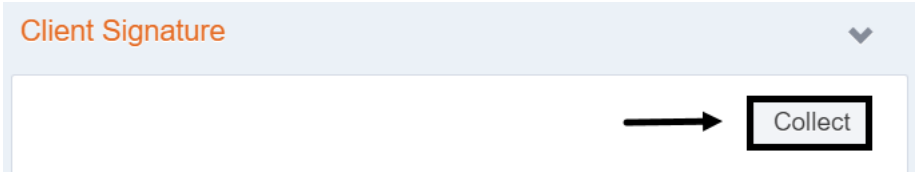
Type of Services- Select at least one service and the frequency of the service to be provided to the client. The <u>frequency</u> of service <u>must</u> be entered if a service is selected. Refer to the SUDPOH and the treatment plan instructions for more information.



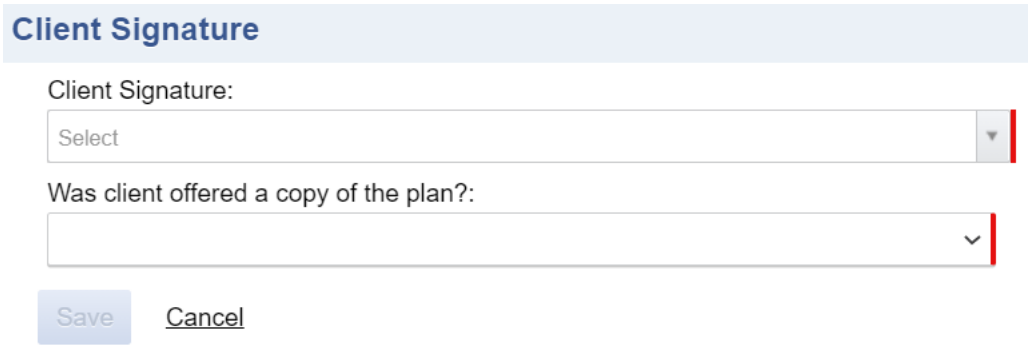
Client Signature Panel

The client signature button is hidden when the treatment plan is pending completion. The Completion Requirements section displays the panels that are incomplete.

The Completion Requirements section is cleared when the plan is completely filled in, and the Collect button in the Client Signature panel is activated. Click **Collect** to complete the client signature.

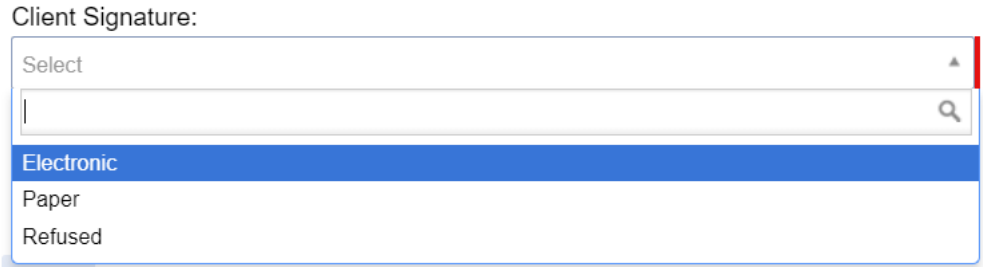


The Client Signature window launches.

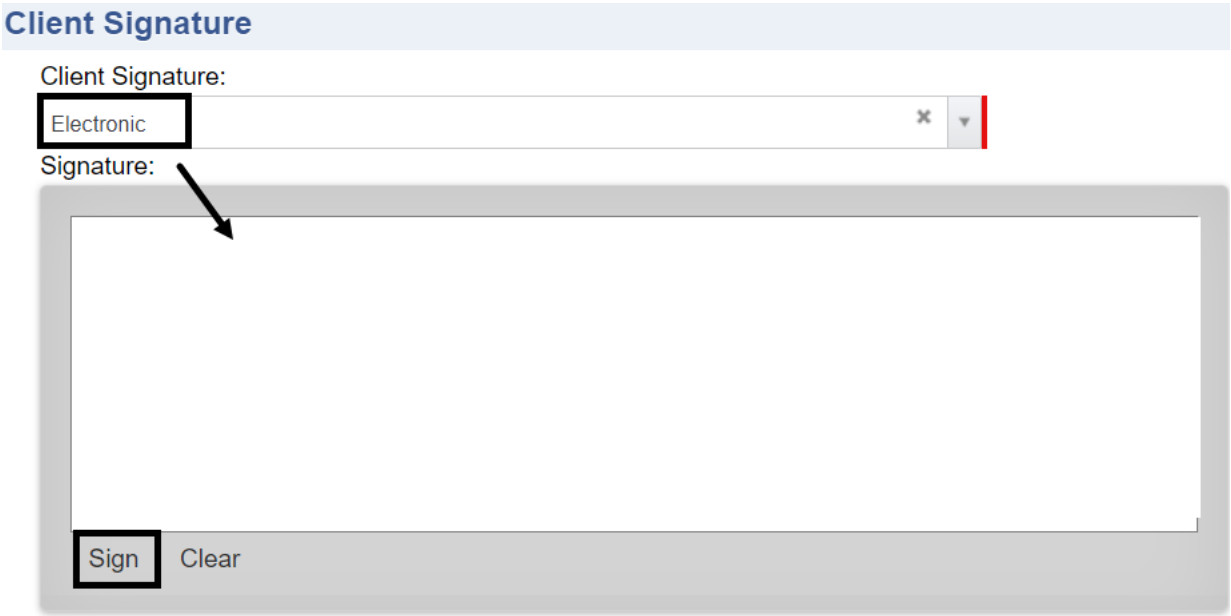


Note: *Refer to the treatment plan instructions and the SUDPOH for signature requirements.*

There are three signature options to choose from- Electronic, Paper, and Refused.



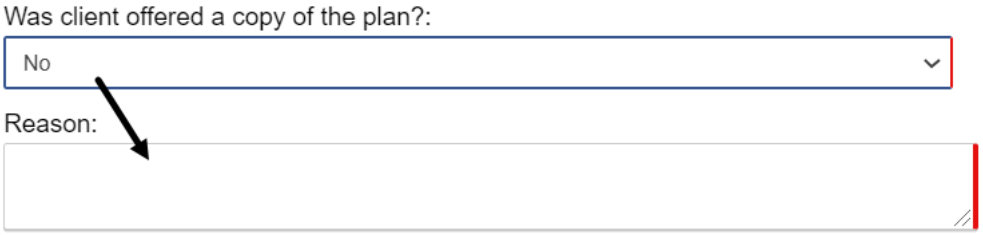
Electronic Signature- If the client is signing electronically, the client may use the mouse pad to sign on the whiteboard provided. Select **Sign** to accept the signature. Select Clear to reject the signature and enable re-signing.



Select Paper if the client signed on paper and explain in the **Reason** field.
Select Refused if the client refused to sign and explain in the **Reason** field. Also, indicate the strategy that will be used to engage the client in completing the treatment plan. Refer to the SUDPOH and the treatment plan instructions for guidelines for this.

If the client was offered a copy of the treatment plan, select **Yes**.

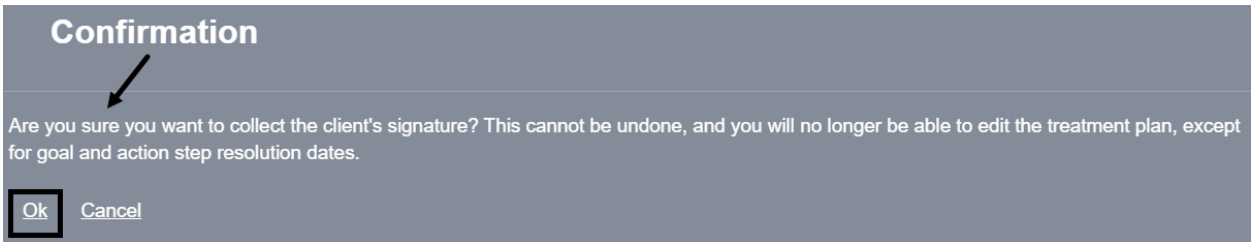
Select **No** if the client was not offered a copy of the treatment plan and explain in the **Reason** field.



After the client signature field is completed and the copy of the plan question is answered, the Save button is activated. Click **Save** to accept the answers. Click Cancel to clear the answers.

Confirmation- The Confirmation message provides one last opportunity to clear or accept the client signature.

Click **Ok** to accept and lock the treatment plan for changes except for the resolution dates on goals and action steps. Select **Cancel** to clear the client signature.



Note: *Once the Client Signature Panel is completed, the treatment plan is locked and can no longer be edited, except for goal and action step resolution dates.*

After the Client Signature Panel is completed, the status of the plan changes to *Pending Signature* if the plan was prepared by the counselor and *Pending Finalization* if prepared by the LPHA.

Status
Pending Signature

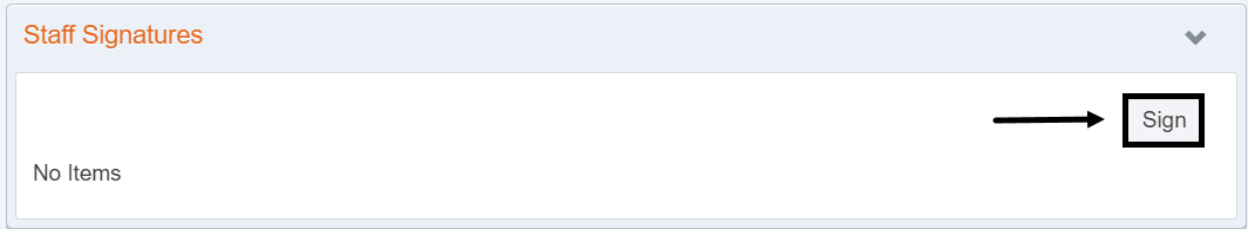
OR

Status
Pending Finalization

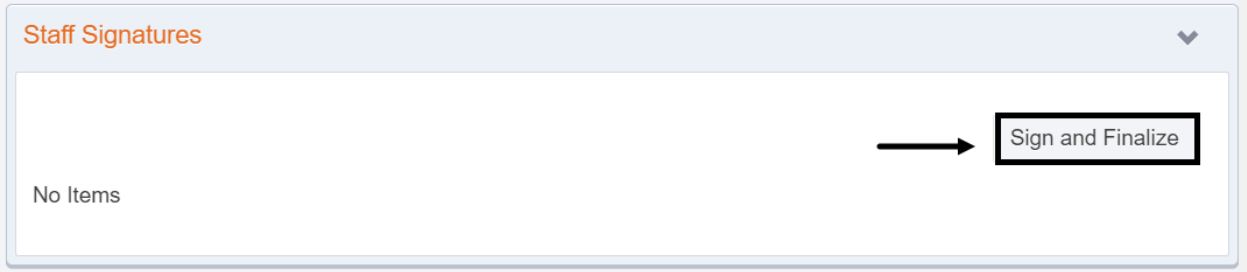
Staff Signatures Panel

The Staff Signatures panel is activated after the Client Signature Panel is completed. Refer to the treatment plan instructions and the SUDPOH for more information on staff signatures.

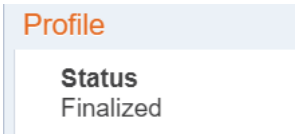
Counselor- If a counselor prepared the treatment plan, click **Sign.** The system will then send the signed plan to the LPHA for review and finalization.



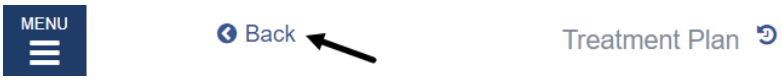
LPHA- If an LPHA prepared the treatment plan or is reviewing the treatment plan that was prepared by a counselor, click **Sign and Finalize**.



After the treatment plan is finalized, the profile status is changed to finalized.



Click the **Back** button to return to the Treatment Plan Search screen.



The Treatment Plan Search screen displays the initial treatment plan as finalized.

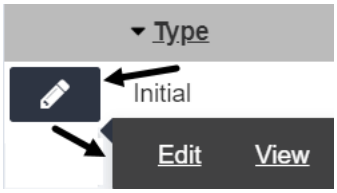
NOTES

Reminder: *Prior to completing treatment plans in the Live environment, review the SUDQM guidelines, SUDPOH, and SUDURM instructions for each treatment plan.*

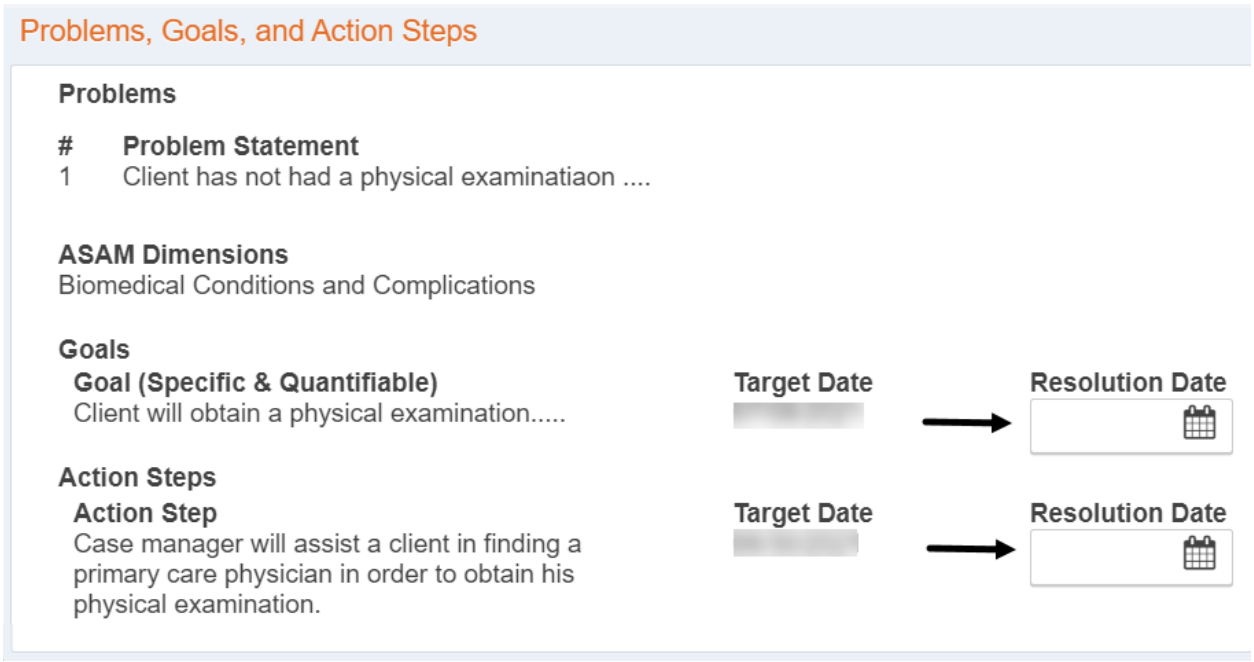
Resolution Dates

The Resolution Date fields are used to document the actual completion dates of established goals and action steps. Follow the treatment plan instructions and SUDPOH guidelines on resolution dates.

To enter the resolution dates from the Treatment Plan Search screen, hover over the pen to the left of the finalized treatment plan and click **Edit**.



Scroll down to the Problems, Goals, and Action Steps panel. In the **Resolution Date** fields, enter the dates the goals and action steps were completed.



Click **Back** at the top of the window to return to the Treatment Plan Search screen.

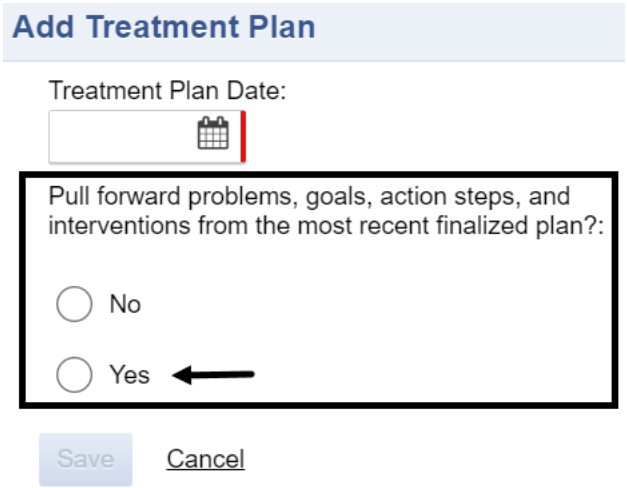
Updated Treatment Plans

Complete an updated treatment plan in accordance with QM guidelines, SUDURM updated treatment plan instructions, and the SUDPOH.

The steps in adding an updated treatment plan in SanWITS are the same as creating an initial treatment plan. This section covers only the sections that are different for updated treatment plans.

Add Treatment Plan

The Add Treatment Plan window includes an additional question for updated plans. Select **Yes** to pull forward the problems, goals, and action steps narratives, and the interventions from the most recent finalized plan. Select No to open a blank treatment plan.

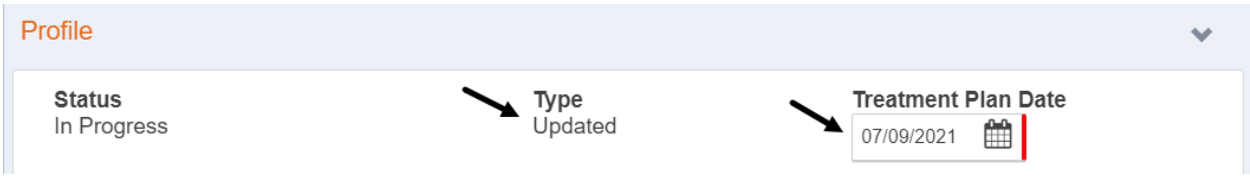


NOTES

Note: *If there is an existing "In Progress" treatment plan, the system will not allow another treatment plan to be created.*

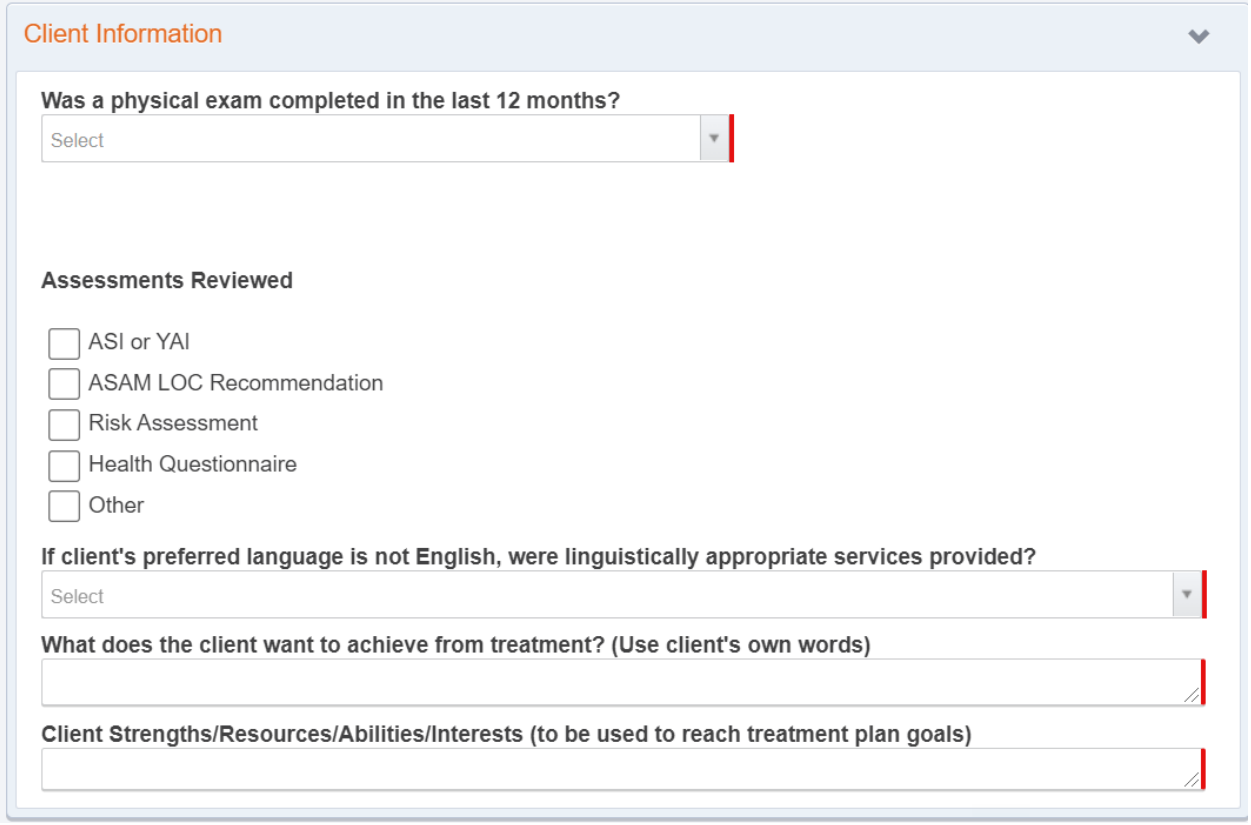
Profile Panel

The Profile panel displays the same information, with one exception. The Type is displayed as ***Updated*** for all subsequent outpatient and residential treatment plans, and **Withdrawal Management** for clients admitted to ODS 3.2 WM (Withdrawal Management) treatment.



Client Information Panel

The client's responses from the most recent finalized treatment plan do not pull forward. Enter the current information to complete the panel.



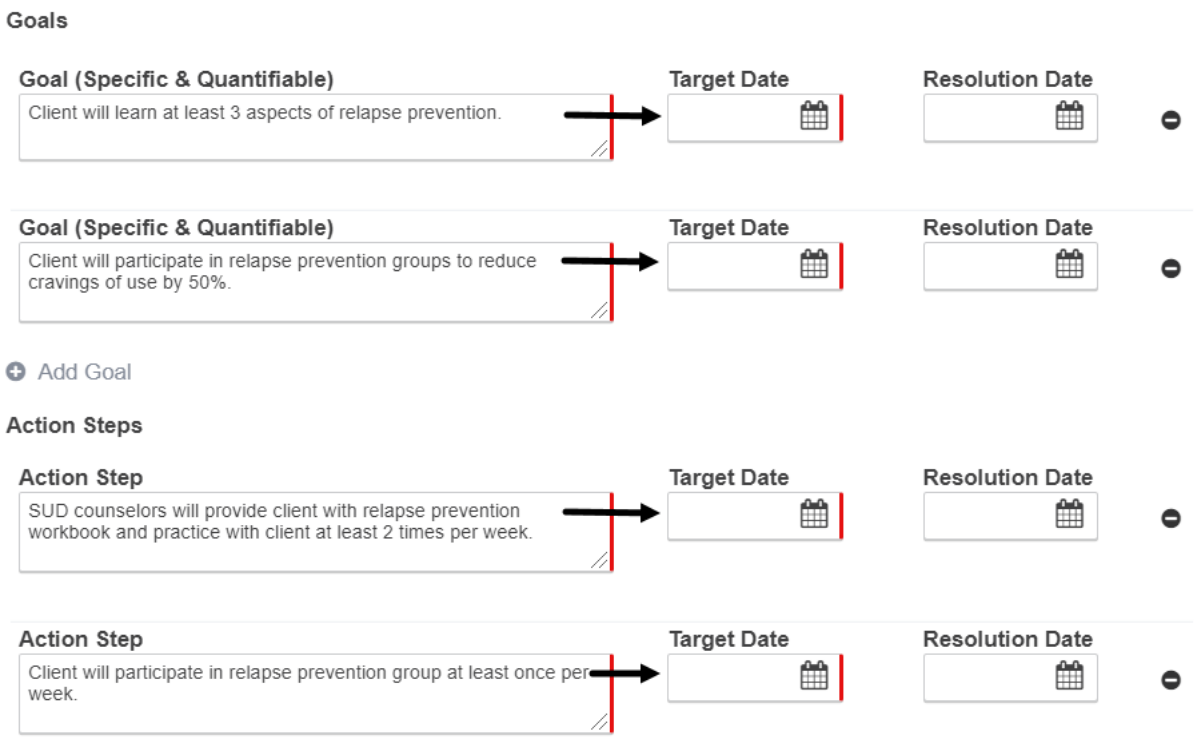
Problems, Goals, and Action Steps Panel

If 'No' was selected in the Add Treatment Plan window, the narratives on the Problems, Goals, and Action Steps panel from the most recently finalized treatment plan do not prepopulate. Start all over to complete this panel.

If 'Yes' was selected, the problem statements from the most recently finalized treatment plan pull forward. The goals and action steps prepopulated if 'Yes' was selected and if resolution dates were not entered prior to the entry of the current treatment plan.

Any goals and action steps that were resolved prior to the entry of the current updated plan do not pull forward. These fields are still active but empty. If there are no new goals or action steps to be achieved, remove the blank fields.

Review the prepopulated narratives according to the updated treatment plan instructions and the SUDPOH. Also, enter the target dates for the goals and action steps since target dates do not prepopulate.



Review the updated plan for accuracy, and then complete the signatures.

Withdrawal Management Treatment Plans

Complete a treatment plan for withdrawal management in accordance with QM guidelines, SUDURM treatment plan instructions, and the SUDPOH.

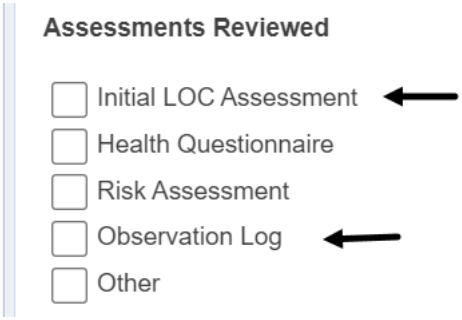
The steps in adding a withdrawal management treatment plan in SanWITS are the same as creating an initial treatment plan. This section covers only the sections that are different for withdrawal management.

Profile Panel

Type- The Profile panel contains the same information, with one exception. The Type is *Withdrawal Management* for the initial and subsequent plans, if any.

Client Information Panel

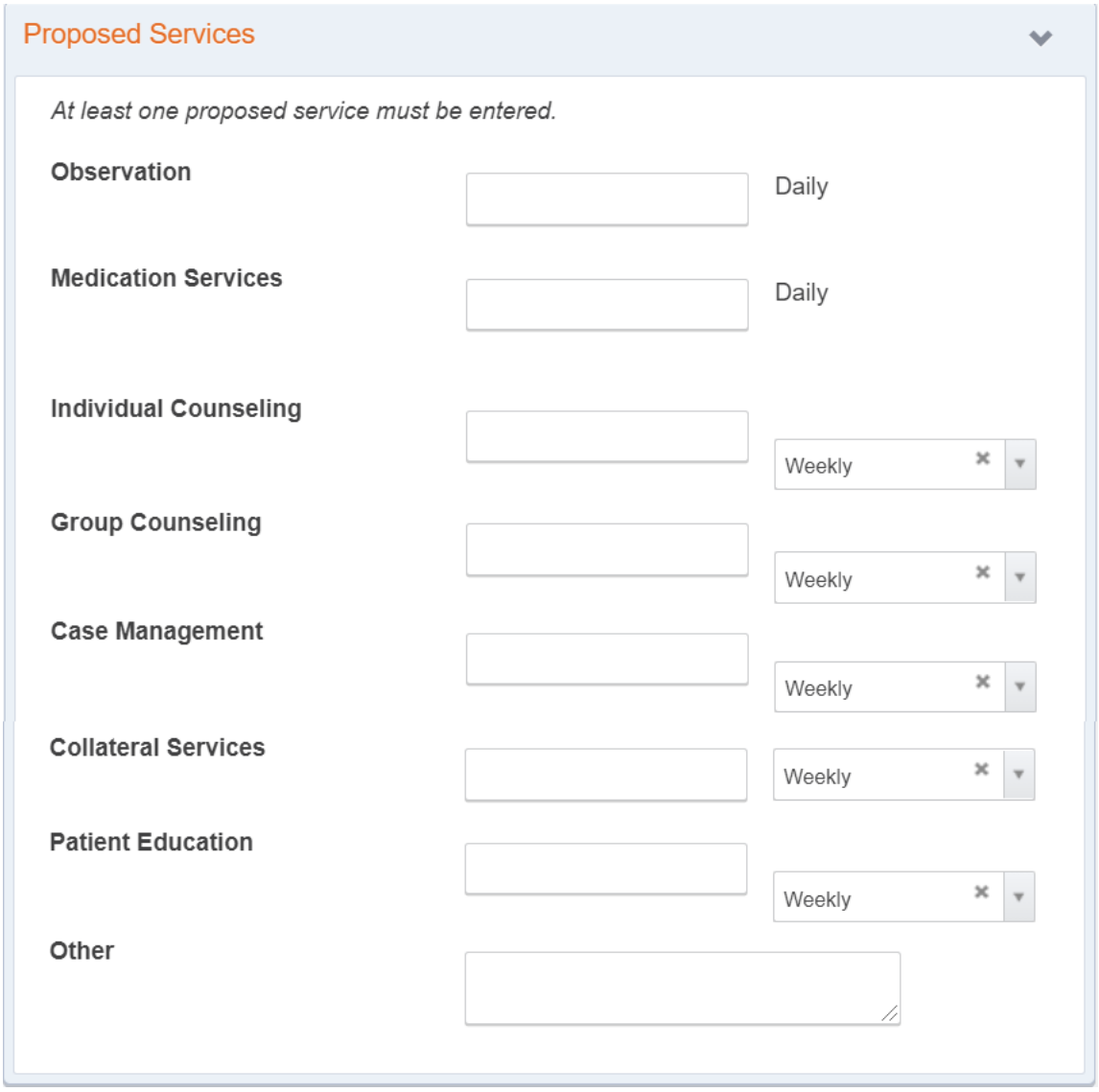
Assessments Reviewed– The list of assessments reviewed include *Initial LOC Assessment* and *Observation Log*. At a minimum, one assessment must be selected.



Reminder: *Review the SUDQM guidelines, SUDPOH, and SUDURM instructions for each treatment plan before entering information in SanWITS.*

Proposed Services Panel

The Interventions panel is titled Proposed Services. Select at least one service and the frequency of the service to be provided to the client. The frequency of services must be entered if a service is selected. Refer to the SUDPOH and the treatment plan instructions for more information.



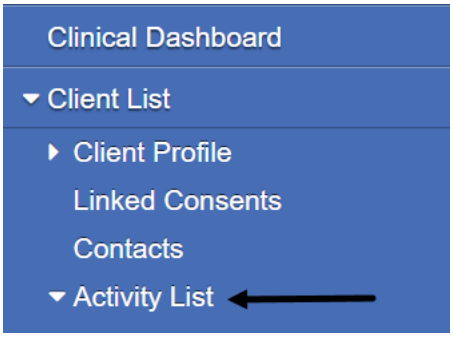
Review the treatment plan for accuracy, and then complete the signatures.

ACCESSING TREATMENT PLANS

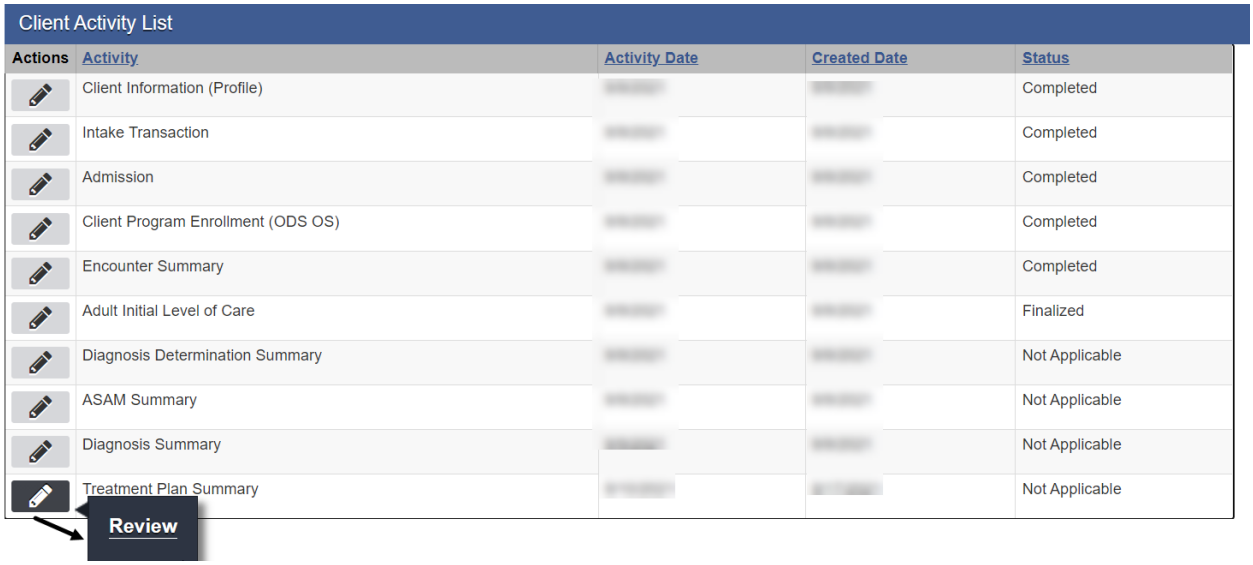
Clinical staff should enter a treatment plan in SanWITS. The treatment plan is within the Activity List as a standalone menu.

Viewing Treatment Plans

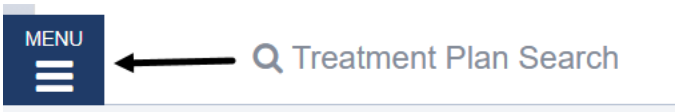
To view an existing treatment plan after launching the client profile from the navigation pane, click **Activity List**.



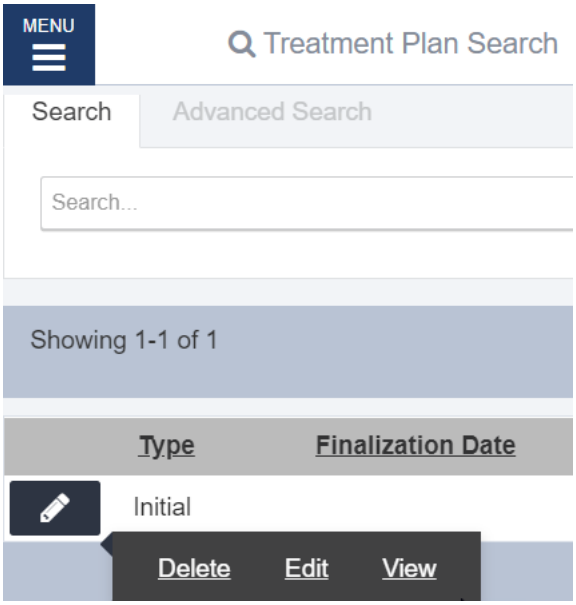
To view an existing treatment plan, find the Treatment Plan Summary in the Client Activity List, hover over the pen in Actions and click **Review.**



To return to the homepage, on the upper left corner of the Treatment Plan Search screen click MENU.



The Treatment Plan Search screen launches. Hover over the pen to view the options- Delete, Edit, or View. The Delete option is active while the plan is in progress. If the Delete button is not available, then the treatment plan has been signed or the staff has no access to the delete function.

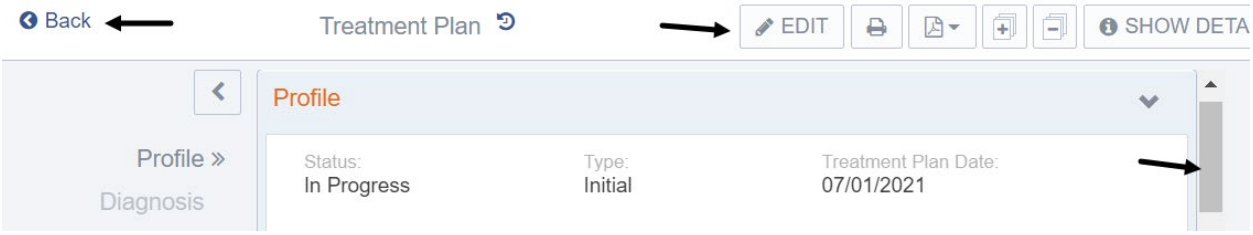


Select **Delete**, if the option is available to the staff, to remove a pending plan that was incorrectly entered. Once a treatment plan is deleted, it is permanently removed from the system and cannot be restored.

Select **Edit** to update a pending plan. Clinical staff with full access to treatment plans may edit a pending treatment plan as long as it is not signed. After the treatment plan has been signed by the client, it is locked for editing.

Select **View** to review a treatment plan that has been finalized or is pending finalization.

If View or Edit was selected, the system launches the treatment plan. Select **Back** to return to the previous screen. If view was selected, click **Edit** to make changes to a pending plan. Use the keyboard, scroll bar, or the panel titles on the left to navigate.

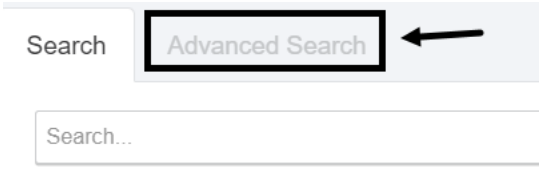


Searching Treatment Plans

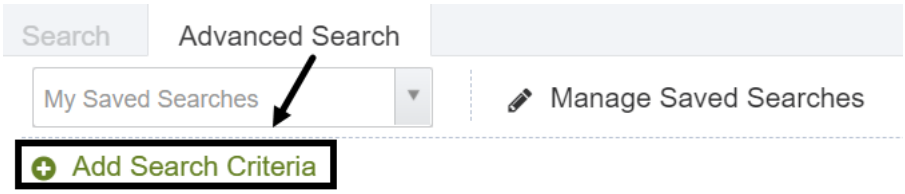
If there are several existing plans created for the client, the search feature can narrow it down.

To search, enter a partial description of the search parameters in the Search field. The system automatically starts the search as soon as a character is entered. For best results, enter three or more characters.

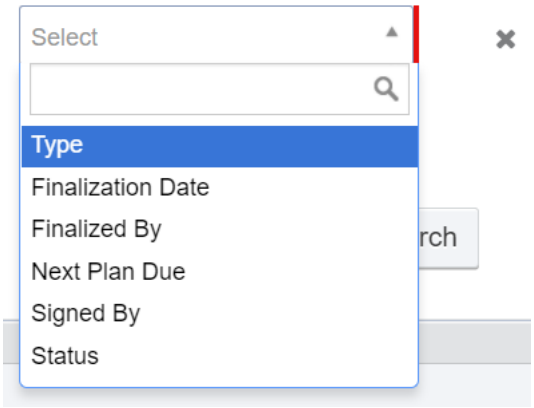
To perform an advanced search, click **Advanced Search**.



Click **Add Search Criteria**.



Select the primary search filter from the dropdown menu.

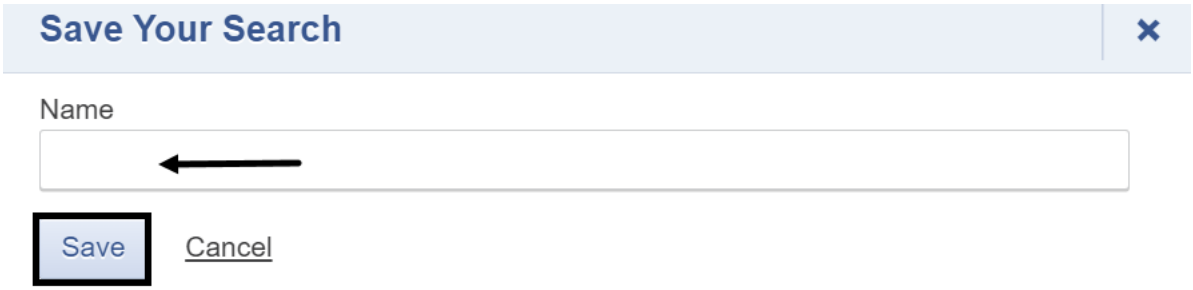


Complete the remaining conditions. Repeat the steps to add additional search criteria. If the search filter was selected in error, click Remove Search Criteria to remove it and start all over.

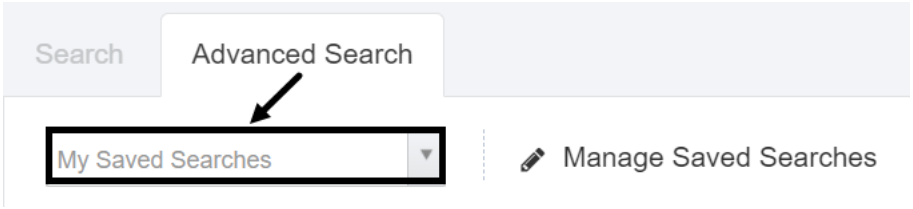
Click **Search**.

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

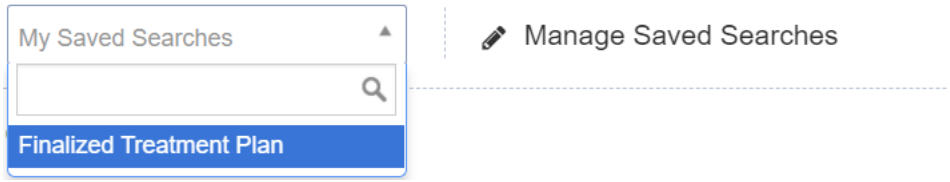
Enter the name of the search and click **Save**.



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

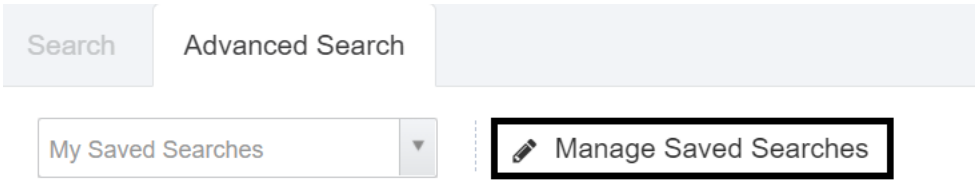


Select the saved search template.



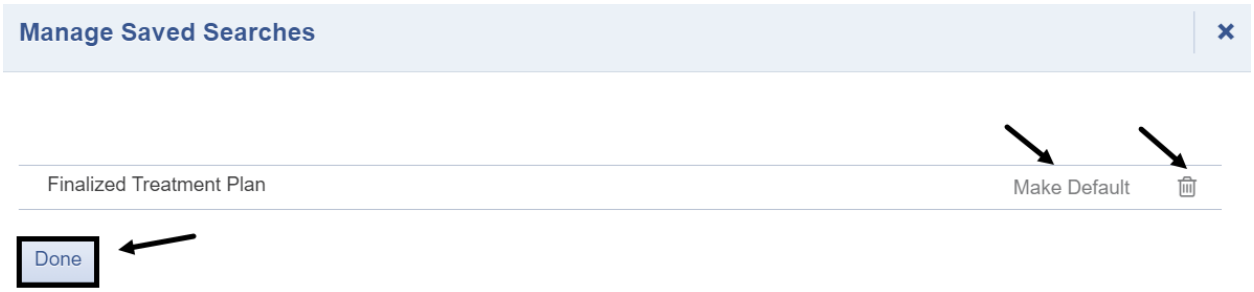
Click **Search**.

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



Select **Make Default** and **Done** to make a saved search the default search.

Select **Delete** and **Done** to delete a saved search template.



NOTES

TIMELINESS OF RECORDS

Document	Modality	Timeframe for Completion
Initial Treatment Plan	Outpatient	Within **30** days of client program enrollment
	Residential	Within **10** days of client program enrollment
	Withdrawal Management (ODS.3.2)	Within **72** hours of client program enrollment
Updated Treatment Plan	Outpatient	Within **90** days of the date the counselor signed the previous plan
	Residential	Within **30** days of the date the counselor signed the previous plan
	Withdrawal Management (ODS.3.2)	As needed
	All Providers	Within 7 days of new LOC determination or updated DDN

NOTES

Note: *Refer to the SUDQM guidelines, SUDPOH, and SUDURM treatment plan instructions for requirements on timelines.*

BHS SUD INSTRUCTIONS ON TREATMENT PLANS

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

Initial Treatment Plan Instructions

REQUIRED FORM:

An Individual Treatment Plan is a required document within the client file.
(Residential Programs: Submit to Optum as part of ongoing authorization process.)

WHEN:

This form is to be completed in accordance with timeframes specified below:

- Outpatient Programs - within 30 calendar days from date of admission.
  - This is date of admission + 29 days.
  - Example – date of admission is August 1 + 29 days would be August 30.
    - Therefore, in order to be in compliance, the initial treatment plan is due with client and counselor signatures by August 30.
    - If it is done/signed August 31 (admit + 30 days) it is out of compliance but there is no disallowance.
    - If it was not done/signed until September 1 (admit + 31 days), it is out of compliance and there is a disallowance for August 31 (service provided outside of the first 30 days with no valid treatment plan on that day).
    - There would continue to be disallowances for each day after this until the treatment plan was done/signed by counselor/client.
- Residential Programs - within 10 days from date of admission.

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during the initial intake, assessment and treatment planning sessions with the client.

REQUIRED ELEMENTS (do not leave any blanks):

CLIENT INFORMATION

- **Client Name:** Legibly print or type client's full name. **(NOTE:** to be entered on each page of the Treatment Plan)
- **Client ID#:** Legibly print or type client's SanWITS Unique Client Number (UCN). **(NOTE:** to be entered on each page of the Treatment Plan)
- **Admission Date:** Date client was admitted to program.
- **Primary Counselor Name:** Primary LPHA/Counselor's name.
- **Case Manager Name:** Case manager's name.
- **DSM-5 Diagnosis(es):** Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the *Primary diagnosis must be a Substance Use Disorder.*
  - *The SUD diagnosis (or diagnoses) as documented by the MD or LPHA on the DDN much match on the treatment plan(s) and language shall be identical.*
  - *ICD-10 codes are not required on the treatment plan; however, if ICD-10 codes are added to a treatment plan with the DSM-5 language for the diagnosis(es), they must match the verbiage of the DSM (and both language and codes must match the DDN).*
- **Date of the Initial Treatment Plan:** Enter date the Treatment Plan was completed.
- **Was a physical exam completed within the last 12 months?** Check the appropriate box (Yes or No).
  - If 'Yes' is checked, provide the date of the physical. Inform client that results of physical exam must be

submitted to program.
    - If 'No' is checked, then the goal to obtain a physical exam shall remain on the treatment plan.
- **If Yes, has client provided a copy of physical exam results?**
    - **If 'Yes' is checked**, MD must review results per SUDPOH requirements (if MD has not yet reviewed results provided, goal for client obtain physical exam must remain on treatment plan(s) on MD has reviewed printed name, signed, and dated documentation of review).
    - **If 'No' is checked**, then goal to obtain a physical exam must remain on treatment plan until provided ***and*** MD has reviewed results.
    - **Check 'N/A'** if client has not had a physical exam in the last 12 months and has not provided a copy
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to obtain from treatment:** Document the client's expectations regarding treatment services and what the client hopes to gain from receiving services at the program. You may use client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.

PROBLEM'S #1, #2, #3

- **Select related ASAM Dimension:** Check appropriate box(s). Review all 6 ASAM dimension criteria to assess which box(s) to check.
- **Problem Statement:**
    - Personalize problem(s) unique to the client.
    - Write problems in client language and *prioritize* (emergent, realistic for completion, what is needed to prevent relapse?)
    - If a physical health concern is identified (e.g., pregnancy or lack of a physical in the last 12 months), this needs to be addressed in one of the problem areas on the plan.
    - Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2.
    - If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, then a problem must identify lack/need for a physical exam.
    - If the client has demonstrated completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; then a problem may be that the client needs to address appropriate treatment for the illness and a goal to address the health need must be included on the treatment plan.

- **Goal(s):** What does the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):
    1. Goals must be measurable and achievable.
    2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
    3. If the client has not received a physical exam within 12 months prior to admission to treatment, a

goal that the client completes a physical examination must be included.

4. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps**: Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
  1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
  2. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
  3. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.

- **Target Date(s)**: Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).

- **Resolution Date(s)**: Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION (INCLUDE FREQUENCY AND DURATION)

- **Check the appropriate Modality box and enter frequency and duration for each box checked:** List includes the following modalities: Outpatient Services (OS), Intensive Outpatient Services (IOS), Residential Treatment.

- **Indicate type of services below**: Check appropriate type(s) of service(s) and indicate frequency of each service.

Does this treatment plan include the Treatment Plan Addendum form for additional problems: Mark Yes or No to indicate if a Treatment Plan Addendum form was utilized to complete this treatment plan.

If yes, how many total problems are documented in this entire treatment plan? If a Treatment Plan Addendum form was utilized, document the total number of problems documented on the entire treatment plan as there will be more than 3 problems.

TREATMENT PLAN SIGNATURES

- **Client was offered a copy of the plan**: Check Yes or No; if No, document why.
- **Client Printed Name, Signature, Date**: Client must legibly print name, sign, and date.
  1. The client must be present and participate in the treatment plan to bill for treatment plan services.
  2. Client signature provides evidence of client participation and agreement with the Individual Recovery/Treatment Planning process.
     - **For Outpatient**: Client must sign within 30 days from the date of admission.

- **For Residential:** All signatures must be in place within 10 days from the date of admission.
- If client **refuses to sign** the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.

- **Counselor/LPHA Name, Signature, and Date:** LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
  - **For Outpatient:** Counselors must sign the treatment plan within 30 days from the date of admission.
  - **For Residential:** All signatures must be in place within 10 days from the date of admission.
  - The date of LPHA/Counselor signature is considered the treatment plan completion date.
- ***LPHA or MD Printed Name, Signature, and Date:** LPHA or MD legibly printed or typed name, signature with credentials and date of signature.
  - **For Outpatient:** The MD or LPHA has up to 15 days after the counselor's signature date to sign the treatment plan.
  - **For Residential:** All signatures must be in place within 10 days from the date of admission.

Updated Treatment Plan Instructions

REQUIRED FORM:

An Individual Treatment Plan is a required document within the client file.
(Residential Programs: Submit to Optum as part of ongoing authorization process, as needed.)

WHEN:

This form is to be completed in accordance with timeframes specified below:

- Outpatient Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 90 calendar days after signing the initial treatment plan, and not later than every 90 calendar days thereafter. (Note: Remember to complete the ASAM Level of Care form whenever completing an Updated Treatment Plan)

- For Residential Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 30 calendar days after signing the initial treatment plan, and not later than every 30 calendar days thereafter. (Note: Remember to complete the ASAM Level of Care form whenever completing an Updated Treatment Plan)

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during the initial Intake, assessment and previous Treatment Plans along with information provided by the client and collateral sources over the course of treatment.

REQUIRED ELEMENTS (do not leave any blanks):

- **Client Name:** Legibly print or type client's full name. **(NOTE:** to be entered on each page of the Treatment Plan)
- **Client ID#:** Legibly print or type client's SanWITS Unique Client Number (UCN). **(NOTE:** to be entered on each page of the Treatment Plan)
- **Admission Date:** Date client was admitted to program.
- **Primary Counselor Name:** Primary LPHA/Counselor's name.
- **Case Manager Name:** Case manager's name.
- **DSM-5 Diagnosis(es):** Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the *Primary diagnosis must be a Substance Use Disorder.*
    - *The SUD diagnosis (or diagnoses) as documented by the MD or LPHA on the DDN much match on the treatment plan(s) and language shall be identical.*
    - *ICD-10 codes are not required on the treatment plan; however, if ICD-10 codes are added to a treatment plan with the DSM-5 language for the diagnosis(es), they must match the verbiage of the DSM (and both language and codes must match the DDN).*
- **Date of the Last Treatment Plan:** Enter date of initial or previous Treatment Plan.
- **Date of Treatment Plan Update:** Enter date this treatment plan was completed.
- **Was a physical exam completed within the last 12 months?** Check the appropriate box.
    - If 'Yes' is checked, provide the date of the physical. Inform client that results of physical exam shall be submitted to program.

- If 'No' is checked, then the goal to obtain a physical exam shall remain on the treatment plan.

- **If Yes, has client provided a copy of physical exam results?**
  - If 'Yes' is checked, MD must review results per SUDPOH requirements.
  - If 'No' is checked, then goal to obtain a physical exam must remain on treatment plan until provided ***and*** MD has reviewed results.
  - Check 'N/A' if client has not had a physical exam in the last 12 months and has not provided a copy
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to change on their current treatment plan from the previous treatment plan?** Attempt to obtain client's expectations regarding continuing treatment services and document using the client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.
- **Current Needs at Time of Treatment Plan Update:** Check the appropriate box after assessing the client's progress on their treatment plan goals and appropriate level of care. Then, enter client's Recommended Level of Care and Actual Level of Care based on the information from the ASAM Level of Care form that was completed with this treatment plan update.

PROBLEM'S #1, #2, #3

- **Select related ASAM Dimension:** Check appropriate box(s). Review all 6 ASAM Dimension criteria to assess which box(s) to check.
- **Problem Statement:**
  - Personalize problem(s) unique to the client.
  - Write problems in client language and *prioritize* (emergent, realistic for completion, what is needed to prevent relapse?)
  - If a physical health concern is identified (e.g., pregnancy or lack of a physical in the last 12 months), this needs to be addressed in one of the problem areas on the plan.
  - Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2.
  - If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, problem must identify lack/need for a physical exam.
  - Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; then a problem may be that the client needs to address appropriate treatment for the illness and a goal to address the health need must be included on the treatment plan.
- **Goal(s):** What do the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):

1. Goals must be measurable and achievable.
2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
3. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
4. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
  1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
  1. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
  2. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.
- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).
- **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

PROPOSED TYPE OF INTERVENTION/MODALITY FOR SUCCESSFUL GOAL COMPLETION (INCLUDE FREQUENCY AND DURATION)

- **Check the appropriate Modality box and enter frequency and duration for each box checked:** List includes the following modalities: Outpatient Services (OS), Intensive Outpatient Services (IOS), Residential Treatment.
- **Indicate type of services below:** check appropriate type(s) of service(s) and indicate frequency of each service.

Does this treatment plan include the Treatment Plan Addendum form for additional problems: Mark Yes or No to indicate if a Treatment Plan Addendum form was utilized to complete this treatment plan.

If yes, how many total problems are documented in this entire treatment plan? If a Treatment Plan Addendum form was utilized, document the total number of problems documented on the entire treatment plan as there will be more than 3 problems.

TREATMENT PLAN SIGNATURES

- **Client was offered a copy of the plan:** Check Yes or No; if No, document why.

- **Client Printed Name, Signature, Date:** Client must legibly print name, sign, and date.
    1. The client must be present and participate in the treatment plan to bill for treatment plan services.
    2. Client signature provides evidence of client participation and agreement with the Individual Recovery/Treatment Planning process.
        - **For Outpatient:** Client must sign within 90 days from the previous treatment plan's completion date.
        - **For Residential:** All signatures must be in place within 30 days from the previous treatment plan.
        - If client **refuses to sign** the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.
- **Counselor/LPHA Name, Signature, and Date:** LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
    - **For Outpatient:** Counselors must sign the treatment plan within 90 days from the previous treatment plan's completion date.
    - **For Residential:** All signatures must be in place within 30 days from the previous treatment plan.
    - The date of LPHA/Counselor signature is considered the treatment plan completion date.
- ***LPHA or MD Name, Signature, and Date:** LPHA or MD legibly printed or typed name, signature with credentials and date of completed Individual Treatment Plan.
    - **For Outpatient:** The MD or LPHA has up to 15 days after the counselor's signature date to sign the treatment plan.
    - **For Residential:** All signatures must be in place within 30 days from the previous treatment plan.

Withdrawal Management Treatment Plan Instructions

REQUIRED FORM:

Based on Intergovernmental Agreement guidelines, a Treatment Plan is a required document within the client file.

WHEN:

This form is to be completed in accordance with timeframes specified below:

- Withdrawal Management – within 72 hours of admission to program.

COMPLETED BY:

To be completed jointly by LPHA/Counselor and client based upon the information obtained during the initial intake, assessment and treatment planning sessions with the client.

REQUIRED ELEMENTS (do not leave any blanks):

CLIENT INFORMATION

- **Client Name:** Client's full name. **(NOTE:** to be entered on each page of the Treatment Plan)
- **Client ID#:** Client ID is SanWITS number **(NOTE:** to be entered on each page of the Treatment Plan)
- **Admission Date:** Date client was admitted to program.
- **Primary Counselor:** Enter the primary LPHA/SUD Counselor's name.
- **Case Manager:** Enter the Case Manager's name.
- **DSM-5 Diagnosis(es):** Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the *Primary diagnosis must be a Substance Use Disorder and must match the DDN.*
    - *The SUD diagnosis (or diagnoses) as documented by the MD or LPHA on the DDN much match on the treatment plan(s) and language shall be identical.*
    - *ICD-10 codes are not required on the treatment plan; however, if ICD-10 codes are added to a treatment plan with the DSM-5 language for the diagnosis(es), they must match the verbiage of the DSM (and both language and codes must match the DDN).*
- **Date of the Initial WM Treatment Plan:** Enter date the Treatment Plan was completed.
- **Was a physical exam completed within the last 12 months?** Check the appropriate box.
    - If 'Yes' is checked, provide the date of the physical. Inform client that results of physical exam must be submitted to program.
    - If 'No' is checked, then the goal to obtain a physical exam shall remain on the treatment plan.
- **If Yes, has client provided a copy of physical exam results?**
    - If 'Yes' is checked, MD must review results per SUDPOH requirements.
    - If 'No' is checked, then goal to obtain a physical exam must remain on treatment plan until provided ***and*** MD has reviewed results.
        - Since WM programs are short term in nature, and the physical exam goal may not be met while client is enrolled, the goal may also include language about linkage for physical exam as part of discharge planning. Please individualize the goal to each specific client's needs.
    - Check 'N/A' if client has not had a physical exam in the last 12 months and has not provided a copy
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to obtain after Withdrawal Management services:** Document the client's

expectations regarding treatment services and what the client hopes to gain from receiving services at the program. You may use client's own words.

- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.

Goals Short Term and Long Term:

- **Select related ASAM Dimension:** Check appropriate box(es). Review all 6 ASAM dimension criteria to assess which box(s) to check.
- **Problem Statement:**
  - Personalize problem(s) unique to the client.
  - Write problems in client language and *prioritize* (withdrawal concerns, medical condition, emergent, realistic for completion, what is needed for safety of client)
  - If a physical health concern is identified (e.g., pregnancy or medical condition such as diabetes), this needs to be addressed in one of the problem areas on the plan. Individualize per each client's needs.
  - Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, medical condition that may be of a concern while detoxing and dental work which could all be incorporated into one problem as they are all related to ASAM dimension 2. Indicate what may be included as part of discharge planning if problems cannot be resolved during WM services.
  - If the client cannot provide the physical exam results within the 12 months prior to admission to treatment, then a problem must identify lack/need for a physical exam or to obtain and review the results while in the WM program. Document attempts to obtain the physical exam results in progress notes during the client's treatment episode.
  - If the client has demonstrated completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified, then a problem may be that the client needs to address appropriate treatment for the illness and a goal to address the health need must be included on the treatment plan. Indicate what may be included as part of discharge planning if problems cannot be resolved during WM services.

- **Goal(s):** What does the client and program want to accomplish? Use "SMART" acronym (Specific, Measurable, Attainable, Realistic, Time-Related):
  1. Goals must be measurable and achievable.
  2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
  3. If client has been identified as having a medical condition, a goal must be included for the client to address the condition.
  4. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
  5. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.

- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
    1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
    2. Include specific actions the client will do to reach their goals (e.g., Client will follow medical advice during withdrawal and take medication as prescribed).
    3. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.

- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).

- **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

WITHDRAWAL MANAGEMENT PROPOSED SERVICES (INCLUDE FREQUENCY)
(Observation should be every 30 minutes for at least 24 hours and then based on medical necessity)

- **Check the appropriate services box and enter frequency for each box checked:** List includes observation and medication services, individual services, case management, collateral services, patient education, and group services.
- **Reminder:** Check the box for "Observation" if WM observation is occurring or is anticipated to occur at the time of or after the creation of the treatment plan.

TREATMENT PLAN SIGNATURES

- **Client was offered a copy of the plan:** Check Yes or No; if No, document why.
- **Client Printed Name, Signature, and Date:** Client's legibly printed or typed name, signature and date of signature.
    1. The client must be present and participate in the treatment plan to bill for treatment plan services.
    2. Client signature provides evidence of client participation and agreement with the Treatment Planning process.
        - **For Withdrawal Management:** Client must sign within 72 hours of admission to the program or counselor must document why the client did not sign the treatment plan.
- **Counselor Name, Signature, and Date:** Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of signature.
    - **For Withdrawal Management:** Counselor must sign within 72 hours of client's admission to the program.
    - The date of Counselor signature is considered the treatment plan completion date.
- ***LPHA or MD Name, Signature, and Date:** MD/LPHA legibly printed or typed name, signature with credentials and date of signature.
    - **For Withdrawal Management:** All signatures must be in place within 72 hours of client's

admission to the program.

*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.

GLOSSARY

ASAM	American Society of Addiction Medicine
BHS	Behavioral Health Services
CalOMS	California Outcomes Measurement System
CPE	Client Program Enrollment
DHCS	Department of Health Care Services
DDN	Diagnosis Determination Note
DMC	Drug Medi-Cal
HHSA	Health and Human Services Agency
LPHA	Licensed Practitioner of the Healing Arts
MD	Medical Doctor
MIS	Management Information Systems
ODS	Organized Delivery System
QM	Quality Management
SanWITS	San Diego Web Infrastructure for Treatment Services
SUD	Substance Use Disorder
SUDPOH	Substance Use Disorder Provider Operations Handbook
SUDURM	Substance Use Disorder Uniform Record Manual

CONTACT INFORMATION

SanWITS System and End User Support

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

Clinical Processes and Documentation

QIMatters.HHSA@sdcounty.ca.gov

BHS SUD Instructions, Manuals, and Forms

www.optumsandiego.com

SanWITS Training Registration

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

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