



FEI Systems



MS-WITS End User Clinical

*End User Clinical
Guide*

Applies to:

WITS Version 18.0+

See Also:

WITS Basics User Guide

Mississippi Department of
Mental Health

Last Updated June 13, 2019

Mississippi Department of Mental Health

MS-WITS End User Clinical

Preface

The WITS System is a web-based application system specifically designed for organizations to manage their TEDS and Block grant data collections effectively. Capable of creating and managing contracts and funds. WITS also includes core clinical features essential to managing substance abuse services and treatment case management.

Intended Audience

This user guide has been prepared for clinical users. Topics covered include client setup, admission process, and other clinical functionality.

System Requirements

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

Internet Browsers

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

- Apple® Safari®
- Google Chrome™
- Mozilla® Firefox®
- Windows Internet Explorer 10 or newer (*recommended*)

i **Note:** Do not allow your Internet browser to save your password, as this information will be routinely updated.

Pop-up Blocker

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

i The **Training Site** allows staff members to practice using the system before entering actual data in the Production Site. **Do not enter real client information in the training site.**

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Part 1: Customer Specific Information

This section is designed to include customer specific information for this particular user guide.

Examples of customer specific information includes:

- Business rules
- Specific terminology
- Workflow diagrams and explanation



Part 2: Client Setup

Search for a Client

 **Where:** [First Section](#) > [Second Section](#) > [Destination Screen](#)

Before creating a new client record, search for your client to make sure the client is not already in WITS.

1. To view clients within your agency, click on the **Client List** menu item. A blank Client List screen will appear.
2. Use the fields in the **ClientSearch** section to narrow your results.

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

3. After selecting from the search fields, click **Go** to view the results.

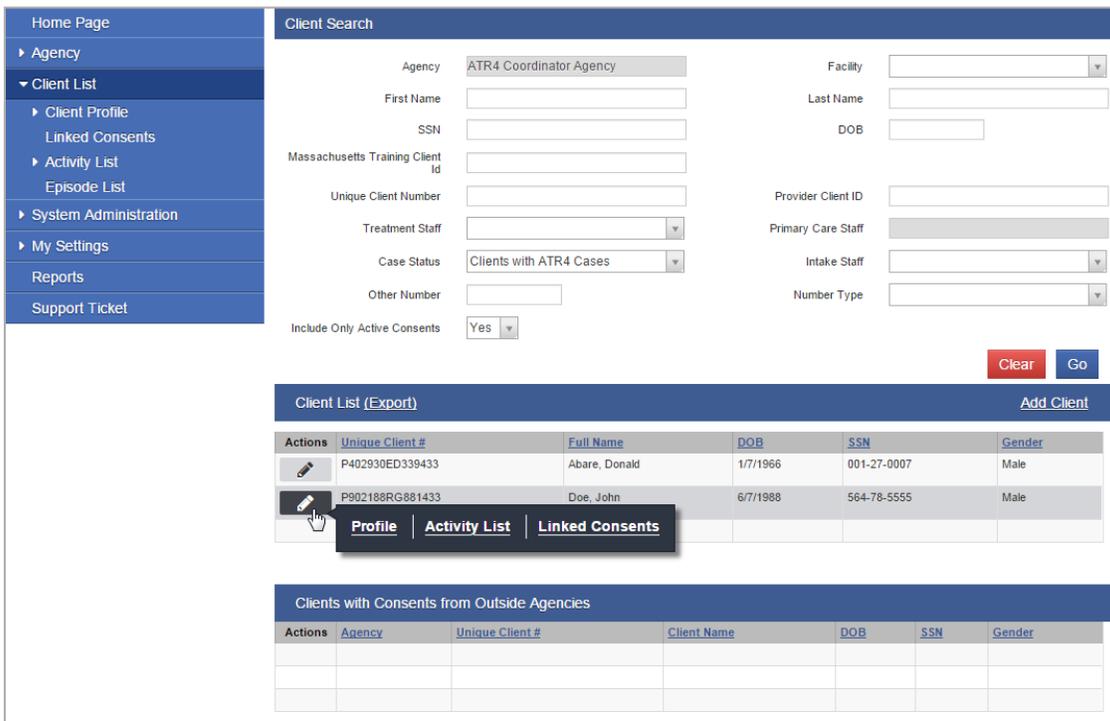


Figure 2-1: Client List screen, Action links

4. Look for your client in the **Client List**. If you find the right person, view their profile by clicking on the **Profile** link under the **Actions** column. If you do not find your client, you can create a new client record.

Client Search Tips

Client Name or Number

Use a client's nickname or alternate names in the **First Name** or **Last Name** fields.

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

Examples:

- Find clients whose last name starts with "Jon": Jon*

Client Search	
Agency	Administrative
First Name	
SSN	
Facility	
Last Name	Jon*
DOB	

- Search by the last 4 digits of a client's SSN: *1123

Client Search	
Agency	Administrative
First Name	
SSN	*1123
Facility	
Last Name	
DOB	

Client Birthday or Age

Search within a timeframe by separating the two dates with a **colon (:)**. Search for clients born after a certain date with a **greater than sign (>)**. Search for clients born before a certain date with a **less than sign (<)**.

Examples:

- Find clients born in the year 1990: 1/1/1990:12/31/1990

Client Search	
Agency	Administrative
First Name	
SSN	
Facility	
Last Name	
DOB	1/1/1990:12/31/1

- Find clients born after a certain date: >12/30/1959

Create Client Profile



Where: **Client List** > **Client Profile**

Note: Please search for each client before creating a new record.

To add a new client to the system, follow the steps below.

1. On the left menu, click **Client List**.
2. On the Client List screen, click **Add Client**.

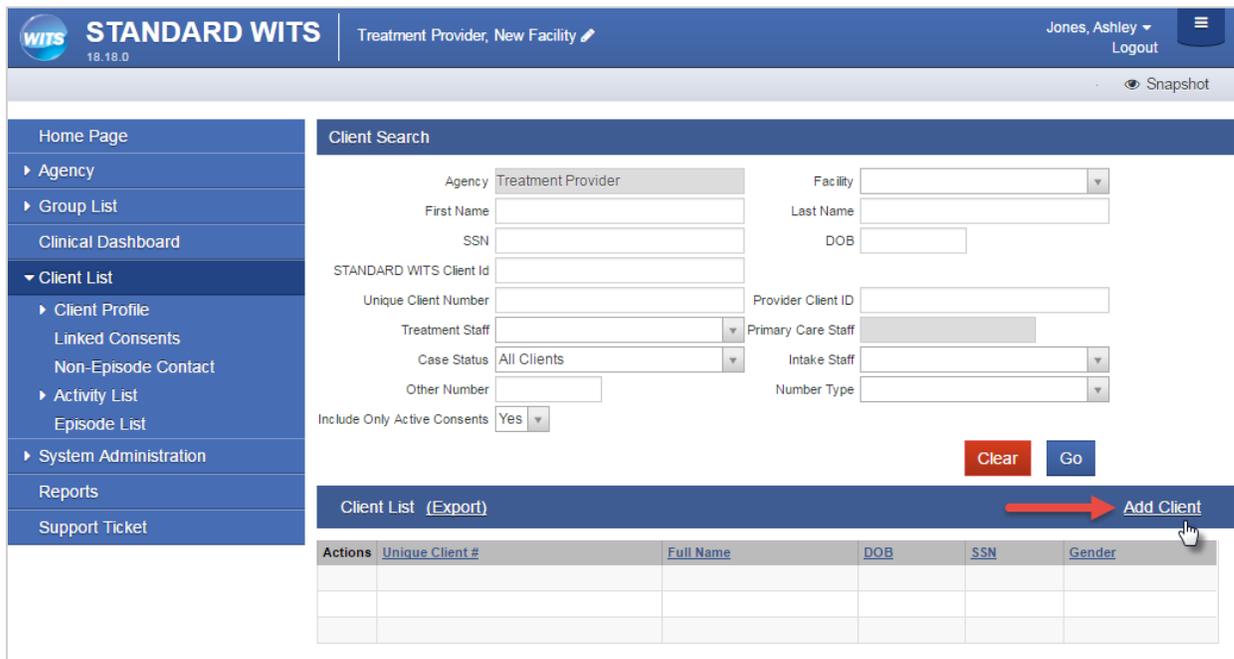


Figure 2-2: Client Search/List screen; Add Client link

3. On the **Client Profile** screen, enter the required client information. See the table below for information on each field.

! When adding new clients to the system, review the **Client Profile** fields for accuracy before saving the screen. Once the Client Profile screen is saved, a **Unique Client Number (UCN)** is created based on the data provided. It's important to enter client information correctly to avoid duplicate client entry in the future.

Table 2-1: Client Profile fields

Field	Description
First Name	Type the client's current first name.
Middle Name	(Optional)
Last Name	Type the client's current last name.
Mother's Maiden Name	(Optional)
Suffix	(Optional)

Field	Description
Gender	Select the client's gender from the drop-down list.
DOB	Enter the client's date of birth.
SSN	Type the client's Social Security Number.
Driver's License and State	(Optional) Type the number and then select the State from the drop-down list.
Has paper file	(Optional) Select Yes or No. Field defaults to Yes.
Provider Client ID	(Optional)

Figure 2-3: Client Profile screen

- Review the profile fields for accuracy and then click **Save**.
- Click the **right-arrow** to move to the **Alternate Names** screen.

Alternate Names

The client's nickname may be entered on this screen.

i Tip: Alternative names can also be used to search for the client's profile in the future. On the Client Search screen, type the client's alternative name in the First Name and/or Last Name fields.

1. On the Alternate Names screen, click **Add Alternate Name**, and the bottom half of the screen becomes editable.

The screenshot shows the 'Alternate Names' interface. At the top is a table with columns: Actions, Last Name, First Name, Middle Name, and Client Alias Type. Below the table is a blue bar with the text 'Add Alternate Name' and a red arrow pointing to it. Underneath are four input fields: First Name, Middle Name, Last Name, and Client Alias Type. At the bottom are buttons for Cancel, Save, Finish, and two navigation arrows.

2. Complete at least the **First Name** field.

This screenshot shows the same 'Alternate Names' interface as the previous one, but the 'First Name' field now contains the text 'Johnny'. The 'Add Alternate Name' button is still visible at the top right. The 'Cancel' and 'Finish' buttons are visible at the bottom.

3. Click **Finish**. The name will now appear in the list at the top of the screen.
4. From the Alternate Names screen, click the **right-arrow** button to open the **Additional Information** screen.

Additional Information (Required)

Note: The light-yellow fields are required for TEDS.

1. On the **Additional Information** screen, complete at least the light-yellow fields, as these are required for TEDS reporting and must be completed before creating an Intake.

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

Field	Description
Ethnicity	Select from the drop-down list.
Selected Races	Select one or more races.
Veteran Status	Select from the drop-down list.

The screenshot shows the 'Additional Information' screen with the following fields and values:

- Ethnicity:** Not Hispanic or Latino
- Races:** Alaska Native, American Indian, Black or African American, Native Hawaiian or Other Pacific Islander, Unknown
- Selected Races:** Asian, Other Race
- Special Needs:** No Response, Developmentally Disabled, Major Difficulty in Ambulating or Nonambulation, Moderate To Severe Medical Problems
- Selected Special Needs:** None
- General Client Comments:** (Empty text area)
- Sexual Orientation:** Not Collected
- Religious Preference:** Cao Dai
- English Fluency:** Moderate
- Preferred Language:** Mandarin
- Interpreter Needed:** No
- Veteran Status:** Not Collected
- Citizenship:** (Empty)

Buttons at the bottom right: Cancel, Save, Finish, and navigation arrows.

Figure 2-4: Client Profile, Additional Information screen

2. When complete, click **Save**, then click the **right-arrow** button to open the **Contact Info** screen.

Contact Info (Required)

Mississippi Requirement: Add Client's Address

1. On the **Contact Info** screen, a phone number can be entered for the client.
2. To enter an address, click **Add Address**. This will open the Address Information screen.

Contact Info					
Home Phone #	<input type="text"/>	Preferred Method of Contact	<input type="text"/>		
Work Phone #	<input type="text"/>				
Mobile #	<input type="text"/>				
Other Phone #	<input type="text"/>				
Fax #	<input type="text"/>				
Email Address	<input type="text"/>				

Addresses						Add Address
Actions	Address Type	Address	Confidential	Created	Updated	

Cancel **Save** **Finish**

Contact Info screen

3. Enter the client's Address Type, Address line 1, City, State, and Zip Code.

Address Information					
Address Type	<input type="text"/>	Confidential	<input type="text" value="No"/>		
Address Line 1	<input type="text"/>				
Address Line 2	<input type="text"/>				
City	<input type="text"/>	State	<input type="text" value="MA"/>	Zip	<input type="text"/>

Cancel **Finish**

Address Information screen

4. When complete, click **Finish**, and the client's address information will show up on the Contact Info screen. You may enter several addresses for a client. If a client has a new address, update the Address Type of the current address record to "Previous", then create a new address.
5. From the **Contact Info** screen, click the **right-arrow** button to open the **Collateral Contacts** screen.

Collateral Contacts

1. On the **Collateral Contacts** screen, note the fields below are grey, and click the **Add Contact** link.

Table 2-3: Caption for Sample Table

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

Collateral Contacts
[Add Contact](#)

Actions	First Name	Last Name	Relation	Phone Numbers	Can Contact?

First Name

Last Name

Relation

Gender

Home Phone

Work Phone

Mobile

Fax

Other

Legal Guardian

Active Date

Inactive Date

Address 1

Address 2

City State Zip

Email

Can Contact

Consent On File

Notes

Created

Last Update

Figure 2-5: Add Collateral Contacts screen

2. When complete, click **Finish**. The names now show up in the table on top of the screen.
3. From the **Collateral Contacts** screen, click the **right-arrow** button to open the **Other Numbers** screen.

Other Numbers

In this section, users can add additional identifying numbers for a client, such as a court case number. This section is **OPTIONAL** and does not need to be completed for the profile to be considered complete.

1. On the **Other Numbers** screen, click the **Add Other Number** link. The bottom half of the screen now becomes editable.
2. Fill in information such as, Number Type, Number, Relation, and Address of the contact.

The screenshot shows the 'Other Numbers' screen. At the top, there is a table with columns: Actions, Number Type, #, Start, End, Contact Name, and Status. Below the table is a blue bar with the text 'Add Other Number'. The form below contains the following fields: Number Type (dropdown), Number (text input), Start Date (calendar icon, value: 11/26/2014), End Date (calendar icon), Status (dropdown, value: Active), Contact (dropdown), and Comments (text area). At the bottom right, there are 'Cancel' and 'Finish' buttons.

Figure 2-6: Other Numbers screen

3. The **Contact** dropdown box will display the names of any saved Collateral Contacts from the previous screen. If the name of the Collateral Contact is not present, click on the **Collateral Contacts** screen to add a new record.

This screenshot shows the 'Add Other Number' form with the 'Contact' dropdown menu open. The dropdown menu displays a search bar and a list of contacts, with 'Smith, Jane' selected. The other fields in the form are the same as in the previous screenshot, but the Start Date is now 12/11/2014. The 'Cancel' and 'Finish' buttons are at the bottom right.

Other Numbers screen, saved collateral contact

4. When complete, click **Finish**. The names now show up in the table on top of the screen.
5. Click **Finish** again, and you are redirected to the **Client Search** screen.

Linked Consents



Where: **Client List** > **Clients with Consents from Outside Agencies**

Each time another agency consents client information to your agency, a row will be displayed on the “**Clients with Consents from Outside Agencies**” section of the **Client List** screen. Always look at the linked consents first to make sure you don’t already have that client entered.

If the consent is sent along with a referral and the referral is accepted at the referred to agency, users with a Clinical Supervisor role may manually link and unlink consents. This action is available when it is clear that a client with consented information is in fact the same person as a client that exists in the agency. They may not have been automatically linked because the names or other identifying information may have been different in the sending agency than they are in the receiving agency.

The screenshot shows the 'Client List' interface. On the left is a navigation menu with options like 'Home Page', 'Agency', 'Clinical Dashboard', 'Client List', 'Client Profile', 'Linked Consents', 'Non-Episode Contact', 'Activity List', 'Episode List', and 'System Administration'. The main area is titled 'Client Search' and contains various input fields for filtering clients, such as Agency, Facility, First Name, Last Name, SSN, and DOB. Below the search filters is a 'Client List (Export)' table with columns for Actions, Unique Client #, Full Name, DOB, SSN, and Gender. A red arrow points to a section titled 'Clients with Consents from Outside Agencies' which contains a table with columns for Actions, Agency, Unique Client #, Client Name, DOB, SSN, and Gender. The table in this section has one row: GREENBRIAR TREATMENT CENTER, F6230813872220, Forrest, Bobby, 8/13/1987, 121-11-2222, Male.

For example:

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

Link to Consented Client

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

The screenshot shows the 'Client Search' interface with various filters. Below the search area is a table titled 'Client List (Export)' with columns: Actions, Unique Client #, Full Name, DOB, SSN, and Gender. Below that is a section titled 'Clients with Consents from Outside Agencies' with columns: Actions, Agency, Unique Client #, Client Name, DOB, SSN, and Gender. A red arrow points to the 'Link' button in the Actions column for the client 'Forrest, Bobby' at GREENBRIAR TREATMENT CENTER.

Actions	Unique Client #	Full Name	DOB	SSN	Gender
	200006018756780	2, Deeksha Test	6/1/1987	213-12-5678	Female
	A23608019956780	Asteraceae, Zinnia	8/1/1999	012-34-5678	Female
	B00009078465980	Bee, New	9/7/1984	852-31-6598	Male
	B60007108274830	Berry, Blue	7/10/1982	090-44-7483	Male
	B60007107298760	Berry, Straw	7/10/1972	173-84-9876	Male
	B00007020355550	Boy, Teen	7/2/1972	123-12-5555	Male

Actions	Agency	Unique Client #	Client Name	DOB	SSN	Gender
Activity List Link Remove	GREENBRIAR TREATMENT CENTER	F62308138722220	Forrest, Bobby	8/13/1987	121-11-2222	Male

Figure 2-8: Client List screen, Clients with Consents from Outside Agencies section, Link action item

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

The screenshot shows the 'Link to Consented Client' screen. At the top, it displays client information: Full Name (Forrest, Bobby), DOB (8/13/1987), Client Number (F62308138722220), and SSN (121-11-2222). Below this is the 'Link Client Search' section with various filters. At the bottom, there is a table with columns: Actions, Unique Client #, Full Name, DOB, SSN, and Gender.

Actions	Unique Client #	Full Name	DOB	SSN	Gender

Figure 2-9: Link Client Search screen

- Use the search fields to find a client with similar information. It is helpful to copy and paste some of the consented client's information into the search fields. The example in Figure 2-10 uses the Consented Client's Unique Client Number in the search field.

The screenshot shows the 'Link Client Search' interface. On the left is a navigation menu with 'Client List' expanded to 'Activity List'. A red arrow points to the 'Unique Client Number' search field, which contains 'F62308138722220'. Other search fields include Agency (Administrative Agency), Facility, First Name, Last Name, SSN, and DOB. Below the search fields are 'Clear', 'Cancel', and 'Go' buttons. At the bottom, a table displays search results:

Actions	Unique Client #	Full Name	DOB	SSN	Gender

Figure 2-10: Link Client Search screen, search by Unique Client Number

- After filling out one or more search fields, click **Go** and then review the search results.

This screenshot shows the same 'Link Client Search' interface after a search. The 'Unique Client Number' field still contains 'F62308138722220'. The search results table now contains one entry:

Actions	Unique Client #	Full Name	DOB	SSN	Gender
	F62308138722220	Forrest, Robert	8/13/1987	121-11-2222	Male

Figure 2-11: Link Client Search screen with search results

- If the information in the search results matches the Consented Client information, hover over the Actions column and then click **Link**.

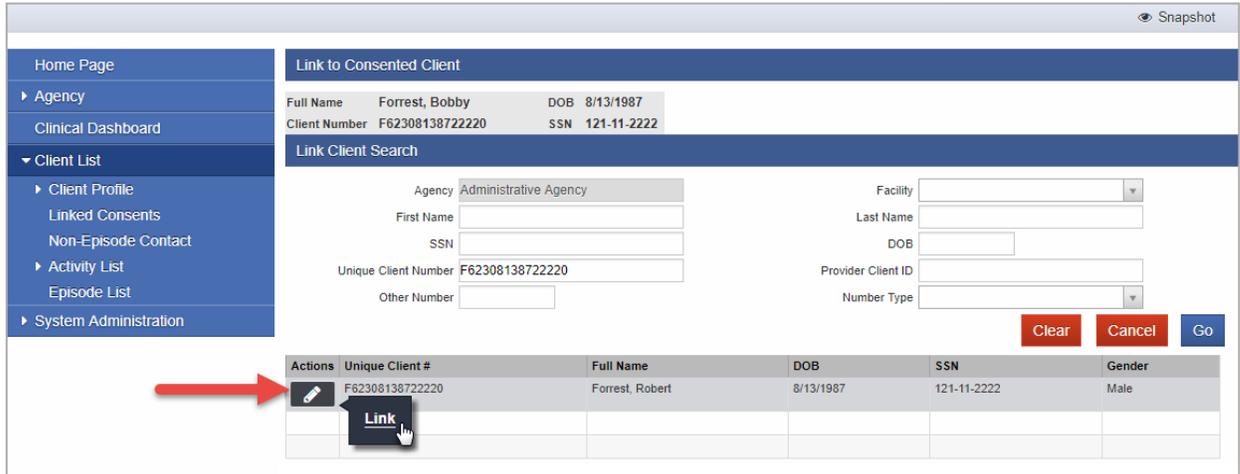


Figure 2-12: Link Client Search screen, Link Consent record

7. Click **Yes**.



Figure 2-13: Are you sure you want to link current consented client to the consent client

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



Figure 2-14: Linked Consents screen

Non-Episode Contact



Where: [Client List](#) > [Non-Episode Contact](#)

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

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Profile**.
3. On the left menu, click **Non-Episode Contact**.
4. Click the **Add New Non-Episode Contact Record** link.

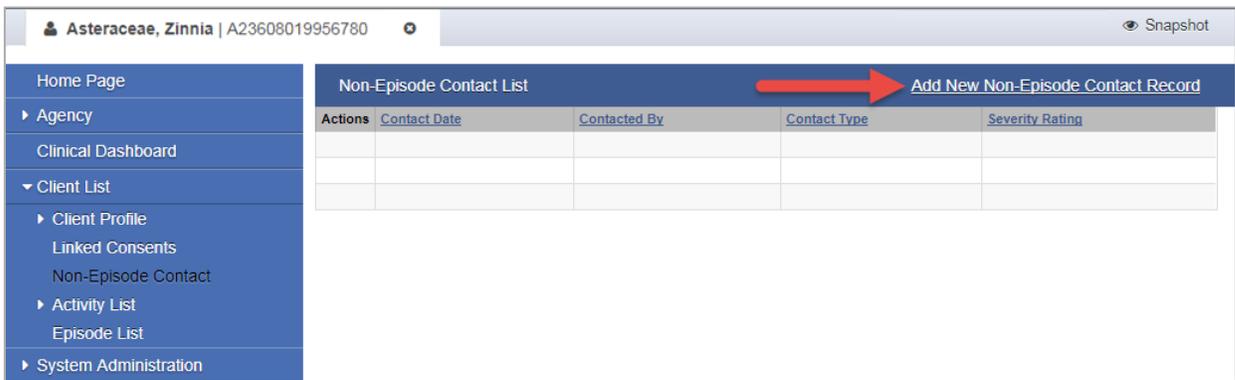


Figure 2-15: Non-Episode Contact List

5. Complete the fields on the Non-Episode Contact Note screen. See the table below for information on each field.

Table 2-4: Non-Episode Contact Note fields

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

Field	Description
Referred By - Phone	(Optional)
Severity Rating	(Optional)
Created Date	Read-only field displaying the date and time the Non-Episode Contact Note was created.
Signed Notes	Read-only field.
Unsigned Notes	Type notes about the event.
Outcome	(Optional) Select from the drop-down list.
Reason for ineligibility	(Optional)
Follow-Up Steps Selected	Select one or more options. Note: These values are controlled by the "Followup Step" code table.

The screenshot displays the 'Non-Episode Contact Note' profile screen. The interface includes a left-hand navigation menu with options such as 'Home Page', 'Agency', 'Clinical Dashboard', 'Client List', 'Client Profile', 'Linked Consents', 'Non-Episode Contact', 'Activity List', 'Episode List', and 'System Administration'. The main content area is titled 'Non-Episode Contact Note' and contains the following fields and sections:

- Contact Information:** Contact Date (8/3/2017), Start Time (1:30 AM), End Time (1:45 AM), Duration (15 Minutes), Contacted By (Jones, Ashley, Case Manager), Referral, Referring Agency, Referred By - First Name, Referred By - Last Name, and Referred By - Phone.
- Reasons and Location:** Contact Reason (Crisis), If Other, Specify, Location (Other), and Contact Type (Phone).
- Severity and Date:** Severity Rating and Created Date (7/6/2017 5:01 PM).
- Notes:** Signed Notes (empty) and Unsigned Notes (containing a text entry about a crisis hotline call). A 'Sign Note' button is located to the right of the unsigned notes.
- Outcome and Eligibility:** Outcome (Proceed to screening) and Reason for ineligibility.
- Follow-Up:** A section titled 'Follow-Up' with 'Follow-Up Steps' (Alcohol treatment, Clinic, Drug treatment, Mental health treatment) and 'Follow-Up Steps Selected' (None). Navigation arrows are present between these two lists.
- Buttons:** 'Cancel', 'Save', and 'Finish' buttons are located at the bottom right of the screen.

Figure 2-16: Non-Episode Contact Note Profile screen

- Click **Save** and then click **Sign Note**.

Non-Episode Contact Note

Contact Date: 6/3/2017
 Start Time: 1:30 AM End Time: 1:45 AM
 Duration: 15 Minutes
 Contacted By: Jones, Ashley; Case Manager
 Referral:
 Referring Agency:
 Referred By - First Name:
 Referred By - Last Name:
 Referred By - Phone:
 Signed Notes:
 Unsigned Notes: Zinnia called our crisis hotline in distress over school and family. She noted this was her first time calling a crisis hotline and has not sought out counseling services in the past. After gathering some basic information and searching through the client list in WITS, I created a new client profile for Zinnia. I recommended she speak with a case manager and she agreed to stay on the phone with our case manager to complete an ASAM screening assessment.
 Outcome: Proceed to screening
 Contact Reason: Crisis
 If Other, Specify:
 Location: Other
 Contact Type: Phone
 Severity Rating:
 Created Date: 7/6/2017 5:01 PM

 **Sign Note**

Figure 2-17: Sign Note

- The signed note will now be displayed in the read-only field. Click **Finish**.

Asteraceae, Zinnia | A23608019956780 Snapshot

Non-Episode Contact Note

Contact Date: 6/3/2017
 Start Time: 1:30 AM End Time: 1:45 AM
 Duration: 15 Minutes
 Contacted By: Jones, Ashley; Case Manager
 Referral:
 Referring Agency:
 Referred By - First Name:
 Referred By - Last Name:
 Referred By - Phone:
 Signed Notes: Signed by Jones, Ashley, 7/6/2017 5:24:57 PM:
 Zinnia called our crisis hotline in distress over school and family. She noted this was her first time calling a crisis hotline and has not sought out counseling services in the past. After gathering some basic information and searching through the client list in WITS, I created a new client profile for Zinnia. I recommended she speak with a case manager and she agreed to stay on the phone with our case manager to complete an ASAM screening assessment.
 Unsigned Notes:
 Outcome: Proceed to screening
 Reason for Ineligibility:
Follow-Up
 Follow-Up Steps: Alcohol treatment, Clinic, Drug treatment, Mental health treatment
 Follow-Up Steps Selected: None
Cancel Save Finish

Sign Note

Figure 2-18: Signed Notes

Part 3: Client Intake and Program Enrollment

Client Activity List

It is important to understand that data collection in WITS happens within a Client's Activity List. The Case, or Episode of Care, is the container that holds all client activities. The beginning and end of a client's Episode of Care are recorded on the Intake transaction, where the Intake Date starts the Episode and the Intake Date Closed marks the end of the Episode (these fields are shown in *Figure 3-6: Intake Case Information screen* on page 23).

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

When an Episode of Care ends for a client, this signifies that the client is no longer receiving services. It's possible for that client to return at a future date.

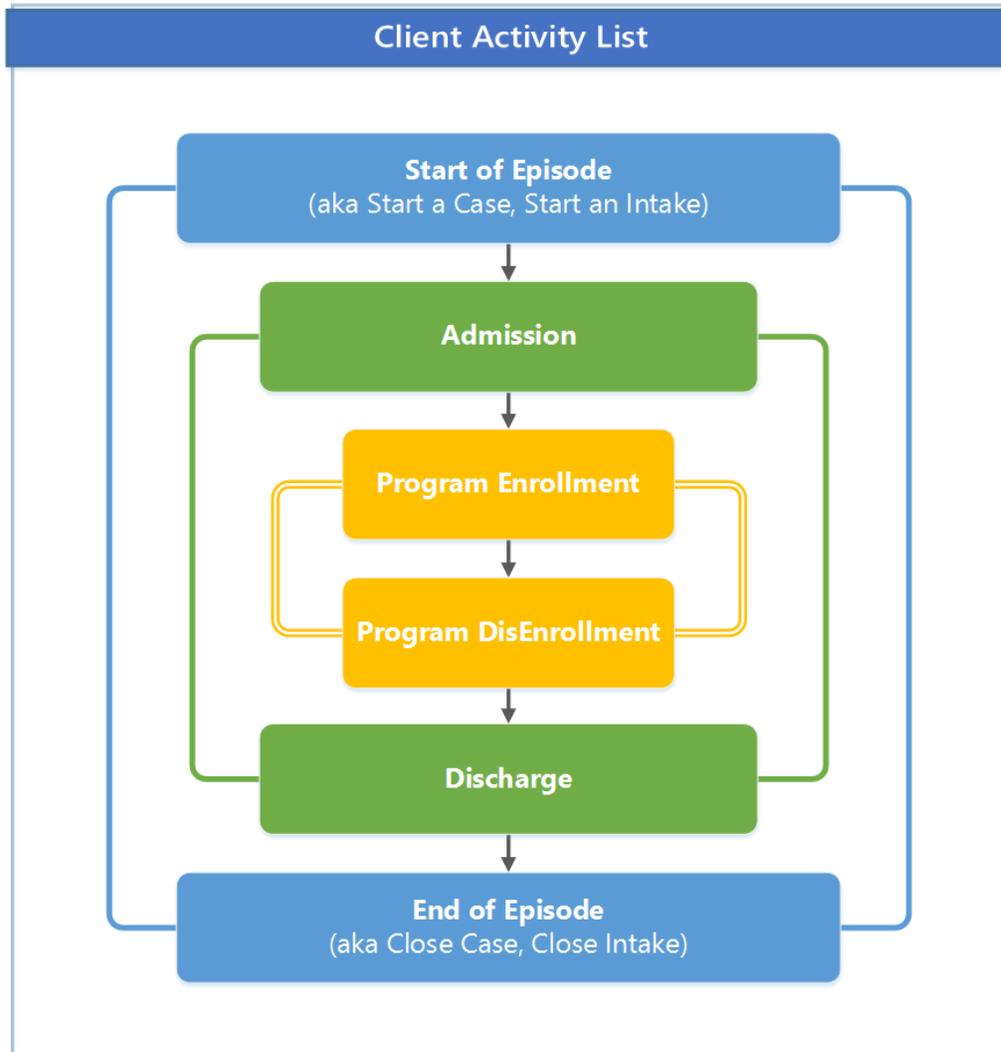


Figure 3-1: Concept Diagram of Data Collection Structure within Client Activity List

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

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

i To access items within the Activity List, a client must be selected first.

Actions	Activity	Activity Date	Created Date	Status
	Client Information (Profile)	6/23/2017	6/30/2017	Completed
	Intake Transaction	6/23/2017	6/30/2017	Completed
	Screening Tool	6/23/2017	6/30/2017	Completed
	Admission	6/30/2017	6/30/2017	Completed
	Outcome Measures - Client Status (Initial)	6/30/2017		In Progress (Details)

Figure 3-2: Client Activity List, Details link

Client Information (Profile) Progress
<ul style="list-style-type: none">• Ethnicity is missing.• Veteran Status is missing.• Race is empty.• Address is empty.

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

i Some Client Activities do not have a concept of being complete. For those activities, the Status will be listed as Not Applicable.

Start New Episode (New Clients)



Where: *Client List* > *Activity List* > *Episode List*

In WITS, all items located in a client’s Activity List are based upon an active Episode of Care. In the screen capture below, note the Activity List in the left menu only displays one item, “Episode List”. An episode must be created before accessing other items in the client’s Activity List.

To start a new episode of care for a client, follow the steps below.

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

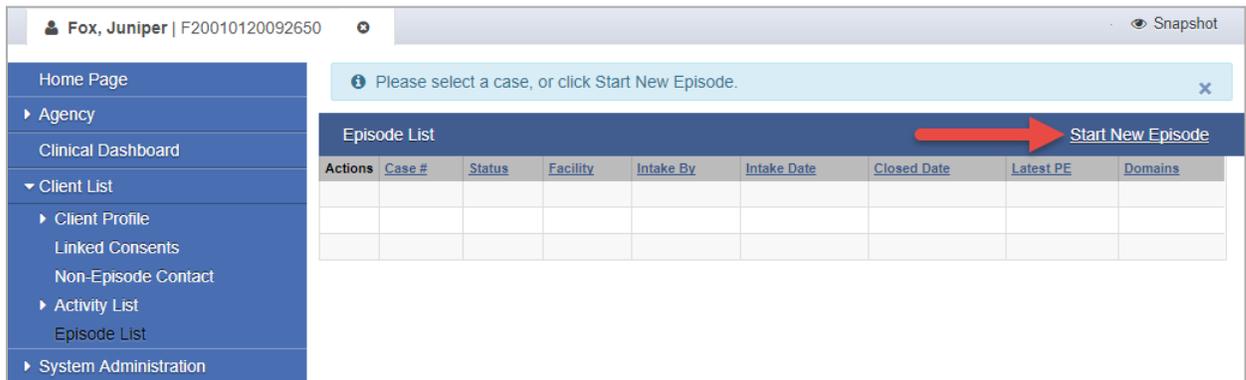


Figure 3-4: Episode List screen, Start New Episode link

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

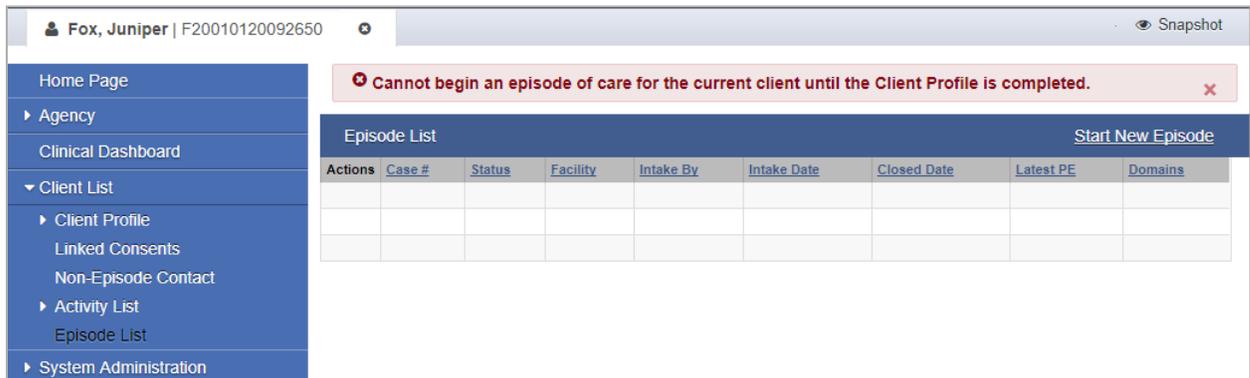


Figure 3-5: Episode List screen, Error Message

If the client profile is complete, clicking **Start New Episode** will open the **Intake Case Information** screen, as shown in Figure 3-6: Intake Case Information screen.

(Continue to next section)

Intake



Where: *Client List* > *Activity List* > *Intake*

Once an episode of care has been created (see above section), complete the client’s intake.

1. On the Intake Case Information screen, complete the fields as shown in the table below.

Table 3-1: Intake Case Information Fields

Field	Description
Intake Facility	Pre-populates with the current facility location.
Intake Staff	Pre-populates with the current staff member name.
Initial Contact	Select from the drop-down list.
Case Status	Defaults to “Open Active”.
Initial Contact Date	The date when the Client first reached out for treatment.
Intake Date	Enter the client’s intake date, (which also marks the beginning of the client’s Episode).
Source of Referral	Select from the drop-down list.
Referral Contact	(Optional) Select from a list of the client’s collateral contacts.
Pregnant	Is the client pregnant at the time of admission? Complete if applicable.
Prenatal Treatment	(Optional) Is the client also receiving prenatal treatment? Select Yes/No if applicable.
Injection Drug User	Select Yes or No.
Problem Area	(Optional)
Presenting Problem (In Client’s Own Words)	(Optional)
Special Initiatives/Populations Selected	Select one or more options.
Inter-Agency Service Selected	(Optional)
Selected Domains	This field will be pre-populated and read-only if there is only one domain associated with the agency. If the agency has multiple domains, select the appropriate domain(s) for the client.
Date Closed Date Closed <input type="text"/>  Save & Close the Case	The Date Closed field is used to mark the end of the client’s Episode.

Intake Case Information

Intake Facility: Provider
 Intake Staff: Jones, Luna N.
 Initial Contact:
 Residence:
 Source of Referral:
 Referral Contact:
[Add Collateral Contact](#)

Case #: 1
 Case Status: Open Active
 Initial Contact Date:
 Intake Date: 8/31/2018
 Pregnant:
 Due Date:
 Prenatal Treatment:
 HIV Positive:
 Injection Drug User:
 Problem Area:
 Presenting Problem (In Client's Own Words):

Special Initiative
 Acquired Brain Disorders
 Adult with Organic Disorder w/o SED
 Adult with Severe and Persistent Mental Illness
 Adult with Severe Emotional Disturbance

Special Initiative Selected

Inter-Agency Service
 Child Protective Services (OCS)
 Court/Legal Interface
 DCSF
 Developmental Disabilities

Inter-Agency Service Selected

Domains
 Selected Domains
 Substance Abuse

Date Closed:

Cancel Save Finish

Figure 3-6: Intake Case Information screen

3. Click **Finish**.

Tx Team (Treatment Team)



Where: *Client List* > *Activity List* > *Treatment Team*

Treatment Teams can be created for each client to ensure the appropriate staff have access to each client record.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Tx Team**.

Add Team Member

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

The screenshot shows the 'Treatment Team' interface. At the top is a table with columns: Actions, Team Member Name, Is Primary Care Member?, Review Member, Role/Relation, Start Date, and End Date. Below the table is a blue header bar labeled 'Assign Group' with an 'Add Team Member' link on the right, highlighted by a red arrow. The main form area contains several input fields: Staff Name, Non Staff Name, Add Collateral Contact, Role/Relation, Review Member, Primary Care Staff, and Deny Access to Client Records. It also has Start Date and End Date fields, a large Notes text area, and two 'Treatment Sub-Teams' dropdown menus (one showing 'Recovery') with arrow buttons between them. A 'Finish' button is located at the bottom right of the form.

Figure 3-7: Treatment Team screen, Add Team Member link

5. Complete the team member fields. See the table below for information on each field.

Table 3-2: Treatment Team Member fields

Field	Description
Staff Name	Select available agency Staff Members from the drop-down list.
Non Staff Name	This drop-down list includes collateral contacts previously entered for the client. Select a contact who is part of the client’s treatment team. If the drop-down list is missing a contact, click the Add Collateral Contact link to enter that contact for the client.

Field	Description
Role/Relation	Select an option from the drop-down list.
Review Member	Will the team member review the client's record, including the treatment plan? Select Yes/No.
Primary Care Staff	Is the team member primarily responsible for the client's treatment? Select Yes/No.
Deny Access to Client Records	Will the client's records be hidden from this team member? Select Yes/No. If this is set as "Yes", then the selected staff will not be able to see that Client record in the Agency Client List screen.
Selected Sub-Teams	"Recovery" must be selected for this Team Member to appear on the Recovery Plan.
Start Date	Defaults to today's date. May need to be updated for each Tx Team Member.
End Date	To remove a member from the treatment team, enter a date in the End Date field.
Notes	(Optional)

Treatment Team

Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date

Assign Group
[Add Team Member](#)

Staff Name

Non Staff Name

[Add Collateral Contact](#)

Role/Relation

Review Member

Primary Care Staff

Deny Access to Client Records

Start Date

End Date

Notes

Treatment Sub-Teams

Selected Sub-Teams

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

6. Click **Save**. Add additional team members as needed.
7. Click **Finish**.

See also

- **Update Treatment Team Information** on page 29

Assign Group

i Treatment Team Groups must be set up by an administrator (or others with necessary permissions). Once Treatment Team Groups have been created, the group(s) will be available to select in this section.

Note: make sure a client is selected first.

1. On the left menu, under the client’s Activity List, click **Tx Team**.
2. Click **Assign Group**.

The screenshot shows the 'Treatment Team' interface. At the top, there is a table with columns: Actions, Team Member Name, Is Primary Care Member?, Review Member, Role/Relation, Start Date, and End Date. One row is visible with the name 'Jones, Sarah A., CCS' and a role of 'Case Manager'. Below the table is a navigation bar with 'Assign Group' (highlighted by a red arrow) and 'Add Team Member'. The main area contains form fields for Staff Name, Non Staff Name, Add Collateral Contact, Role/Relation, Review Member, Primary Care Staff, and Deny Access to Client Records. There are also date pickers for Start Date and End Date, and a large text area for Notes. At the bottom, there are two list boxes: 'Treatment Sub-Teams' (containing 'Recovery') and 'Selected Sub-Teams', with arrow buttons between them. A 'Finish' button is located at the bottom right.

Figure 3-9: Treatment Team screen, Assign Group link

3. In the **Available Groups** box, select the appropriate treatment team group(s). Click the **top arrow** (>) button to move the selected teams to the **Selected Groups** box.

The screenshot shows a dialog box titled 'Select Groups to Add to Treatment Team'. It features two list boxes: 'Available Groups' (containing 'Mental Health Treatment Team') and 'Selected Groups' (containing 'Co-occurring Treatment Team'). Arrow buttons (> and <) are positioned between the list boxes. At the bottom right, there are 'Cancel' and 'Assign' buttons.

Figure 3-10: Select Groups to Add to Treatment Team

4. Click **Assign**.

- Staff members who are included in the Selected Groups will then be listed in the client's Treatment Team.

Treatment Team						
Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
	Jones, Sarah A., CCS	No	Yes	Case Manager	6/10/2017	
	Jones, Ashley	No	No	Team Lead	7/10/2017	
	O'Reilly, Kristyn	No	No	Counselor	7/10/2017	
	Amadi, Uche	No	No	Neurologist	7/10/2017	
	Riegel, Amber	No	No	Psychologist	7/10/2017	

Assign Group
Add Team Member

Staff Name

Non Staff Name

Add Collateral Contact

Role/Relation

Review Member

Primary Care Staff

Deny Access to Client Records

Start Date

End Date

Notes

Treatment Sub-Teams

Recovery

Selected Sub-Teams

Figure 3-11: Treatment Team with team members added to list

- When complete, click **Finish**.

See also

- **Update Treatment Team Information** on page 29

Update Treatment Team Information

To update information for an individual team member, follow the steps below. **Note:** make sure a client is selected first.

1. On the left menu, under the client's Activity List, click **Tx Team**.
2. Locate the desired Treatment Member Name, hover over the **Actions** column, and then click **Review**.

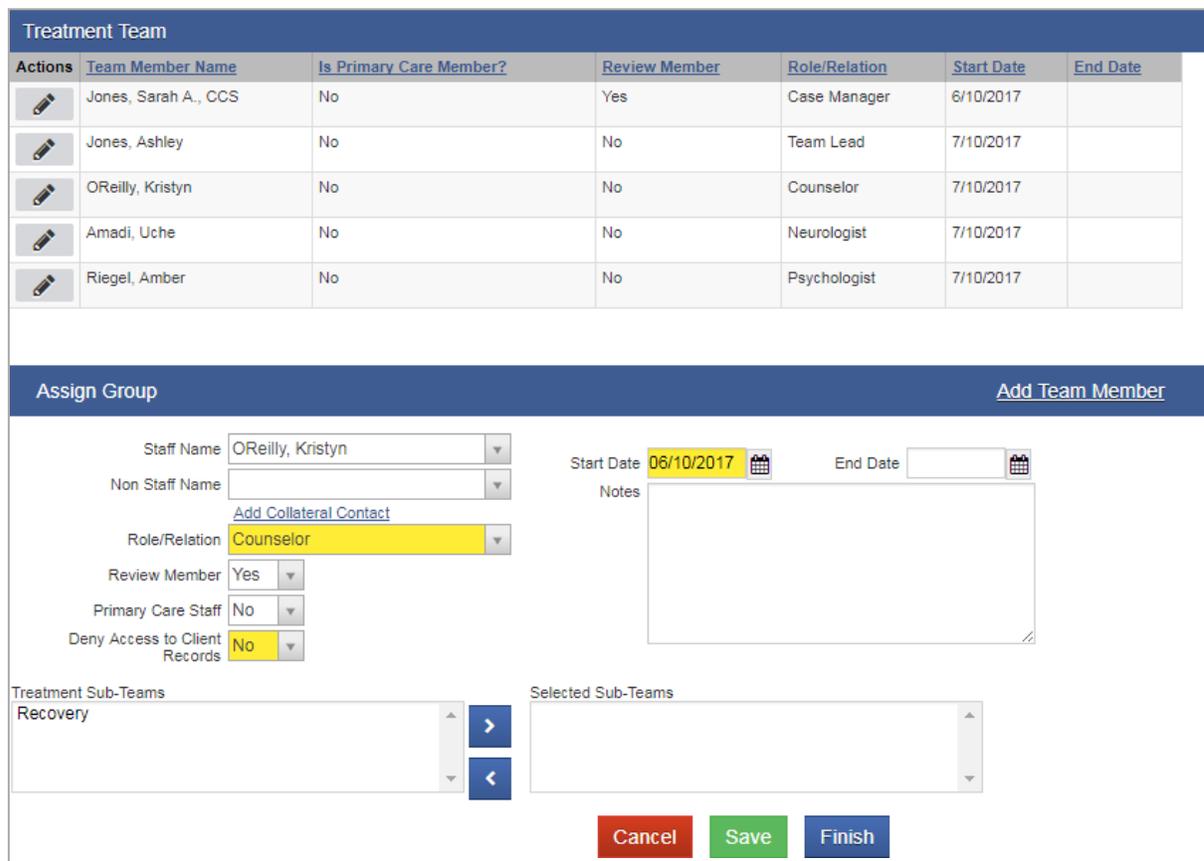


Treatment Team						
Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
	Jones, Sarah A., CCS	No	Yes	Case Manager	6/10/2017	
	Jones, Ashley	No	No	Team Lead	7/10/2017	
	O'Reilly, Kristyn	No	No	Counselor	7/10/2017	
		No	No	Neurologist	7/10/2017	
	Riegel, Amber	No	No	Psychologist	7/10/2017	

Figure 3-12: Treatment Team screen, Review Team Member link

3. The Team Member's information will be displayed on screen. Update the fields as needed.

i To remove a member from the treatment team, enter a date in the **End Date** field.



Treatment Team						
Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
	Jones, Sarah A., CCS	No	Yes	Case Manager	6/10/2017	
	Jones, Ashley	No	No	Team Lead	7/10/2017	
	O'Reilly, Kristyn	No	No	Counselor	7/10/2017	
	Amadi, Uche	No	No	Neurologist	7/10/2017	
	Riegel, Amber	No	No	Psychologist	7/10/2017	

Assign Group		Add Team Member
Staff Name	O'Reilly, Kristyn	
Non Staff Name		
	Add Collateral Contact	
Role/Relation	Counselor	
Review Member	Yes	
Primary Care Staff	No	
Deny Access to Client Records	No	
Start Date	06/10/2017	End Date
Notes		
Treatment Sub-Teams		
Recovery		
Selected Sub-Teams		
<input type="button" value="Cancel"/> <input type="button" value="Save"/> <input type="button" value="Finish"/>		

Figure 3-13: Treatment Team screen, Review and Update Team Member information

4. Click **Save**. Make additional updates to other team members, otherwise, click **Finish**.



Where: [Client List](#) > [Activity List](#) > [ASAM](#)

Follow the steps below to select a client and add an ASAM assessment. If you've already selected a client, skip to step 3.

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

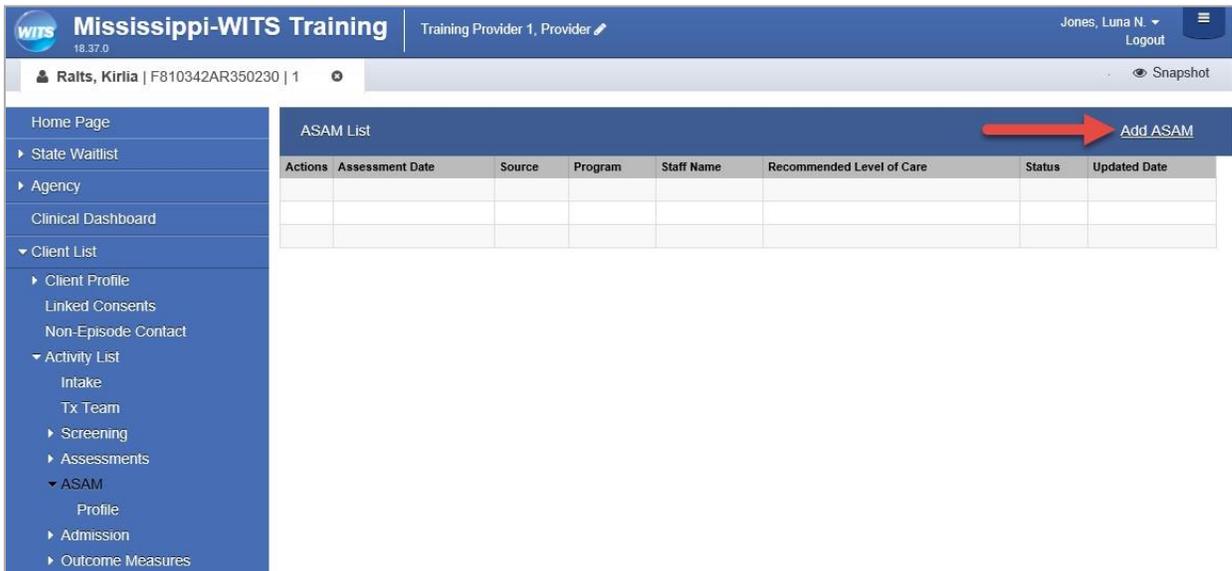


Figure 3-14: ASAM List screen, Add ASAM

5. Complete the fields on the ASAM screen. For each of the six (6) Dimensions, select the **Level of Risk, Level of Care**, and complete the **Comments** field.

Table 3-3: ASAM Fields

Field	Description
*Dimension 1 - Acute Intoxication and/or Withdrawal Potential	
*Dimension 2 - Biomedical Conditions and *Complications	
*Dimension 3 - Emotional, Behavioral, or Cognitive Conditions and Complications	
*Dimension 4 - Readiness to Change	
*Dimension 5 - Relapse, Continued Use, or Continued Problem Potential	
*Dimension 6 - Recovery / Living Environment	
Recommended Level of Care	Select from the drop-down list.

Field	Description
Actual Level of Care	Select from the drop-down list.
Clinical Override	
Comments	Type any applicable comments.
Date	Enter the date when the ASAM was administered.
Program	

The screenshot displays the ASAM Placement screen. The left sidebar contains a navigation menu with options like Home Page, State Waitlist, Agency, Clinical Dashboard, Client List, and System Administration. The main content area is titled 'ASAM' and lists six dimensions for assessment. Each dimension has a 'Level of Risk' dropdown, a 'Level of Care' dropdown, and a 'Comments' text area. Below the dimensions are fields for 'Recommended Level of Care', 'Actual Level of Care', and 'Clinical Override'. The 'Assessment Date' is set to 9/5/2018, and the 'Program' dropdown is empty. An 'Administrative Actions' box at the bottom contains a 'Sign ASAM' link. At the very bottom, there are 'Cancel', 'Save', and 'Finish' buttons.

Figure 3-15: ASAM Placement screen

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

Administrative Actions

[Sign ASAM](#)

Home Page		ASAM	
▶ Agency		Type Admission	
Clinical Dashboard			
▼ Client List			
▶ Client Profile			
Linked Consents			
Non-Episode Contact			
▼ Activity List			
Intake			
Screening Tool			
▶ Assessments			
▼ ASAM			
Profile			
PCPC Summary			
▶ Admission			
▶ Outcome Measures			
Program Enroll			
Diagnosis List			
▶ Encounters			
▶ Notes			
Tx Team			
Treatment Plan			
▶ Discharge			
▶ Recovery Plan			
Consent			
Referrals			
Episode List			
▶ System Administration			
		Dimension	
		Level of Risk	
		Level of Care	
1 - Acute Intoxication and/or Withdrawal Potential		3.1 - Clinically Managed Low-Intensity Residential	
Criteria Included/Comments		TEST	
2 - Biomedical Conditions and Complications		3.5 - Clinically Managed Medium-Intensity Residential	
Criteria Included/Comments		TEST	
3 - Emotional, Behavioral, or Cognitive Conditions and Complications		2.1 - Intensive Outpatient	
Criteria Included/Comments		TEST	
4 - Readiness to Change		2.5 - Partial Hospitalization	
Criteria Included/Comments		TEST	
5 - Relapse, Continued Use, or Continued Problem Potential		3.5 - Clinically Managed Medium-Intensity Residential	
Criteria Included/Comments		TEST	
6 - Recovery / Living Environment		2.5 - Partial Hospitalization	
Criteria Included/Comments		TEST	
Recommended Level of Care		3.5 - Clinically Managed Medium-Intensity Residential	
Actual Level of Care		3.7 - Medically Monitored High-Intensity Inpatient	
		Clinical Override Capacity Issues	
		Comments JUSTIFICATION FOR DIFFERENT LEVEL OF CARE	
Date 9/1/2017		Program Facility A/Program 1B : 9/1/2017 -	
Administrative Actions			
Signed by: 07, ClinicalFullTrainee		Signed on: 10/31/2017 9:46 AM	
		Cancel Save Finish	

8. Click **Finish**.

Admission



Where: *Client List* > *Activity List* > *Admission*

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

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

Table 3-4: Admission Profile Fields

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

The screenshot shows the 'Admission Profile' screen in the MS-WITS TRAINING system. The header includes the DMH logo, 'MS-WITS TRAINING 18.38.0', and user information 'Training Provider 1, Provider' and 'Jones, Luna N. Logout'. The breadcrumb trail is 'Fox, Fig | M09020987FI | 1'. The left navigation menu is expanded to 'Admission' > 'Profile'. The main content area shows the following details:

- Full Name:** Fox, Fig
- Residence/Borough:** Forrest
- Referral Source:** School (Educational)
- Race:** Other Race
- Gender:** Male
- Ethnicity:** Unknown
- DOB:** 9/24/2002
- Age:** 15

Below the details are three dropdown menus:

- Admission Type: Admission
- Admission Staff: Jones, Luna N.
- Admission Date: 9/19/2018

At the bottom, there are two large text input areas: 'Administrative Checklist' and 'Selected Administrative Checklist Items'. To the right of these are 'Cancel', 'Save', and 'Finish' buttons, along with a right-pointing arrow button.

Figure 3-16: Admission Profile screen

5. Click **Save** and then click **Finish**.

NOTE • Optional information can be entered by clicking the right-arrow button. Please see the following page.

Fox, Juniper | F20010120092650 | 1 Generate Report Snapshot

Admission

Youth Admission

Client is a Student Client is a Gang Member

Guardian Name

Guardian Type

School Name

School Contact [Add School Contacts](#)

Attending Grade Days Suspended in Last 30 Days

Current GPA Days Absent in Last 30 Days

POSIT Scores

Substance Abuse Score Peer Score Leisure Recreational Score

Physical Health Score Education Status Score Aggression Score

Mental Health Score Vocational Status Score HIV Risk Score

POSIT Family Score Social Skill Score

Figure 3-17: Admission, Youth Admission screen

Rose, Lavender | R20010129011110 | 1 Generate Report Snapshot

Admission

Assessment Scores

Medical

Employment

Drug

Alcohol

Legal

Family

Psychiatric

Controlled Environment

[Load Latest Assessment Scores](#)

[Clear Assessment Scores](#)

Figure 3-18: Admission, Assessment Scores screen

Part 4: Outcome Measures



Where: *Client List* > *Activity List* > *Outcome Measures*

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

! An **Initial Outcome Measure** must be completed and finalized within **fourteen (14) days** of enrolling a client in a TEDS treatment program. This requirement is only applicable to programs that report TEDS data. Enrollment in Case Management programs do not have this requirement.

Initial Outcome Measures

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Outcome Measures**.
4. On the Outcome Measures List screen, click **Add New**. This will open the Outcome Measures - Client Status screen.

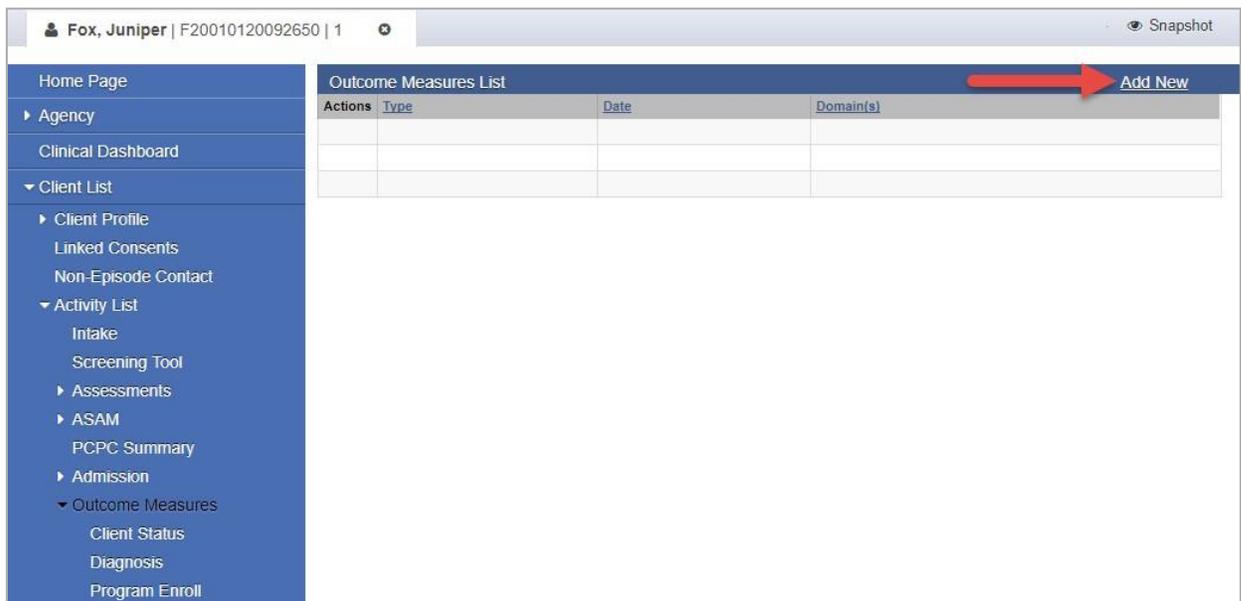


Figure 4-1: Outcome Measure screen, Add New link

Continue to next page

Client Status



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#) > [Client Status](#)

The **Outcome Measures – Client Status** screen displays a series of questions grouped in to separate sections on screen.

Note: This portion of the documentation follows a slightly different format than the rest of the user guide.

MS-WITS TRAINING | Training Provider 1, Provider | Jones, Luna N. | Logout

Fox, Fig | M09020987F1 | 1 | Snapshot

Outcome Measures - Client Status

Date: 9/19/2018 | Type: Initial | Pregnant: Not Applicable | Due Date: []

Domains: [] | Selected Domains: Substance Abuse

Profile

Codependent/Collateral: [] | Co-Occurring SA and MH Problem: [] | Medication Assisted Tx: [] | SMI/SED Status: [] | # of Prior SA Tx Episodes: []

of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence. []

Education

Education Status: []

Financial/Household

Employment Status: [] | Source of Income: [] | Primary Payment Source: [] | Health Insurance: [] | Marital Status: [] | Living Situation: []

Legal

of Arrests in Past 30 Days: [] | Mental Health Legal Status: []

Legal History: 180 Day Commitment, 30 Day Commitment, 90 Day Commitment, Case Pending | Selected Legal History: []

Substance Abuse

Rank	Substance	Severity	Frequency	Method	Detailed Drug Code
Primary:	[]	[]	[]	[]	[]
Secondary:	[]	[]	[]	[]	[]
Tertiary:	[]	[]	[]	[]	[]

At what age did the client FIRST use the substances indicated above (if unknown, enter '97') | Primary: [] | Secondary: [] | Tertiary: []

of DAYS since LAST use of the substances indicated above: Primary: [] | Secondary: [] | Tertiary: []

Tobacco/Nicotine

Have you ever used Tobacco/Nicotine products? []

Smoker Status? []

Age of First Use []

In the past 30 days, what tobacco/nicotine product did you use most frequently? []

Other (Please Describe) []

In the past 30 days, how often did you use tobacco/nicotine product(s)? []

Cancel Save Finish

Figure 4-2: Initial Outcome Measures – Client Status screen

5. Complete the fields on the **Outcome Measures – Client Status** screen as shown in the sections provided below.

The screenshot shows the 'Outcome Measures - Client Status' interface. At the top, the title is 'Outcome Measures - Client Status'. Below the title, there are several input fields: 'Date' with a calendar icon and the value '9/5/2018', 'Type' with a dropdown menu set to 'Initial', 'Pregnant' with a dropdown menu set to 'Not Applicable', and 'Due Date' which is currently empty. Below these fields, there are two boxes: 'Domains' and 'Selected Domains'. The 'Domains' box is empty, and the 'Selected Domains' box contains the text 'Substance Abuse'. There are navigation arrows between the two boxes.

Table 4-1: Outcome Measures – Client Status (Initial) fields

Field	Description
Date	Pre-populates with the Admission Date.
Type	Defaults to “Initial” when adding the first Outcome Measure.
Pregnant	Pre-populates with the selection entered on the Intake screen. Select Yes or No, if applicable.
Due Date	Pre-populates with the selection entered on the Intake screen. Enter client’s Due Date, if applicable.
Selected Domains	In the Domains box, select the appropriate option(s). Click the top arrow (>) button to move the chosen domain(s) to the Selected Domains box. Note: This field will be read-only until another domain is available in the system.

Profile

Complete the fields in the **Profile** section.

The screenshot shows the 'Profile' section of the 'Outcome Measures - Client Status' screen. It contains several dropdown menus and a text input field. The fields are: 'Codependent/Collateral' set to 'No', 'Co-Occurring SA and MH Problem' set to 'Yes', 'Medication Assisted Tx' set to 'Unknown', 'SMI/SED Status' set to 'Unknown', and '# of Prior SA Tx Episodes' set to '0'. Below these fields, there is a text input field for '# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.' The value entered is 'No attendance in the past month'.

Table 4-2: Outcome Measures – Client Status screen; Profile section fields

Field	Description
Codependent/Collateral	Select Yes/No.
Co-Occurring SA and MH Problem	Select an option from the drop-down list.
Medication Assisted Tx	Select an option from the drop-down list.
SMI/SED Status	(Optional) Select an option from the drop-down list.
# of Prior SA Tx Episodes	Type an integer.

Field	Description
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	Select an option from the drop-down list.

Education

Complete the field in the **Education** section.

Education	
Education Status	8 Years completed

Table 4-3: Outcome Measures – Client Status screen; Education section

Field	Description
Education Status	Select an option from the drop-down list.

Financial/Household

Complete the fields in the **Financial/Household** section.

Financial/Household			
Employment Status	Not in Labor Force - Student	Source of Income	Other
Primary Payment Source	Other Health Insurance Companies	Health Insurance	Private Insurance
Marital Status	Now Married	Living Situation	Dependent Living

Table 4-4: Outcome Measures – Client Status screen; Financial/Household section

Field	Description
Employment Status	Select an option from the drop-down list.
Source of Income	Select an option from the drop-down list.
Primary Payment Source	Select an option from the drop-down list.
Health Insurance	Select an option from the drop-down list.
Marital Status	Select an option from the drop-down list.
Living Situation	Select an option from the drop-down list.

Legal

Complete the fields in the **Legal** section.

Legal

of Arrests in Past 30 Days Mental Health Legal Status

Legal History Selected Legal History

180 Day Commitment
30 Day Commitment
90 Day Commitment
Case Pending

> <

Unknown

Table 4-5: Outcome Measures – Client Status screen; Legal section

Field	Description
# of Arrests in Past 30 Days	Type an integer.
Mental Health Legal Status	Select an option from the drop-down list. Note: System Administrators control the values displayed in this drop-down list through a code table. If values are missing, contact your System Administrator for assistance.
Selected Legal History	In the Legal History box, select the appropriate option(s). Click the top arrow (>) button to move the selected options to the Selected Legal History box.

Substance Abuse

For each field in the Substance Abuse section, select options for the client's Primary, Secondary, and Tertiary substances as applicable.

Substance Abuse					
Rank	Substance	Severity	Frequency	Method	Detailed Drug Code
Primary:	Alcohol	Severe Problem/Dysf...	Daily	Oral	Alcohol
Secondary:	Over-the-Counter	Moderate Problem/D...	1-3 times in the pas...	Oral	Other Over-the-Counter
Tertiary:	Unknown	N/A	Unknown	Unknown	Unknown
At what age did the client FIRST use the substances indicated above (if unknown, enter '97')					
			Primary 13	Secondary 15	Tertiary 97
# of DAYS since LAST use of the substances indicated above:					
			Primary 2	Secondary 5	Tertiary

Table 4-6: Outcome Measures – Client Status screen; Substance Abuse section

Field	Description
Substance	Select an option from the drop-down list.
Severity	(Optional) Select an option from the drop-down list.
Frequency	Select the frequency of use from the drop-down list.
Method	This field may pre-populate based on the option selected in Substance field. Select an option from the drop-down list as applicable.
Detailed Drug Code	This field may pre-populate based on the option selected in Substance field. Select an option from the drop-down list as applicable.
At what age did the client FIRST use the substances indicated above (if unknown, enter '97')	Type an integer.
# of DAYS since LAST use of the substances indicated above:	(Optional) Type an integer.

Tobacco/Nicotine

In the Tobacco/Nicotine section, complete the field, **“Have you ever used Tobacco/Nicotine products?”** by selecting **Yes**, **No**, or **Unknown**. This answer will update the other fields in the Tobacco/Nicotine section.

Tobacco/Nicotine

Have you ever used Tobacco/Nicotine products?

Smoker Status?

Age of First Use

In the past 30 days, what tobacco/nicotine product did you use most frequently?

Other (Please Describe)

In the past 30 days, how often did you use tobacco/nicotine product(s)?

Table 4-7: Outcome Measures – Client Status screen; Tobacco/Nicotine section

Field	Description
Have you ever used Tobacco/Nicotine products?	Select Yes, No, or Unknown. If Yes is selected, the following fields will become editable.
Smoker Status?	Read-only field unless client answered “Yes” to ever using Tobacco/Nicotine products.
Age of First Use	Read-only field unless client answered “Yes” to ever using Tobacco/Nicotine products.
In the past 30 days, what tobacco/nicotine product did you use most frequently?	Read-only field unless client answered “Yes” to ever using Tobacco/Nicotine products.
Other (Please Describe)	Read-only field unless client answered “Yes” to ever using Tobacco/Nicotine products and if “Other” was selected as the type of product used most frequently in the last 30 days.
In the past 30 days, how often did you use tobacco/nicotine product(s)?	Read-only field unless client answered “Yes” to ever using Tobacco/Nicotine products.

Tobacco/Nicotine

Have you ever used Tobacco/Nicotine products? Yes

Smoker Status?

Age of First Use

In the past 30 days, what tobacco/nicotine product did you use most frequently?

Other (Please Describe)

In the past 30 days, how often did you use tobacco/nicotine product(s)?

Outcome Measures - Client Status

Date: 9/5/2018 Type: Initial
 Pregnant: Not Applicable Due Date:

Domains: Selected Domains: Substance Abuse

Profile

Codependent/Collateral: No Co-Occurring SA and MH Problem: Yes
 Medication Assisted Tx: Unknown SMI/SED Status: Unknown # of Prior SA Tx Episodes: 0
 # of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.
 No attendance in the past month

Education

Education Status: 8 Years completed

Financial/Household

Employment Status: Not in Labor Force - Student Source of Income: Other
 Primary Payment Source: Other Health Insurance Companies Health Insurance: Private Insurance
 Marital Status: Now Married Living Situation: Dependent Living

Legal

of Arrests in Past 30 Days: 0 Mental Health Legal Status:

Legal History: 180 Day Commitment, 30 Day Commitment, 90 Day Commitment, Case Pending Selected Legal History: Unknown

Substance Abuse

Rank	Substance	Severity	Frequency	Method	Detailed Drug Code
Primary:	Alcohol	Severe Problem/Dysf...	Daily	Oral	Alcohol
Secondary:	Over-the-Counter	Moderate Problem/D...	1-3 times in the pas...	Oral	Other Over-the-Counter
Tertiary:	Unknown	N/A	Unknown	Unknown	Unknown

At what age did the client FIRST use the substances indicated above (if unknown, enter '97') Primary: 13 Secondary: 15 Tertiary: 97
 # of DAYS since LAST use of the substances indicated above: Primary: 2 Secondary: 5 Tertiary:

Tobacco/Nicotine

Have you ever used Tobacco/Nicotine products? No
 Smoker Status? Never smoked
 Age of First Use:
 In the past 30 days, what tobacco/nicotine product did you use most frequently? NA
 Other (Please Describe):
 In the past 30 days, how often did you use tobacco/nicotine product(s)? NA

Administrative Actions

[Finalize](#)

Cancel Save Finish

- Click **Save**.
- Click the **right-arrow** button. This will open the ASAM screen.

ASAM



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#) > [ASAM](#)

8. Complete the fields on the ASAM screen.



Note: See section titled "ASAM" on page 30 above for additional information on the ASAM screen.

The screenshot displays the ASAM (Assessment of Subacute Mental Health) screen within the MS-WITS TRAINING system. The interface is divided into a left-hand navigation menu and a main content area. The navigation menu includes options like Home Page, State Waitlist, Agency, Clinical Dashboard, Client List, Client Profile, Activity List, and Outcome Measures. The ASAM screen itself features six dimensions for assessment, each with a 'Level of Risk' dropdown, a 'Level of Care' dropdown, and a 'Comments' text area. Below these dimensions are fields for 'Recommended Level of Care', 'Actual Level of Care', and 'Clinical Override'. The 'Assessment Date' is set to 8/31/2018, and there is a 'Program' dropdown. At the bottom of the screen, there are 'Cancel', 'Save', and 'Finish' buttons, along with left and right navigation arrows.

Figure 4-3: Outcome Measures - ASAM screen

9. Click **Save**.

10. Click the **right-arrow** button. This will open the Client Diagnosis screen.

Client Diagnosis



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#) > [Client Diagnosis](#)

11. Complete the required fields on the **Client Diagnosis** screen as listed in the table below.

Note: These fields may be prepopulated by the system. If so, please review and edit the fields as needed.

Table 4-8: Client Diagnosis fields

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

Figure 4-4: Outcome Measures - Diagnosis screen

- Click **Edit Diagnosis** to add one or more diagnoses for the client. This will open the Edit Diagnosis screen. (Continue to next page)

The screenshot shows the 'Client Diagnosis' form. At the top right, there is a blue header with the text 'Client Diagnosis' and a red arrow pointing to a link labeled 'Edit Diagnosis'. Below the header, there are input fields for 'Primary', 'Secondary', and 'Tertiary' diagnosis types. To the right, there are fields for 'Effective Date' (8/31/2018), 'Time' (4:42 PM), 'Expiration Date', and another 'Time' field. Below these are fields for 'Diagnosing Clinician' and 'GAF Score'. A table with columns 'Code', 'Description', 'Comments', and 'Principal' is visible, with a 'Behavioral Diagnosis' label on the left. At the bottom right, there are buttons for 'Cancel', 'Save', 'Finish', and navigation arrows. An 'Actions' field is at the bottom left.

Figure 4-5: Outcome Measures - Client Diagnosis screen, Edit Diagnosis link

Note: This link can also be used to edit a previously recorded diagnosis.

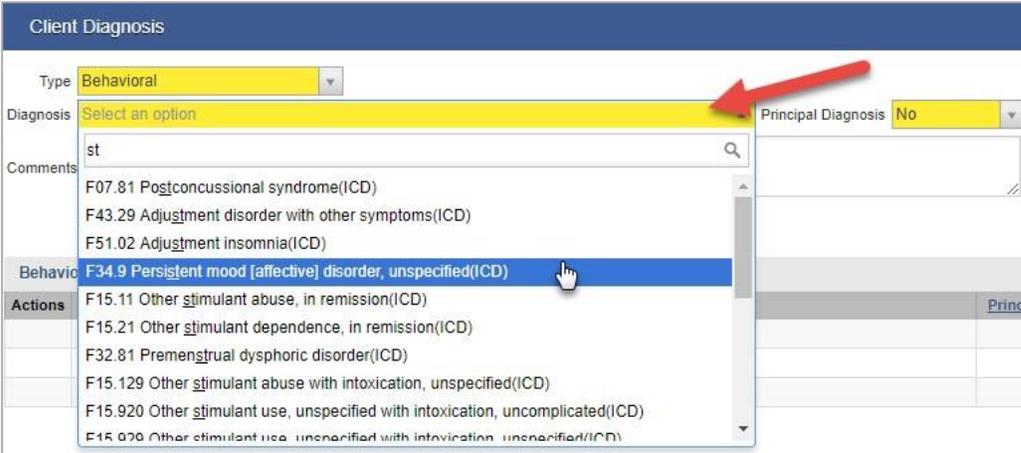
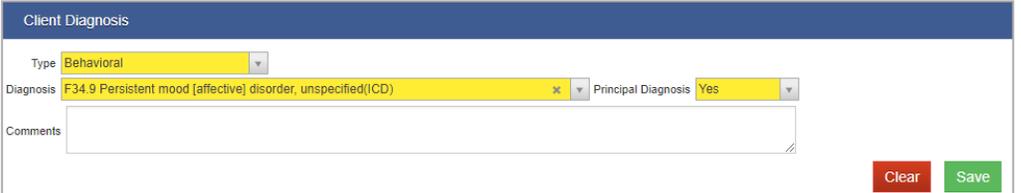
Edit Diagnosis

- On the **Edit Diagnosis** screen, add one or more diagnoses by completing the fields described in the table below.

Table 4-9: Client Diagnosis, Edit Diagnoses fields

Field	Description
Type	Select "Behavioral", "Medical", or "Psychosocial" from the drop-down list.

The screenshot shows the 'Edit Diagnosis' form. The 'Type' dropdown menu is open, showing options: 'Behavioral', 'Medical', and 'Psychosocial'. A red arrow points to the 'Behavioral' option. The form also shows a 'Diagnosis' search field, a 'Principal Diagnosis' dropdown set to 'No', and a 'Comments' text area.

Field	Description
Diagnosis	<p>Type at least two (2) characters for options to appear in the drop-down list. Select an option.</p>  <p>Client Diagnosis</p> <p>Type Behavioral</p> <p>Diagnosis Select an option</p> <p>Principal Diagnosis No</p> <p>Comments st</p> <p>F07.81 Postconcussional syndrome(ICD)</p> <p>F43.29 Adjustment disorder with other symptoms(ICD)</p> <p>F51.02 Adjustment insomnia(ICD)</p> <p>F34.9 Persistent mood [affective] disorder, unspecified(ICD)</p> <p>F15.11 Other stimulant abuse, in remission(ICD)</p> <p>F15.21 Other stimulant dependence, in remission(ICD)</p> <p>F32.81 Premenstrual dysphoric disorder(ICD)</p> <p>F15.129 Other stimulant abuse with intoxication, unspecified(ICD)</p> <p>F15.920 Other stimulant use, unspecified with intoxication, uncomplicated(ICD)</p> <p>F15.929 Other stimulant use, unspecified with intoxication, unspecified(ICD)</p>
Principal Diagnosis	<p>Select Yes or No.</p> <p>Note: At least one diagnosis must be marked “Yes” as the Principal Diagnosis.</p>  <p>Client Diagnosis</p> <p>Type Behavioral</p> <p>Diagnosis F34.9 Persistent mood [affective] disorder, unspecified(ICD)</p> <p>Principal Diagnosis No</p> <p>Comments</p> <p>No</p> <p>Yes</p>
Comments	<p>Type any comments if applicable.</p>  <p>Client Diagnosis</p> <p>Type Behavioral</p> <p>Diagnosis F34.9 Persistent mood [affective] disorder, unspecified(ICD)</p> <p>Principal Diagnosis Yes</p> <p>Comments</p> <p>Clear Save</p>

- Click **Save**. The diagnosis will be saved in its corresponding Type list on screen.
- Stay on this screen to enter additional diagnoses as applicable, otherwise click **Finish**. This will return to the Client Diagnosis screen. If adding additional diagnoses, please see section, “(Optional) Add Secondary & Tertiary Diagnosis” on page 49 below.

Client Diagnosis

Type

Diagnosis Principal Diagnosis

Comments

Behavioral Diagnosis

Actions	Code	Description	Comments	Principal
	F34.9	Persistent mood [affective] disorder, unspecified		Yes

Figure 4-6: Outcome Measures - Client Diagnosis, Edit Diagnosis screen, click Finish

- On the Client Diagnosis screen, notice the read-only field labeled "Primary" has been filled in with the client's primary diagnosis.

Client Diagnosis [Edit Diagnosis](#)

Primary

Effective Date Time

Secondary

Expiration Date

Tertiary

Diagnosing Clinician

GAF Score

Code	Description	Comments	Principal
F34.9	Persistent mood [affective] disorder, unspecified		Yes

Figure 4-7: Outcome Measures - Client Diagnosis screen, Primary diagnosis field highlighted

- On the Client Diagnosis screen, click **Save** and then click the **right-arrow** button. This will open the Program Enrollment screen.

Mississippi-WITS Training | Training Provider 1, Provider | Jones, Luna N. | Logout

Ralts, Kiria | F810342AR350230 | 1 | Snapshot

Client Diagnosis Edit Diagnosis

Primary: F34.9-Persistent mood [affective] disorder, unspecified(ICD) | Effective Date: 8/31/2018 | Time: 4:42 PM
 Secondary: | Expiration Date: | Time: |
 Tertiary: |

Diagnosing Clinician: | GAF Score: |

	Code	Description	Comments	Principal
Behavioral Diagnosis	F34.9	Persistent mood [affective] disorder, unspecified		Yes
Medical Diagnosis				
Psychosocial Diagnosis				

Cancel Save Finish ◀ ▶

Actions: _____

Figure 4-8: Outcome Measures - Client Diagnosis screen, Click Save then click the right-arrow button

(Optional) Add Secondary & Tertiary Diagnosis

Note: TEDS does not collect Secondary and Tertiary diagnoses.

Continuing from section, “*Edit Diagnosis*” on page 45 above. The following screen capture displays the Edit Diagnosis screen where multiple diagnoses have been added for a client.

1. Click **Finish**. This will return to the Client Diagnosis screen.

Client Diagnosis

Type

Diagnosis Principal Diagnosis

Comments

Clear Save

Behavioral Diagnosis

Actions	Code	Description	Comments	Principal
	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder		Yes
	F34.9	Persistent mood [affective] disorder, unspecified		No

Medical Diagnosis

Actions	Code	Description	Comments	Principal
	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No

Psychosocial Diagnosis

Actions	Code	Description	Comments	Principal
	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Finish

Figure 4-9: Client Diagnosis, Edit Diagnosis screen with multiple diagnoses

- On the Client Diagnosis screen, notice the read-only field labeled "Primary" has been filled in with the client's primary diagnosis.

The screenshot shows the 'Client Diagnosis' screen with the following details:

- Primary:** F10.94-Alcohol use, unspecified with alcohol-induced mood disorder(ICD)
- Effective Date:** 6/4/2017
- Time:** 12:00 AM
- Diagnosing Clinician:** Jones, Sarah A., CCS
- GAF Score:** (empty field)

Category	Code	Description	Comments	Principal
Behavioral Diagnosis	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder		Yes
	F34.9	Persistent mood [affective] disorder, unspecified		No
Medical Diagnosis	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No
Psychosocial Diagnosis	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Buttons: Cancel, Save, Finish, and navigation arrows.

Figure 4-10: Outcome Measures - Client Diagnosis screen with list of client's diagnoses

- In the **Secondary** field, click the drop-down field and select the client's Secondary diagnosis, as applicable.

The screenshot shows the 'Client Diagnosis' screen with the Secondary diagnosis dropdown menu open. A red arrow points to the dropdown field, and a mouse cursor is hovering over the first option in the list.

- Primary:** F10.94-Alcohol use, unspecified with alcohol-induced mood disorder(ICD)
- Effective Date:** 6/4/2017
- Time:** 12:00 AM
- Diagnosing Clinician:** Jones, Sarah A., CCS
- GAF Score:** (empty field)

Category	Code	Description	Comments	Principal
Behavioral Diagnosis	F10.94	Alcohol use, unspecified with alcohol-induced mood disorder		Yes
	F34.9	Persistent mood [affective] disorder, unspecified		No
Medical Diagnosis	O99.311	Alcohol use complicating pregnancy, first trimester		No
	O26.11	Low weight gain in pregnancy, first trimester		No
	O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No
Psychosocial Diagnosis	Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
	Z81.1	Family history of alcohol abuse and dependence		No

Dropdown menu options for Secondary diagnosis:

- F34.9-Persistent mood [affective] disorder, unspecified(ICD)
- O09.91-Supervision of high risk pregnancy, unspecified, first trimester(ICD)
- O26.11-Low weight gain in pregnancy, first trimester(ICD)
- O99.311-Alcohol use complicating pregnancy, first trimester(ICD)
- Z63.79-Other stressful life events affecting family and household(ICD)
- Z81.1-Family history of alcohol abuse and dependence(ICD)

Figure 4-11: Client Diagnosis screen, select Secondary diagnosis

- In the **Tertiary** field, click the drop-down field and select the client's Tertiary diagnosis, as applicable.

The screenshot shows the 'Client Diagnosis' interface. The 'Tertiary' field is active, and a dropdown menu is open, displaying a list of ICD codes. The code 'Z63.79-Other stressful life events affecting family and household(ICD)' is highlighted. A red arrow points to the dropdown field. Below the dropdown, there are two tables: 'Medical Diagnosis' and 'Psychosocial Diagnosis'.

Code	Description	Comments	Principal
O09.91	Supervision of high risk pregnancy, unspecified, first trimester		No
O26.11	Low weight gain in pregnancy, first trimester		No
O99.311	Alcohol use complicating pregnancy, first trimester		No

Code	Description	Comments	Principal
Z63.79	Other stressful life events affecting family and household	Client's parents are currently going through the divorce process.	No
Z81.1	Family history of alcohol abuse and dependence		No

Figure 4-12: Client Diagnosis screen, select Tertiary diagnosis

- Click **Save**.

Finalize Outcome Measure



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#) > [Client Status](#)

After completing the required information on each screen within the **Outcome Measures** section, this record can be finalized. When the Outcome Measures is finalized, the record becomes read-only.

! An **Initial Outcome Measure** must be completed and finalized within **fourteen (14) days** of enrolling and disenrolling a client from a TEDS treatment program. This requirement is only applicable to programs that report TEDS data. Case Management programs do not have this requirement for program enrollment/disenrollment.

6. On the Outcome Measures – Client Status screen, in the **Administrative Actions** box, click **Finalize**.

7. On the left menu, click **Program Enroll**. Continue to the next section.

Program Enrollment (TEDS)



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#) > [Program Enroll](#)

! An **Initial Outcome Measure** must be completed and finalized within **fourteen (14) days** of enrolling a client in a TEDS treatment program. This requirement is only applicable to programs that report TEDS data. Enrollment in Case Management programs do not have this requirement.

1. On the Program Enrollment screen, click **Add Enrollment**. This will open the Program Enrollment Profile screen.

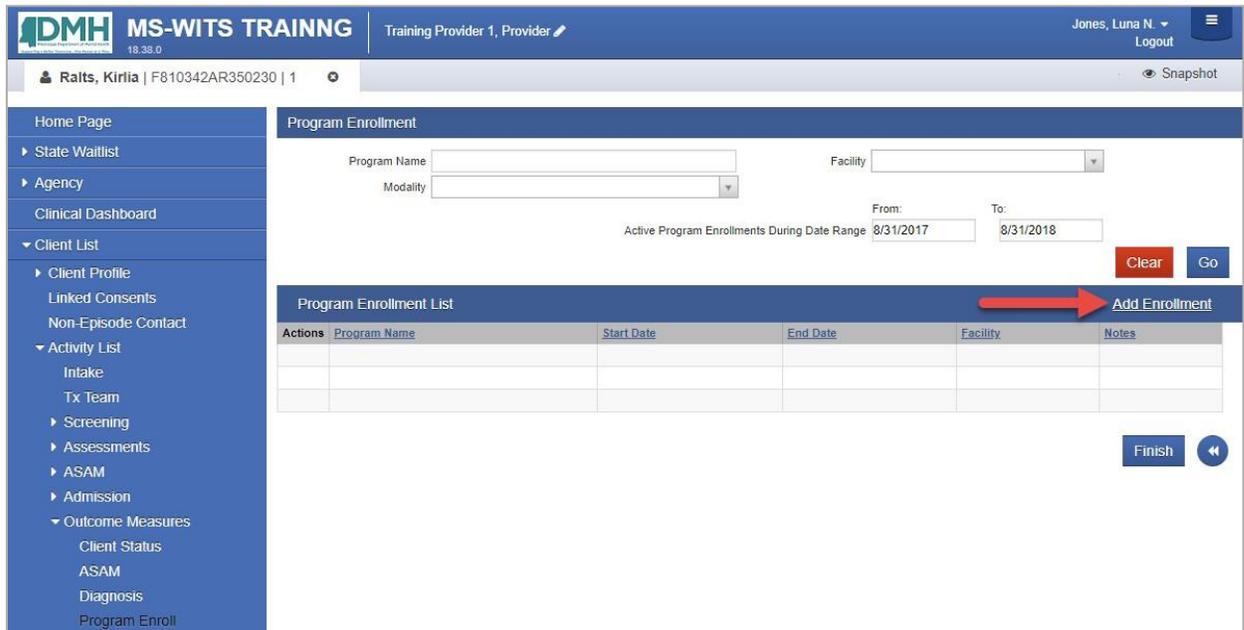


Figure 4-13: Outcome Measures – Program Enrollment screen

2. Complete fields on the Program Enrollment Profile as described in the table below.

Table 4-10: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the currently Facility name.
Program Name	Select from the programs available.
Program Staff	Pre-populates with the current staff member name.
Start Date	Pre-populates with the Outcome Measure date.
Domain	Read-only field. Displays the domain associated with the selected Program Name.
Days on Wait List	Type the number of days the client was waiting, if applicable.
Notes	Type any notes as needed.



Figure 4-14: Program Enrollment Profile screen

3. On the Program Enrollment Profile screen, click **Save** and then click **Finish**.

Note: If the Outcome Measures have not been finalized, the following warning message may appear as shown in the screen capture below. In this case, the screen cannot be saved. Click **Cancel** and navigate to the **Outcome Measures-Client Status** screen to finalize the Outcome Measures.

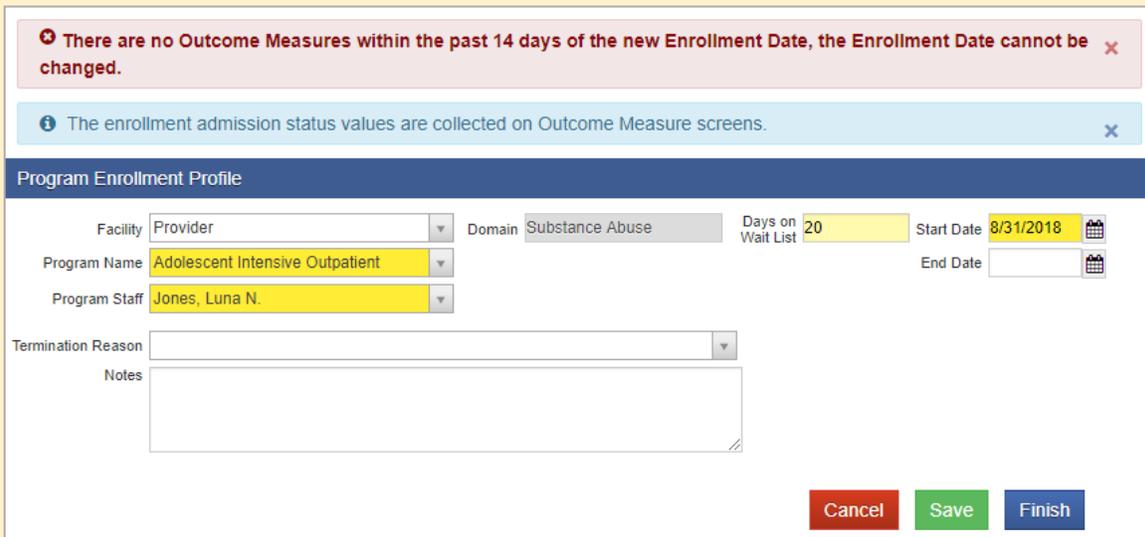


Figure 4-15: Program Enrollment Profile screen, warning message

4. On the Program Enrollment screen, click **Finish**.

Update/Final Outcome Measures



Where: [Client List](#) > [Activity List](#) > [Outcome Measures](#)

When the client is ready to be disenrolled from a treatment program, or if the client needs to be moved to a different level of care, an **Update** or **Final Outcome Measure** will be required. The client's Outcome Measure data must be collected and finalized within **fourteen (14)** days of disenrolling the client from a TEDS program.

! An **Initial Outcome Measure** must be completed and finalized within **fourteen (14) days** of enrolling a client in a TEDS treatment program. This requirement is only applicable to programs that report TEDS data. Enrollment in Case Management programs do not have this requirement.

5. On the left menu, click **Client List** and search for a client.
6. Hover over the Actions column, and click **Activity List**.
7. On the left menu, click **Outcome Measures**.
8. On the Outcome Measures List screen, click **Add New**. This will open the Outcome Measures - Client Status screen.



Figure 4-16: Add New Outcome Measure

9. On the Outcome Measures – Client Status screen, in the **Type** field, select “Update” or “Final”.

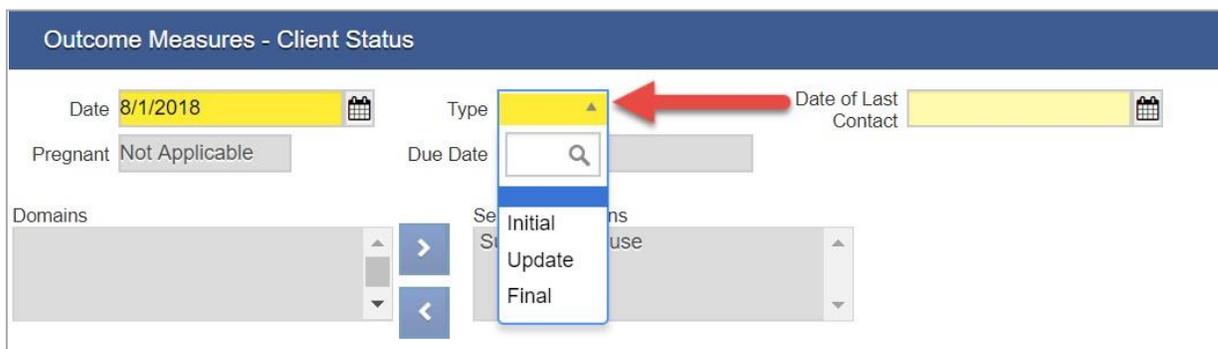


Figure 4-17: In the Type field, select either Update or Final

10. In the **Date of Last Contact** field, enter the date.
11. Responses from the client's previous Outcome Measures are pre-populated in the remaining fields on screen. Make additional updates as needed. See section, “
12. *Initial Outcome Measures*” on page 35 above for more information.

Part 5: Case Management/Treatment Planning

Program Enroll (Non-TEDS) (Optional)



Where: [Client List](#) > [Activity List](#) > [Program Enroll](#)

Case Management or Non-TEDS Program Enrollment

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

Note: Clients only need to be enrolled in a TEDS program. Enrolling clients in a non-TEDS program (such as a Case Management program) is optional.

Note: This screen can also be used to enroll clients in to a TEDS program. When adding an enrollment, the type of program is selected at that time.

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

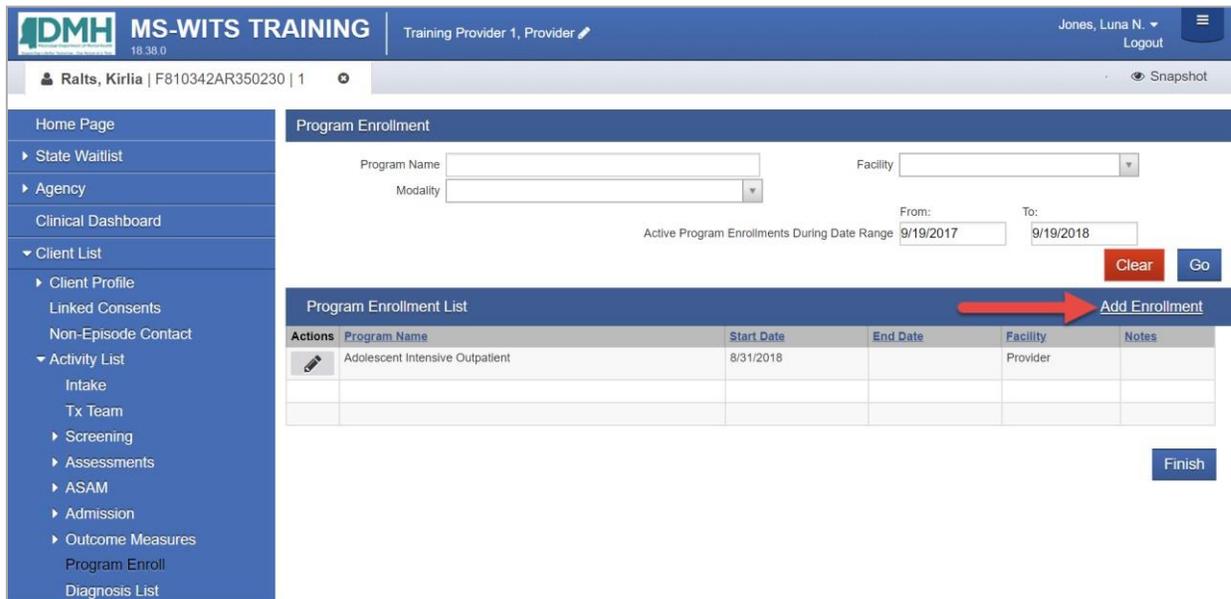


Figure 5-1: Program Enrollment screen

5. Complete fields on the Program Enrollment Profile.

Table 5-1: Program Enrollment Profile fields

Field	Description
Facility	Defaults to the current Facility name.

Field	Description
Program Name	Select the appropriate program for the client. This drop-down field includes programs available within your agency/facility.
Program Staff	Pre-populates with the current staff member name.
Start Date	Defaults to the current date.
Days on Wait List (TEDS Only)	Leave blank.
Notes	Type any notes as needed.

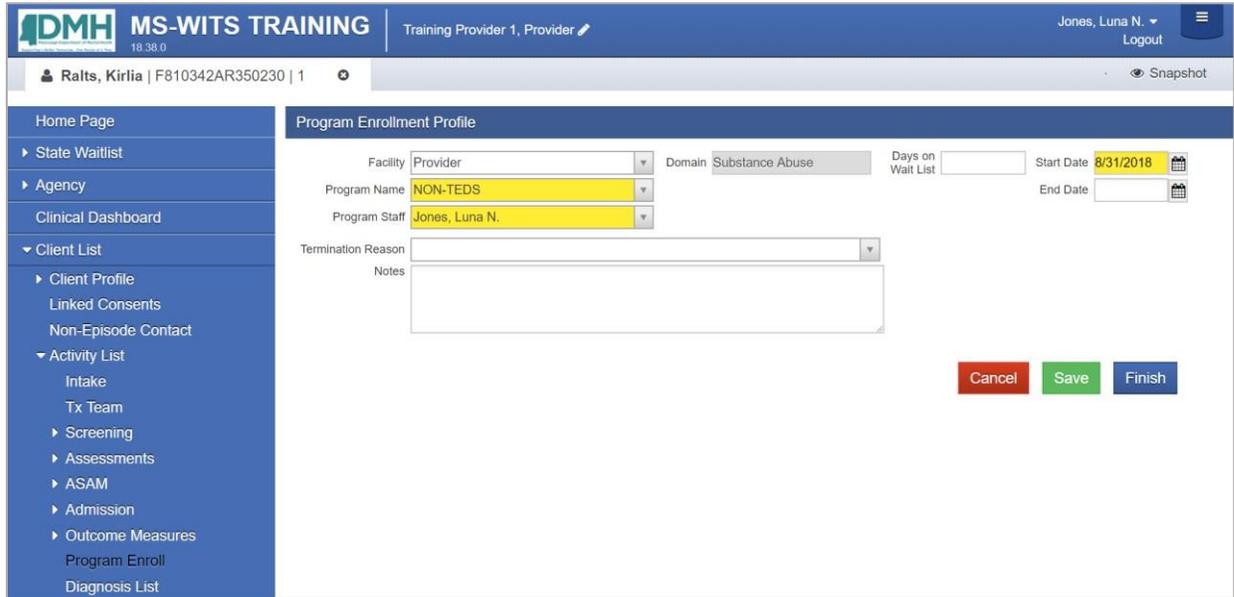
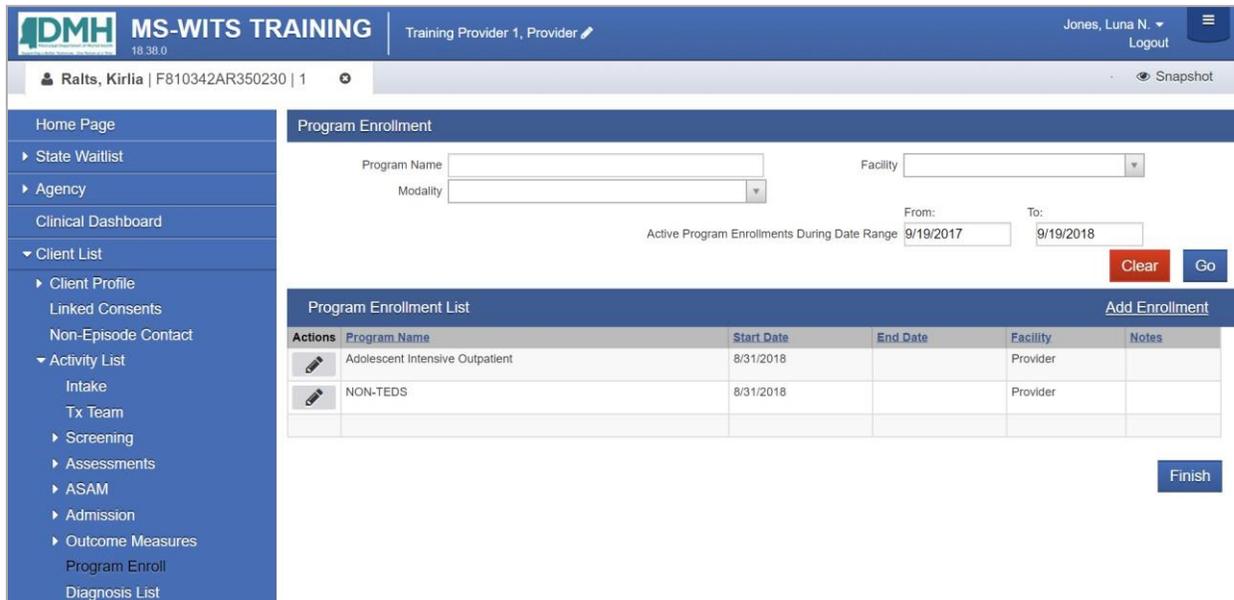


Figure 5-2: Program Enrollment Profile screen

- Click **Finish**.



Actions	Program Name	Start Date	End Date	Facility	Notes
	Adolescent Intensive Outpatient	8/31/2018		Provider	
	NON-TEDS	8/31/2018		Provider	

Figure 5-3: Program Enroll screen

7. On the Program Enrollment screen, click **Finish**.

Encounters



Where: [Client List](#) > [Activity List](#) > [Encounters](#)

The Encounters screen allows staff members to view and search through an individual client’s encounter records for services received at the current location. In addition, new encounter records can also be added through this screen.

Follow the steps below to view the Encounters screen.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Encounters**. This will display the Encounter Search/List screen.
4. To view previous encounters, complete the search fields and click **Go**.

The screenshot displays the MS-WITS TRAINING interface. The top navigation bar includes the DMH logo, the text 'MS-WITS TRAINING', and the user 'Training Provider 1, Provider'. The right side of the bar shows the user 'Jones, Luna N.' and a 'Logout' button. Below the navigation bar, the breadcrumb path is 'Ralts, Kirtia | F810342AR350230 | 1'. The main content area is titled 'Encounter Search' and contains several search filters: Start Date (9/19/2017), End Date (9/19/2018), Rendering Staff, Encounter Status, Allow Disclosure of Note, Service, and Program. There are 'Clear' and 'Go' buttons. Below the search form is the 'Encounter List' table, which has an '(Export)' link and an 'Add Encounter' button. The table contains three rows of encounter data.

Actions	Svc Date	Service	ENC ID	Rendering Staff	Program Name	Status
	9/6/2018	(309) Therapeutic Day Treatment - Substance Abuse	7	Garcia, Sofia J., CCS	Adolescent Intensive Outpatient	Not Released
	9/3/2018	Psychotherapy, 30 minutes with patient and/or family member	6	Jones, Luna N.	Adolescent Intensive Outpatient	Released
	8/31/2018	(416) Intake/Bispsycho-Social Assessment	5	Jones, Luna N.	Adolescent Intensive Outpatient	Not Released

Figure 5-4: Encounter List screen

Create Encounter Notes



Where: [Client List](#) > [Activity List](#) > [Encounters](#)

Follow the steps below to add an Encounter for a client.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Encounters**. This will display the Encounter Search/List screen.
4. Click **Add Encounter**. This will open the Encounter Profile screen.

The screenshot displays the 'Mississippi-WITS Training' interface. The top navigation bar includes the WITS logo, version 18.37.0, and the user 'Jones, Luna N.' with a 'Logout' option. The breadcrumb trail shows 'Ralts, Kiriia | F810342AR350230 | 1'. The left sidebar lists various navigation options, with 'Encounters' expanded to show 'Profile' and 'Encounter Note'. The main content area features an 'Encounter Search' section with a message: 'No results match your search criteria.' Below this is a search form with fields for 'Start Date' (8/31/2017), 'End Date' (8/31/2018), 'Rendering Staff', 'Service', 'Encounter Status', and 'Allow Disclosure of Note'. There are 'Clear' and 'Go' buttons. Below the search form is an 'Encounter List' table with columns: 'Actions', 'Svc Date', 'Service', 'ENC ID', 'Rendering Staff', 'Program Name', and 'Status'. A red arrow points to the 'Add Encounter' button located in the top right corner of the table area.

Figure 5-2: Encounter screen, Add Encounter

Note: The client must be enrolled in a program before an encounter note can be added. If the client has not been enrolled in a program, the following message will appear on screen:

i Client is not yet enrolled in a program. Complete the program enrollment first.

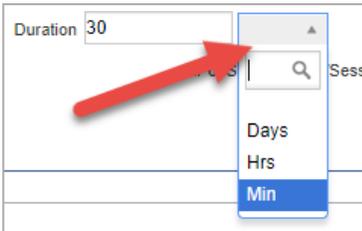
Encounter Profile

Figure 5-5: Encounter Profile screen

5. Complete the fields on the Encounter Profile screen. See table below for information on each field.

Table 5-2: Encounter Profile fields

Field	Description
Note Type	Select from the drop-down field.
ENC ID	Read-only field. When the encounter is saved, this field will display its unique ID number.
Created Date	Read-only field. This field will display the date and time when the encounter is saved.
Program Name	This field will pre-populate with the client’s current program enrollment name and program enrollment start date. 
Service	Select a service from the drop-down list.
Billable	This field may be pre-populated.
Service Location	Select an option from the drop-down list. This field may be pre-populated if this information was added to the facility profile.
Start Date	Enter the date when this service was rendered. Note: The start date for this encounter must occur within the same program enrollment period. Encounter date cannot be before the intake date.
Start Time	Enter the time when this service was rendered. This field may be optional or required depending on the selected service. Some services may be set up to require this information.

Field	Description
End Date	Enter the date when this service ended. This field may be optional or required depending on the selected service. Some services may be set up to require this information. Note: The end date for this encounter must occur within the same program enrollment period.
End Time	Enter the time when this encounter ended. This field may be optional or required depending on the selected service. Some services may be set up to require this information.
Duration	In the Duration field, type an integer to record time spent for this encounter. In the Duration drop-down field, select the unit of time. Note: The duration field will only accept whole numbers. Decimals (e.g., 0.5) are not accepted.  These fields may be optional or required depending on the selected service. Some services may be set up to require this information.
# of Service Units/Sessions	Type an integer representing the number of units or sessions spent for this service. Your administrator may have established policy guidelines regarding how services are recorded.
Emergency	(Optional) Select from the drop-down list.
Pregnant	(Optional) Select from the drop-down list.
Diagnoses for this Service	
Primary	(Optional) This field will pre-populate with the client's primary diagnosis based on the encounter start date.
Secondary	(Optional) This field will pre-populate with the client's secondary diagnosis based on the encounter start date.
Tertiary	(Optional) This field will pre-populate with the client's tertiary diagnosis based on the encounter start date.
Rendering Staff	
Rendering Staff	This field will pre-populate to the user logged in. To change the rendering staff, select the correct staff member from the drop-down list.
Supervising Staff	(Optional) In the drop-down list, select the Supervisor for the Rendering Staff member, if applicable. Note: Declaring staff members as "supervisors" is a feature controlled through the staff member's profile by adding relationships.

- Click **Save**, then click the **right-arrow** button.

Encounter Error/Warning Message Examples

- Client is not yet enrolled in a program. Complete the program enrollment first.
- Encounter date cannot be before the intake date.
- The start date and end date for this encounter must occur within the same program enrollment period.
- Encounter date should not be before the admission date.

 Client is not yet enrolled in a program. Complete the program enrollment first. 

 Encounter date cannot be before the intake date. 

 The start date and end date for this encounter must occur within the same program enrollment period. 

 Encounter date should not be before the admission date. 

Encounter << < 1 of 1 > >>

Note Type: Case Management Note

ENC ID: 5

Created Date: 9/19/2018 11:18 AM

Program Name: Provider/Adolescent Intensive Outpatient : 8/31/2018 -

Service: (416) Intake/Bispsycho-Social Assessment

Billable: Yes

Service Location: Community Mental Health Center

Start Date: 8/31/2018

End Date:

Start Time:

End Time:

Duration: 30 Min

Emergency:

of Service Units/Sessions: 1

Pregnant:

Diagnoses for this Service

Primary: F34.9-Persistent mood [affective] disorder, unspecified(ICD)

Secondary: Select an option

Tertiary: Select an option

Rendering Staff: Jones, Luna N.

Supervising Staff: Garcia, Sofia J., CCS

Administrative Actions

[Release to Billing](#)

Cancel Save Finish

Figure 5-6: Encounter Profile screen saved

Encounter Notes

The **Encounter Notes** section of the Encounter allows staff to enter notes related to the time spent with the client. If the client has an Active Treatment Plan, the staff can add Goals, Objectives, and Interventions to the encounter.

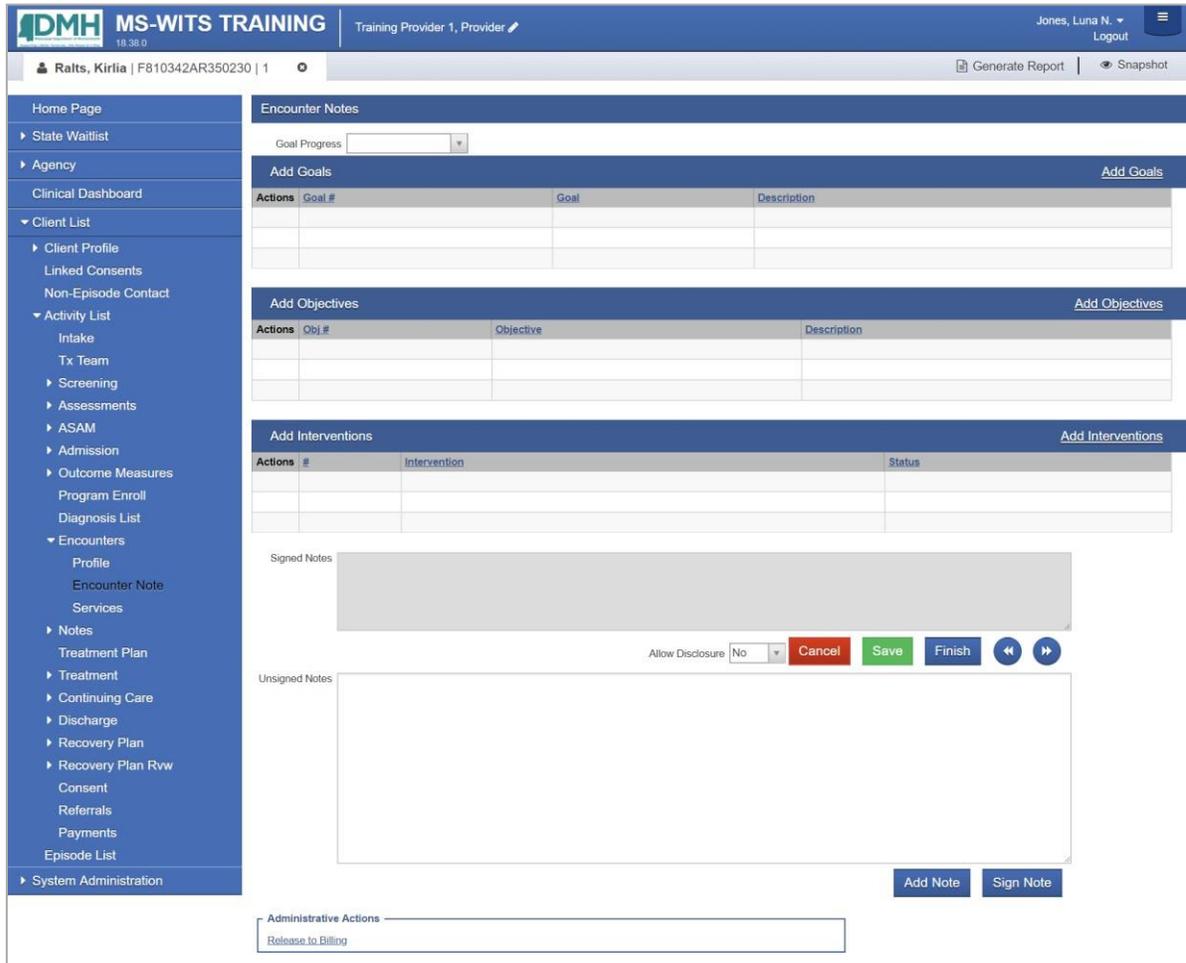


Figure 5-4: Encounter Note, Add Goals, Objectives, and Interventions

7. On the **Encounter Notes** screen, in the **Unsigned Notes** text box, type notes regarding the service provided.

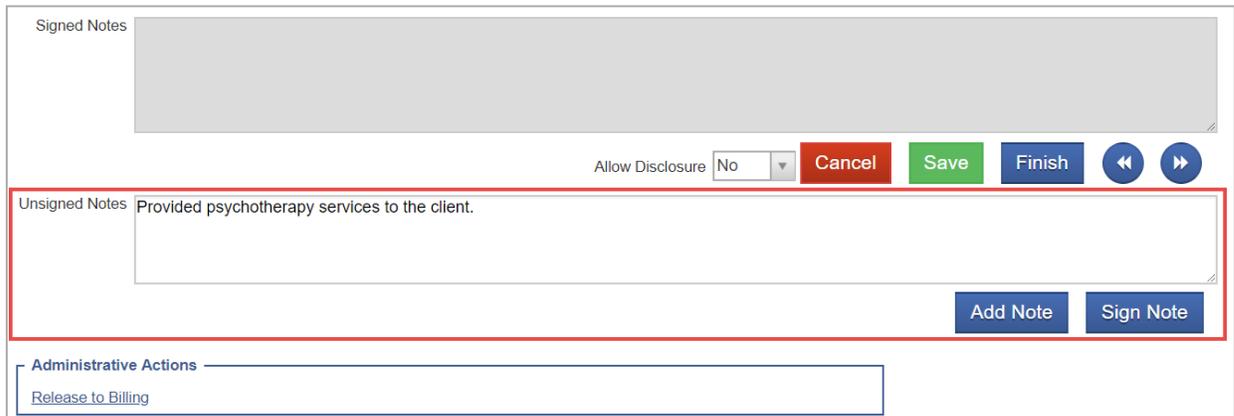


Figure 5-7: Unsigned Notes text box

8. To sign the notes, click **Sign Note**.

Signed Notes

Allow Disclosure **Cancel** **Save** **Finish** ◀ ▶

Unsigned Notes Provided psychotherapy services to the client.

Add Note **Sign Note**

Administrative Actions

[Release to Billing](#)

The notes will then be displayed in the read-only field, **Signed Notes**.

Signed Notes Signed by Jones, Luna N., 9/19/2018 6:07:32 PM:
Provided psychotherapy services to the client.

Allow Disclosure **Cancel** **Save** **Finish** ◀ ▶

Unsigned Notes

Add Note **Sign Note**

Administrative Actions

[Release to Billing](#)

9. Click **Save** to stay on screen. Click **Finish** to return to the Encounter List screen.

Release to Billing

Required Role(s):

- Release To Billing

When an encounter record is complete, it should be released to billing. To release an encounter, staff members must have the role "Release to Billing" assigned. Staff members with this role will have a link available in the **Administrative Actions** box on encounter screens.



Figure 5-8: Administrative Actions box, Release to Billing link

Administrative Actions are available on both the Encounter Profile screen and the Encounter Notes screen. Click the **Release to Billing** link on either of these screens.

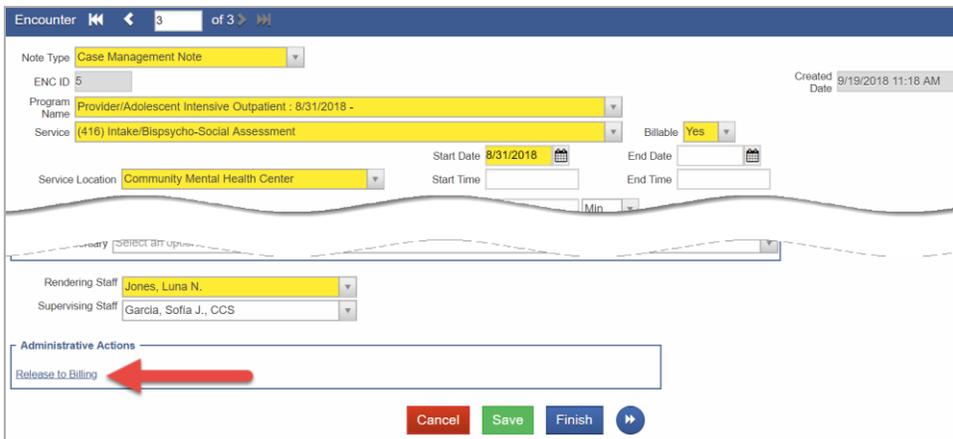


Figure 5-9: Encounter Profile screen, Release to Billing link

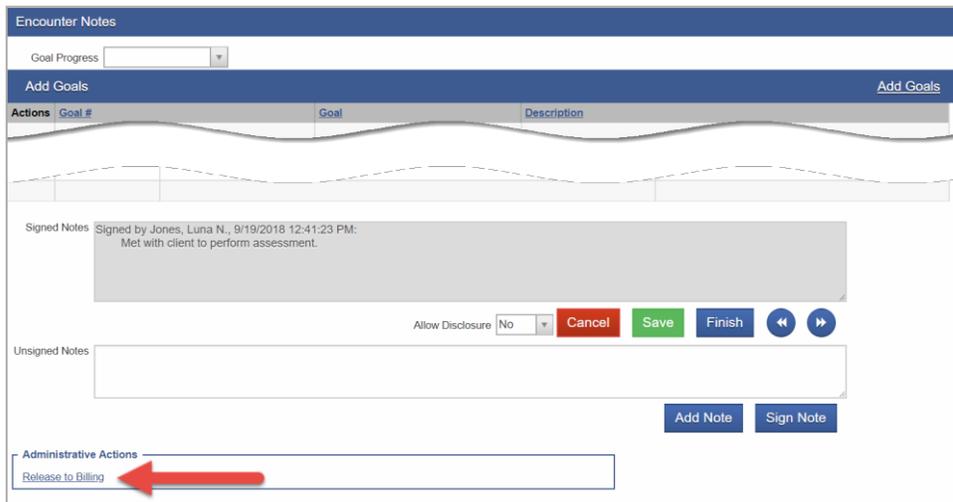


Figure 5-10: Encounter Notes screen, Release to Billing link

Consent

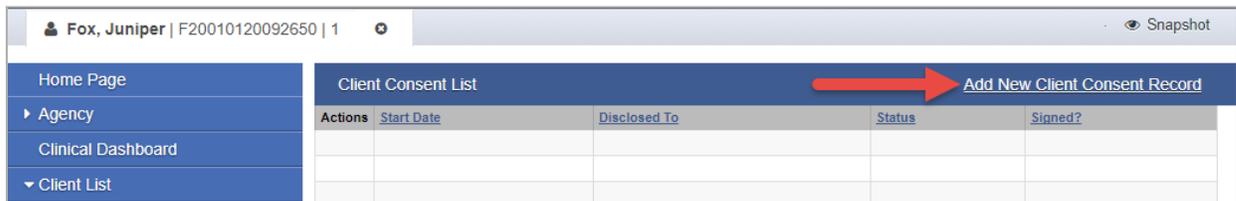
Create Client Consent Record



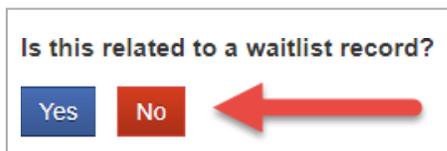
Where: [Client List](#) > [Activity List](#) > [Consent](#)

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

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



5. Select **Yes** or **No**.



6. If **Yes** is selected, the following screen will appear. Select from the drop-down list, then click **Go**.



7. On the Client Disclosure Agreement screen, complete the following fields.

Table 5-3: Client Disclosure Agreement fields

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

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

Figure 5-11: Client Disclosure Agreement screen

8. If additional consent information needs to be added or removed from the client's disclosure agreement, update the options from the "Client Information To Be Consented" section. Your agency administrator may have set up templates for the disclosure agreement.

Table 5-4: Client Information To Be Consented fields

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

9. When all required fields are complete, click **Save**.

Print the Client Consent Form

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

The screenshot shows the PA-WITS Training interface. At the top, the user is identified as Jones, Ashley, LSW. The main content area is titled 'Client Disclosure Agreement' and contains the following information:

- Note: Consented information may not be redisclosed.
- Client Name: Fox, Juniper
- Unique Client Number: F20010120092650
- Disclosed From Agency: Community Counseling Center of Mercer County
- Entities with Disclosure Agreements: All Other Agencies
- System Agency: Yes
- Disclosed To Agency: Administrative Agency
- Facility: Administrative Unit
- Purpose for disclosure: Client's level of care has changed and needs services fr

A red arrow points to the 'Generate Report' link in the top right corner of the main content area.

Figure 5-12: Client Disclosure Agreement screen, Generate Report

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

- Has client signed the paper agreement form:** select "Yes"
- Date client signed consent:** defaults to current date

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

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

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

The screenshot shows a printable version of the Client Consent Form. The title is 'CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENT RECORDS'. The text includes:

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

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

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

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

See 42 U.S.C. Sec. 2906a-2 for federal law and 42 CFR Part 2 for federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records.

Source: "A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA", Legal Action Center (1998).

CONSENT FOR TWO-WAY RELEASE OF CONFIDENTIAL INFORMATION

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

The purpose of the disclosure authorized herein is:

- to verify my eligibility to receive and to pay West Care Coordination Inc. for the following ATR services: _____; OR
- needed for other facility _____

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

This authorization expires six months from today's date.

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

Printable Consent Form

The screenshot shows the PA-WITS Training interface, similar to Figure 5-12. The 'Create Referral Using this Disclosure Agreement' link is highlighted with a red arrow in the top right corner of the main content area.

Figure 5-13: Create Referral Using this Disclosure Agreement link

Referrals

Create a Client Referral



Where: [Client List](#) > [Activity List](#) > [Referrals](#)

Continuing from previous section...

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

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

The screenshot shows the 'Referral' form with two main sections: 'Referred By' and 'Referred To'.
Referred By: Agency (Administrative Agency), Facility (Administrative Unit), Staff Member (Jones, Ashley), Program (dropdown), State Reporting Category, Reason (dropdown), If Other, Is Consent Verification Required? (dropdown), Is Consent Verified? (dropdown), Continue This Episode of Care? (No dropdown), Comments, Referral Status (Referral Created/Pending dropdown), Projected End Date, Created Date (7/24/2017 2:20 PM).
Referred To: Signed Consents (ALCOHOL AND DRUG ABUSE SERVICES dropdown), Agency (ALCOHOL AND DRUG ABUSE SERVICES), Facility (CHESTNUT ST-A&D ABUSE SRVCS), Staff Member, Program (dropdown), State Reporting Category, Non-System Agency, Non-System Modality, Non-System Specifier, Appt Date (Undetermined), Consents Granted (Consent Date: 6/30/2017, Disclosure Domains: Admission (UD, +30), ASAM (UD, +30), Client Information (Profile) (UD, +30), Client Screening (UD, +30), Intake Transaction (UD, +30)).
 Buttons: Cancel, Save, Finish.

Figure 5-14: Referral screen

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

Table 5-5: Referred By fields

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

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

Table 5-6: Referred To fields

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

- When complete, click **Save**.

Diagnosis List



Where: [Client List](#) > [Activity List](#) > [Diagnosis List](#)

Note: If Outcome Measures have already been created for the client, the Diagnosis List screen will display the diagnoses previously entered for the client in the Outcome Measures section.

Review Diagnosis (Read-only View)

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Diagnosis List**.
4. On the Diagnosis List screen, locate a previously entered diagnosis from the list, hover over the Actions column and click **Review**. This will display a read-only view of the Client Diagnosis screen.



Figure 5-15: Diagnosis List, Review previously entered Diagnosis

5. Review the Client Diagnosis screen, and then click **Finish**. The system will redirect to the Diagnosis List screen.

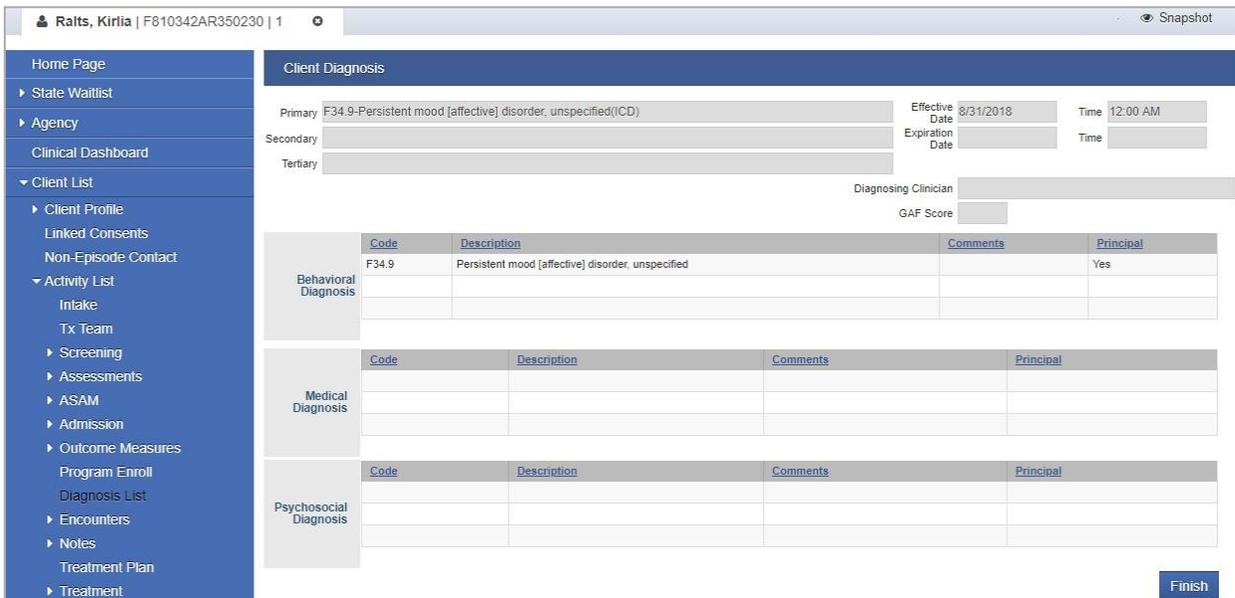


Figure 5-16: Review Diagnosis

Add New Diagnosis

i See also: Part 3 "Client Diagnosis" on page 39 above.

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Diagnosis List**.
4. On the Diagnosis List screen, click **Add New Diagnosis**.

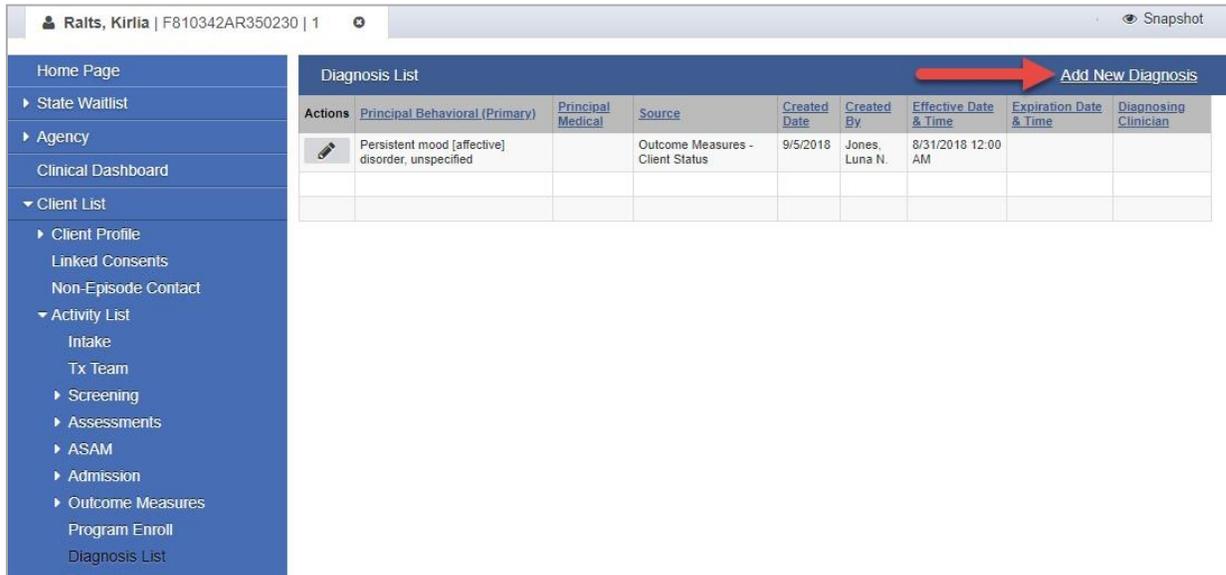


Figure 5-17: Diagnosis List screen, Add New Diagnosis

5. A new Client Diagnosis screen will appear. Click **Edit Diagnosis**.

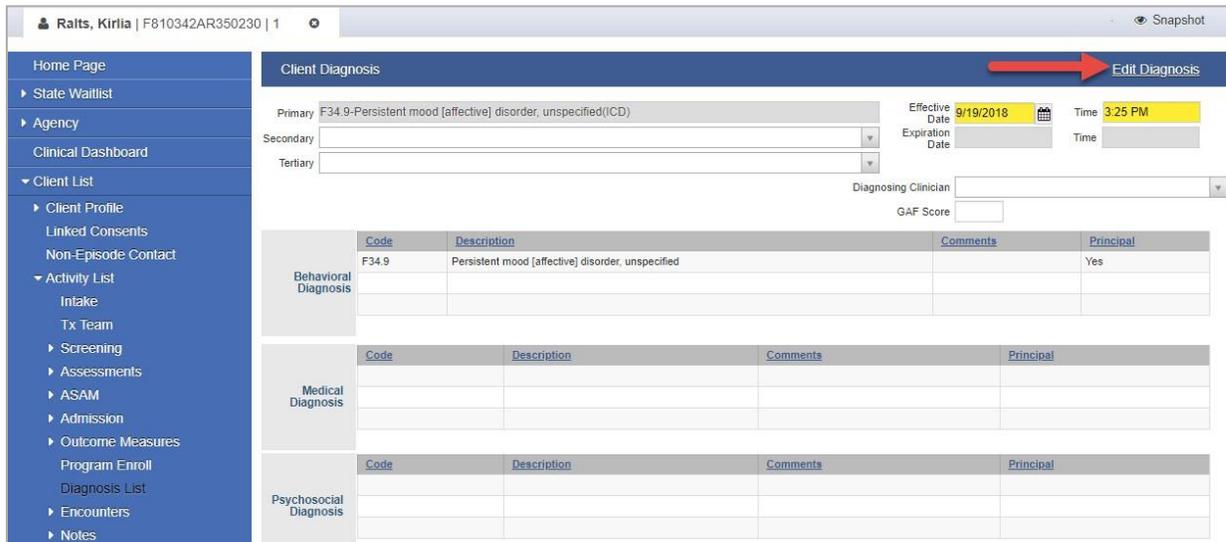
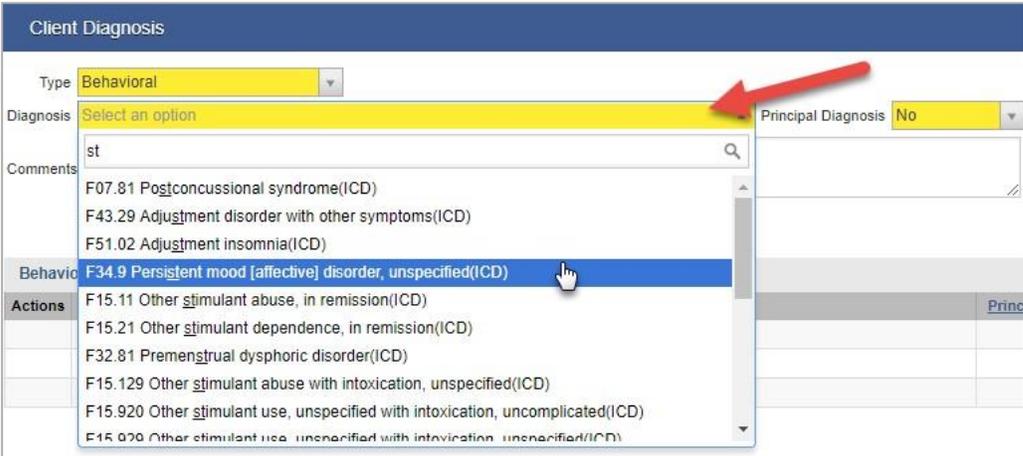
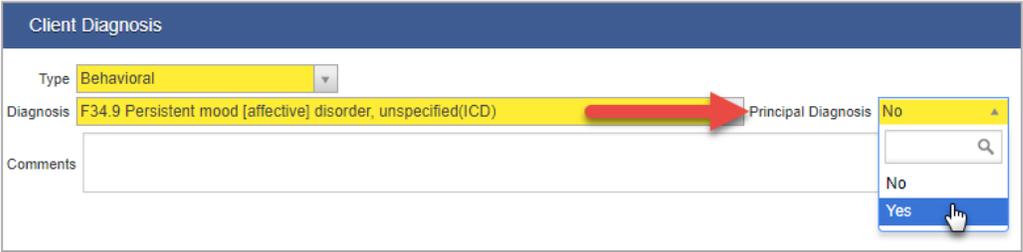


Figure 5-18: Add New Diagnosis from Diagnosis List

Edit Diagnosis

- On the **Edit Diagnosis** screen, add one or more diagnoses by completing the fields described in the table below.

Table 5-7: Client Diagnosis, Edit Diagnoses fields

Field	Description
Type	<p>Select "Behavioral", "Medical", or "Psychosocial" from the drop-down list.</p> 
Diagnosis	<p>Type at least two (2) characters for options to appear in the drop-down list. Select an option.</p> 
Principal Diagnosis	<p>Select Yes or No. Note: At least one diagnosis must be marked "Yes" as the Principal Diagnosis.</p> 
Comments	<p>Type any comments if applicable.</p> 

- Click **Save**. The diagnosis will be saved in its corresponding Type list on screen.

- Stay on this screen to enter additional diagnoses as applicable.
- Click **Finish**. This will return to the Client Diagnosis screen.

The screenshot shows the 'Client Diagnosis' form. At the top, there is a 'Type' dropdown menu. Below it, the 'Diagnosis' field contains 'Select an option', and the 'Principal Diagnosis' field is set to 'No'. A 'Comments' text area is located below these fields. To the right of the comments area are 'Clear' and 'Save' buttons. Below the form is a section titled 'Behavioral Diagnosis' containing a table with columns for 'Actions', 'Code', 'Description', 'Comments', and 'Principal'. The table has one row with the code 'F34.9' and the description 'Persistent mood [affective] disorder, unspecified', with 'Yes' in the 'Principal' column. At the bottom right of the screen, a red arrow points to a blue 'Finish' button.

Figure 5-19: Diagnosis List - Client Diagnosis, Edit Diagnosis screen, click Finish

- On the Client Diagnosis screen, update the Secondary and Tertiary fields with a diagnosis, as applicable.

The screenshot shows the 'Client Diagnosis' screen in the MS-WITS TRAINING system. The header includes the DMH logo, 'MS-WITS TRAINING', and the user 'Jones, Luna N.'. The patient information is 'Ralts, Kirilia | F810342AR350230 | 1'. The 'Client Diagnosis' section has three dropdown menus for 'Primary', 'Secondary', and 'Tertiary' diagnoses. The Primary diagnosis is 'F34.9-Persistent mood [affective] disorder, unspecified(ICD)', the Secondary is 'S06.0X9A-Concussion with loss of consciousness of unspecified duration, initial encounter(ICD)', and the Tertiary is empty. The 'Effective Date' is 9/5/2018 and the 'Time' is 3:25 PM. Below the diagnosis fields are 'Diagnosing Clinician' and 'GAF Score' fields. The 'Behavioral Diagnosis' table has one row with code 'F34.9' and description 'Persistent mood [affective] disorder, unspecified', with 'Yes' in the 'Principal' column. The 'Medical Diagnosis' table has two rows: 'S06.0X9A Concussion with loss of consciousness of unspecified duration, initial encounter' (Principal: Yes) and 'W07.XXXA Fall from chair, initial encounter' (Principal: No). The 'Psychosocial Diagnosis' table is empty. At the bottom right are 'Cancel', 'Save', and 'Finish' buttons.

Figure 5-20: Diagnosis List - Client Diagnosis screen

- Click **Finish**. This will return to the Diagnosis List screen.

On the Diagnosis List screen, notice the previously entered diagnosis now has an expiration date and time.

Actions	Principal Behavioral (Primary)	Principal Medical	Source	Created Date	Created By	Effective Date & Time	Expiration Date & Time	Diagnosing Clinician
	Persistent mood [affective] disorder, unspecified	Concussion with loss of consciousness of unspecified duration, initial encounter	Diagnosis List	9/19/2018	Jones, Luna N.	9/5/2018 3:25 PM		
	Persistent mood [affective] disorder, unspecified		Outcome Measures - Client Status	9/5/2018	Jones, Luna N.	8/31/2018 12:00 AM	9/5/2018 3:24 PM	

Figure 5-21: Diagnosis List screen, additional diagnosis

Diagnosis List								Add New Diagnosis
Actions	Principal Behavioral (Primary)	Principal Medical	Source	Created Date	Created By	Effective Date & Time	Expiration Date & Time	Diagnosing Clinician
	Persistent mood [affective] disorder, unspecified	Concussion with loss of consciousness of unspecified duration, initial encounter	Diagnosis List	9/19/2018	Jones, Luna N.	9/5/2018 3:25 PM		
	Persistent mood [affective] disorder, unspecified		Outcome Measures - Client Status	9/5/2018	Jones, Luna N.	8/31/2018 12:00 AM	9/5/2018 3:24 PM	

Drug Testing (Optional)



Where: *Client List* > *Activity List* > *Drug Testing*

1. On the left menu, click **Client List** and search for a client.
2. Hover over the Actions column, and click **Activity List**.
3. On the left menu, click **Drug Testing**.
4. Click **Add Test Result**.

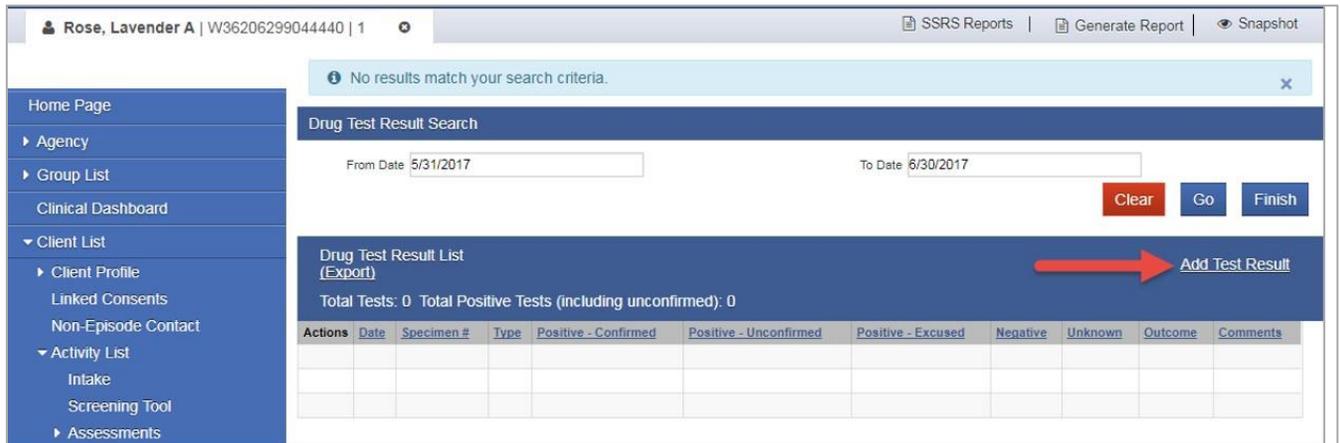


Figure 5-22: Drug Testing screen

5. Complete the Drug Test Results Profile fields.

Table 5-8: Drug Test Results Profile fields

Field	Description
Specimen #	Type the Specimen Identification, or Tracking Number.
Date	Type the date of the drug test.
Client Outcome	Select the outcome of the drug test from the drop-down list.
Specimen Type	If the client produced a specimen, this field will become required. Select an option from the drop-down list.
Staff	Defaults to the staff member currently signed in.
Facility	Defaults to the current facility location.
Location	(Optional) Select the specimen collection location from the drop-down list.
Comments	Type any comments as needed.

Figure 5-23: Drug Test Result Profile screen

6. In the **Add Drug Test Results** section, in the **Drug Type** field, select one or more types. Then in the **Test Result** field, select an option from the drop-down list and click **Add**. These options will be displayed in the **Drug Test Results** section of the screen.

Figure 5-24: Add Drug Test Results

Drug Test Result Profile

Specimen # J-8327619 Staff Jones, Ashley

Date 6/12/2017 Facility Administrative Unit

Client Outcome Specimen Collected Location Other Service Agency

Specimen Type Urine Sample Blood Alcohol Content

Marijuana Content

Comments

Cancel Save Finish

Add Drug Test Results

Drug Type: Barbiturates, Benzodiazepine, Cocaine, Creat, Hallucinogens, Inhalants, Methadone, PCP, Propoxyphene, Sedatives

Test Result: Negative Add

Drug Test Results Test Result: [Edit Test Result](#)

Actions	Drug	Test Result
	<input type="checkbox"/> Marijuana	Negative
	<input type="checkbox"/> Amphetamines	Negative
	<input type="checkbox"/> Alcohol	Negative
	<input type="checkbox"/> Heroin	Negative
	<input type="checkbox"/> Other Opiates	Negative

Figure 5-25: Drug Test Profile with Drug Test Results added

- To update a Drug Test Result(s), click the **check box** beside the drug name(s). In the **Test Result** field, select an option from the drop-down list.

The screenshot shows a table titled "Drug Test Results" with columns for "Drug" and "Test Result". A red arrow points to the "Test Result" column header. The "Sedatives" row has a checked checkbox in the "Actions" column and a dropdown menu open in the "Test Result" column. The dropdown menu lists options: "Positive - Confirmed", "Negative", "Unknown", "Positive - Unconfirmed", and "Positive - Excused".

Actions	Drug	Test Result
<input type="checkbox"/>	Alcohol	Positive - Confirmed
<input type="checkbox"/>	Marijuana	Positive - Confirmed
<input type="checkbox"/>	Amphetamines	Negative
<input type="checkbox"/>	Other Opiates	Positive - Unconfirmed
<input checked="" type="checkbox"/>	Sedatives	Negative
<input type="checkbox"/>	Heroin	Negative
<input type="checkbox"/>	Cocaine	Unknown

The screenshot shows the "Drug Test Result Profile" form. It contains fields for Specimen # (PI-3.14159265359), Date (6/11/2017), Client Outcome (Specimen Collected), Specimen Type (Urine Sample), Staff (Jones, Sarah A., CCS), Facility (Administrative Unit), Location (Treatment Agency), Blood Alcohol Content, and Marijuana Content. There is a large text area for "Comments" and buttons for "Cancel", "Save", and "Finish".

The screenshot shows the "Add Drug Test Results" form. It has a "Drug Type" dropdown menu with options: Barbiturates, Benzodiazepine, Creat, Hallucinogens, Inhalants, Methadone, PCP, and Propoxyphene. There is a "Test Result" dropdown menu set to "Unknown" and an "Add" button.

The screenshot shows the "Drug Test Results" table with the "Sedatives" row selected. The "Test Result" column for the selected row shows "Positive - E...". A red arrow points to the "Edit Test Result" button next to the dropdown menu.

Actions	Drug	Test Result
<input type="checkbox"/>	Alcohol	Positive - Confirmed
<input type="checkbox"/>	Marijuana	Positive - Confirmed
<input type="checkbox"/>	Amphetamines	Negative
<input type="checkbox"/>	Other Opiates	Positive - Unconfirmed
<input checked="" type="checkbox"/>	Sedatives	Negative
<input type="checkbox"/>	Heroin	Negative
<input type="checkbox"/>	Cocaine	Unknown

The Drug Result List screen displays all previously entered test results. You can see the type, result, and outcome from the list screen. For more detailed information, click on the pencil icon to review the test result profile.

The screenshot shows the "Drug Test Result Search" and "Drug Test Result List" screens. The search screen has "From Date" (6/10/2017) and "To Date" (7/10/2017) fields, with "Clear", "Go", and "Finish" buttons. The list screen shows "Total Tests: 2 Total Positive Tests (including unconfirmed): 1" and a table of results.

Actions	Date	Specimen #	Type	Positive - Confirmed	Positive - Unconfirmed	Positive - Excused	Negative	Unknown	Outcome	Comments
	6/10/2017	N/A							Excused Absence	
	6/11/2017	PI-3.14159265359	Urine Sample	Alcohol, Marijuana	Other Opiates	Sedatives	Amphetamines, Heroin	Cocaine, Hallucinogens	Specimen Collected	

Part 6: State Waitlist



Where: State Waitlist

Role(s) Needed:

- Cross-Agency Waitlist Management (Full Access or Read-Only)
- Facility Administrator role is needed to view "Facility Details" for each program location

State Waitlist allows for the monitoring and management of any program or modality of care across the state. The state will set up the programs available on the State Waitlist. Once a program is included on the State Waitlist, agencies within WITS can place clients on the State Waitlist. When clients are assessed for treatment but the level of care needed is not available, a client could be put on a waiting list at another agency.

Actions	Agency/Facility	Facility City	Program	Modality	Available Program Slots	# on Waitlist	Age/Gender
	Administrative Agency/Administrative Facility	Columbia	Residential Outpatient	Ambulatory- Non-Intensive Outpatient	100	0	None/None
	Catholic Charities, Inc./Born Free/New Beginnings	Jackson	PRIMARY RESIDENTIAL SERVICES	Rehabilitation/Residential-Short Term (30 days or fewer)	20	3	None/None
	Harbor Houses of Jackson/Harbor House of Jackson, Females		Transitional Residential	Transitional Residential Services	10	0	None/Female
	Training Provider 1/Provider	Petal	Adolescent Intensive Outpatient	Ambulatory-Intensive-Outpatient	99	0	Youth (<21)/Not Specific
	Training Provider 2/Main Office		>30 SUD Residential	Rehabilitation/Residential-Short Term (30 days or fewer)	8	3	None/None

Table 6-1: State Waitlist Column Descriptions

Column Header	Description
Agency/Facility	Name of the Agency and Facility
Facility City	Displays the city listed on the facility's address.
Program	Displays the name of the Program.
Modality	Displays the Program's Modality.
Available Program Slots	Displays the number of slots available for the program.
# on Waitlist	Displays the number of clients currently on the waitlist.
Age/Gender	Displays the Age and Gender of the Program.

Add Client to Waitlist

Follow the steps below to add a client to the Waitlist.

1. On the left menu, click **State Waitlist**.
2. Use the search fields to filter the list of programs displayed on screen. Locate a program from the list, hover over the Actions column and click **Review List**. This will display the Client Waitlist screen.

State Waitlist Search

Modality: Program Name:
 Facility GeoCode: Beds/Slots Available:
 Agency Name: Facility Name:
 Age Group: Gender Specific:

Clear Go

State Waitlist List

Actions	Agency/Facility	Facility City	Program	Modality	Available Program Slots	# on Waitlist	Age/Gender
	Administrative Agency/Administrative Facility	Columbia	Residential Outpatient	Ambulatory- Non-Intensive Outpatient	100	0	None/None
	Catholic Charities, Inc./Born Free/New Beginnings	Jackson	PRIMARY RESIDENTIAL SERVICES	Rehabilitation/Residential-Short Term (30 days or fewer)	20	3	None/None
				Ambulatory- Non-Intensive Outpatient	100	0	None/None
	Harbor Houses of Jackson/Harbor Houses of Jackson		Primary Residential	Primary Residential Services	10	0	None/None

Figure 6-1: State Waitlist, Review List link

3. On the Client Waitlist screen, click **Add Client to Waitlist**. This will open the Client Waitlist Profile screen.

Client Waitlist

Agency: Catholic Charities, Inc. Facility: Born Free/New Beginnings
 Program Name: PRIMARY RESIDENTIAL SERVICES Modality: Rehabilitation/Residential-Short Term (30 days or fewer)
 Available Slots: 20 Age/Gender: None/None
 Status: Pending
 Unit Capacity:

Clear Go Finish

Client Waitlist List

Actions	Waitlist ID	Placed by Agency	Gender	Age	Due Date	HIV Tested	IV Drug User	Days Waiting	Priority	Status
	2	Administrative Agency	Male	63		No	Yes	1	2	Pending
	5	Department of Mental Health TEST	Male	28		No	No	1	0	Pending
	8	Department of Mental Health TEST	Female	30	1/1/2019	Yes	No	1	3	Pending

Add Client to Waitlist

Figure 6-2: Client Waitlist screen, Add Client to Waitlist

Figure 6-3: Client Waitlist Profile

4. On the Client Waitlist Profile, in the **Client Name** field, search for a client by typing the client's last name.

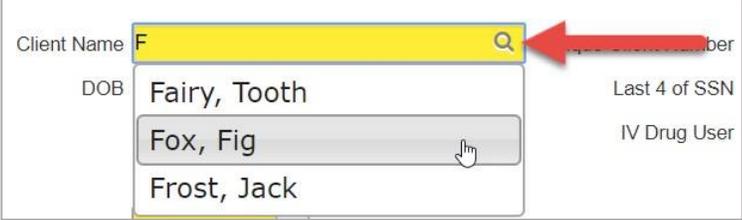
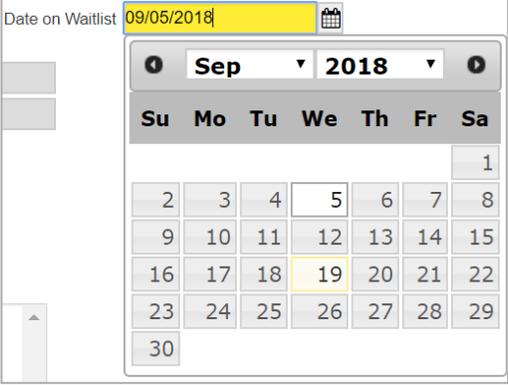
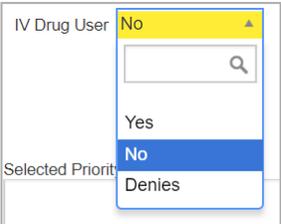
5. Click the client's name from the drop-down list.

Figure 6-4: Client Waitlist Profile, Client Name search field

6. Complete the required fields on the Client Waitlist Profile and refer to the table below for information on each field.

Table 6-2: Client Waitlist Profile fields

Field	Description
Agency	Read-only field. Displays the agency name for the program selected.

Field	Description
Facility	Read-only field. Displays the facility name for the program selected.
Age/Gender	Read-only field. Displays the age/gender for the program selected.
Program Name	Read-only field. Displays the selected program name.
Modality	Read-only field. Displays the modality for the program selected.
Available Slots	Read-only field. Displays the available slots for the program selected.
Waitlist Status	Read-only field. Displays the client's waitlist status for the program selected.
Client Name	<p>Search for a client by typing the client's last name. Click the client's name from the drop-down list.</p> 
Date on Waitlist	<p>Enter the date the client is placed on the waitlist. Once the client name is selected from the Client Name field, the date field will pre-populate with today's date.</p> 
Unique Client Number	Read-only field. Displays the selected client's UCN number.
Gender	Read-only field. Displays the selected client's Gender from the client profile.
DOB	Read-only field. Displays the selected client's date of birth from the client profile.
Last 4 of SSN	Read-only field. Displays the selected client's last four digits of their social security number, from the client profile.
Pregnant	Read-only field. Displays information for the selected client if applicable.
Due Date	Read-only field. Displays information for the selected client if applicable.
IV Drug User	<p>Select Yes, No, or Denies from the drop-down list.</p> 

Field	Description
HIV Tested	Select Yes, No, or Unknown from the drop-down list. 
Selected Priority Options	In the Other Priority box, select the appropriate option(s). Click the top arrow (>) button to move the selected options to the Selected Priority Options box. 
BG Priority	Read-only field. When the screen is saved, this field displays the Block Grant priority for the client, if applicable.
Add client to all waitlists for this modality?	"No" is selected by default. 
Rejection Reason	Read-only field. If the client is rejected from the selected program, the reason will be displayed in this field.

- Click **Save**. A confirmation screen will appear.
- On the confirmation screen, click **Yes** to add the client to the waitlist.



Figure 6-5: Add Client to Waitlist, Confirmation screen

- On the Client Waitlist Profile screen, click **Finish**. This will return to the Client Waitlist screen.
- On the Client Waitlist screen, click **Finish**. This will return to the State Waitlist screen.

My Programs



Where: State Waitlist > My Programs

This screen allows you to manage and view the waitlists for programs within your agency.

- **Accept:** If a client is accepted, an email will be sent to the originating agency informing them that they will need to create a Consent and Referral to your agency, as shown in Figure 6-9 below.
- **Reject:** If a client is rejected, that client cannot be added to the Waitlist for this program again.

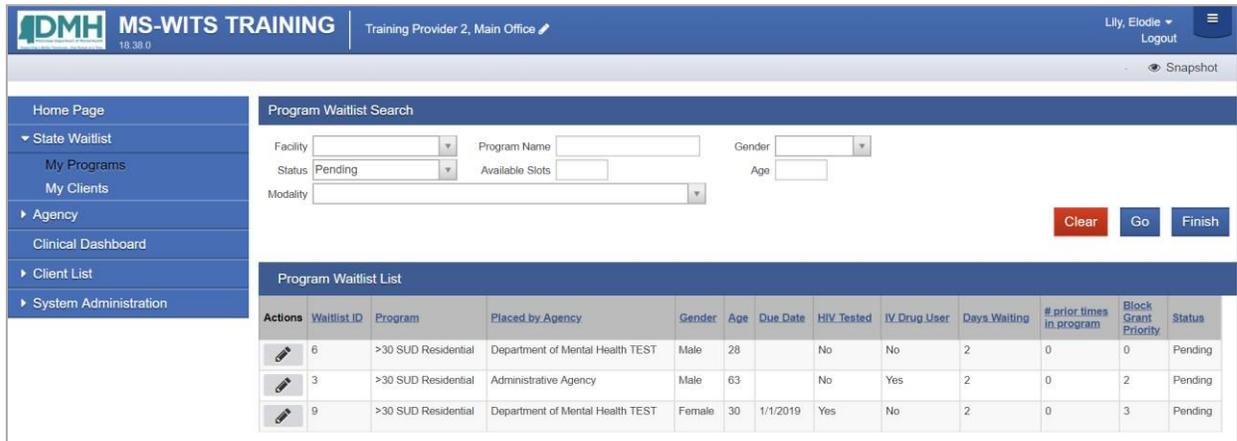


Figure 6-6: State Waitlist, My Programs screen

Accept Client to Program

1. On the left menu, click **State Waitlist**, and then click **My Programs**.
2. On the My Programs screen, review the list of clients placed on your agency's waitlist(s). Locate a client, hover over the Actions column, and then click **Accept**.

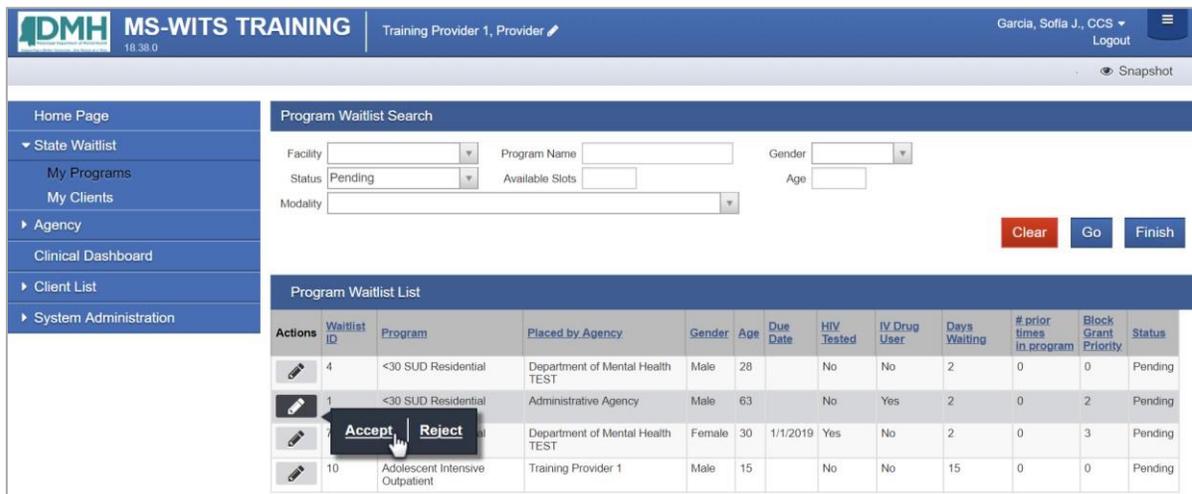


Figure 6-7: Program Waitlist screen, Accept client

3. On the confirmation screen, click **Yes** to accept the client into the program.



Figure 6-8: Accept Client into Program confirmation screen

When a client is accepted to a program, staff members* within the client's agency will receive an email notification as shown in the screen capture below.

i *Note: Staff Members with the following role assignment will receive an email notification: Cross-Agency Waitlist Management (Full Access)

Waitlist Notification Email

"One of your clients has been accepted from the waitlist for [Program Name] at [Agency Name]. Please go to the Waitlist Client Management screen to refer the client to the program."



Figure 6-9: Client Accepted from Waitlist, Notification Email

Reject Client from Program

1. On the left menu, click **State Waitlist**, and then click **My Programs**.
2. On the My Programs screen, review the list of clients placed on your agency's waitlist(s). Locate a client, hover over the Actions column, and then click **Reject**.

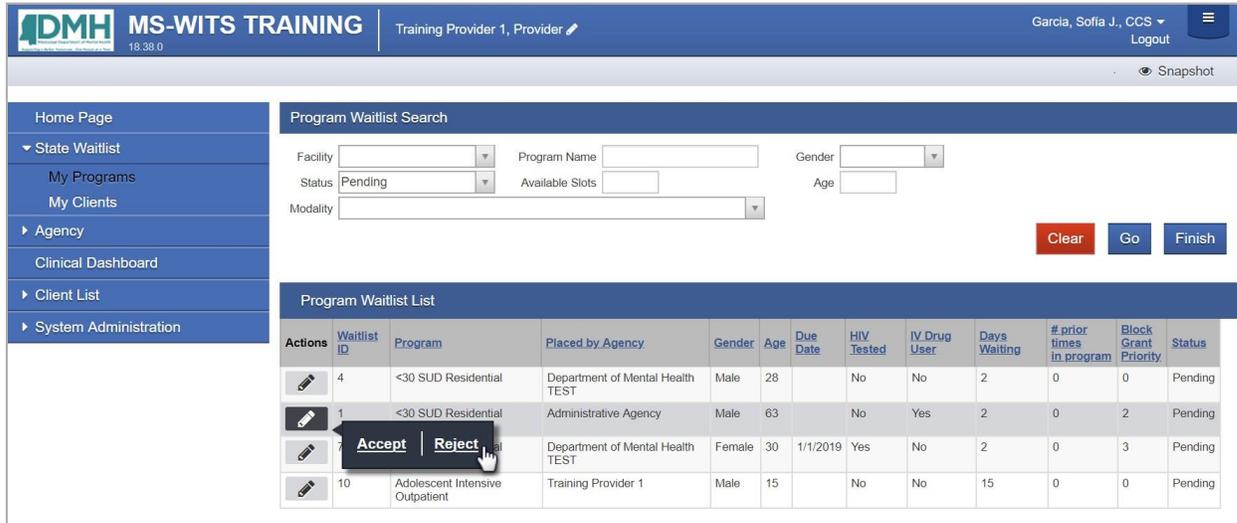
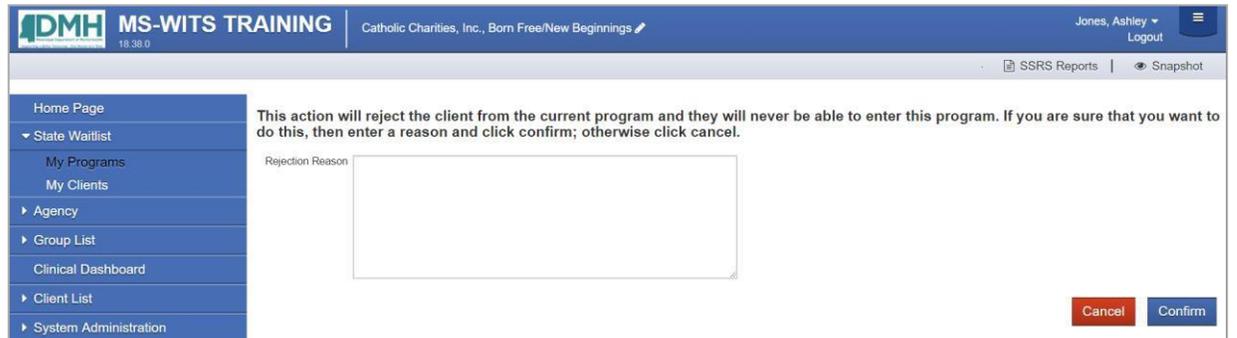


Figure 6-10: Program Waitlist screen, Reject client



My Clients



Where: **State Waitlist > My Clients**

Use this screen to view a list of this agency's clients that have been placed on waitlists throughout the system.

- On the left menu, click **State Waitlist** and then click **My Clients**.

The screenshot shows the 'Client Waitlist Search' interface with various filters and a table of clients. The search filters include Client FN, Agency, Program Name, Age, HIV, Client LN, Modality, Status (set to Pending), Days Waiting, Gender, Pregnant, IV Drug Use, Unique Client Number, and Waitlist ID. Buttons for 'Clear', 'Go', and 'Finish' are visible.

Actions	Waitlist ID	Client Name	Agency/Facility	Program Name	Days Waiting	Priority	HIV Tested	IV Drug User	Due Date	Age	Gender	Status
	3	poppins, mary	DEERFIELD CENTER FOR ADDICTIONS TREATMENT/WARREN-DEERFIELD CENTER	Warren Special Program	26	3		No		41	Female	Pending
	5	Asteraceae, Zinnia	Administrative Agency/Administrative Unit	TEDS	0	3		No	2/5/2018	17	Female	Pending
	6	Vera, Aloe	Administrative Agency/Administrative Unit	TEDS	0	2		Yes		19	Male	Pending
	7	Kabitan, Hosta	Administrative Agency/Administrative Unit	TEDS	4	0		Denies		17	Male	Pending
	1	Test, Phase1	DEERFIELD CENTER FOR ADDICTIONS TREATMENT/WARREN-DEERFIELD CENTER	Warren Special Program	39	0		No		47	Male	Pending
	2	test, christine	Administrative Agency/Administrative Unit	TEDS	39	0		No		27	Female	Pending

Figure 6-11: State Waitlist, My Clients screen

- Hover over the Actions column for a client and a list of action items will appear.

This screenshot is identical to Figure 6-11, but with the Actions menu for the client with Waitlist ID 7 open. The menu contains the following options: Review, Delete, Accept, and Referral.

Figure 6-12: State Waitlist, My Clients screen, Actions links

Part 7: Agency Billing

Review and Adjust Claims



Where: **Agency > Billing > Claim Item List**

Once an Encounter is released to billing, it is now referred to as a "Claim Item".

Required Role(s):

- Create Agency Claim Batch
 - Create Facility Claim Batches
1. To view claim items, click **Agency**, then **Billing**, and then click **Claim Item List**. Note the Claim Item List will display claim items with a status of "All Awaiting Review" by default.

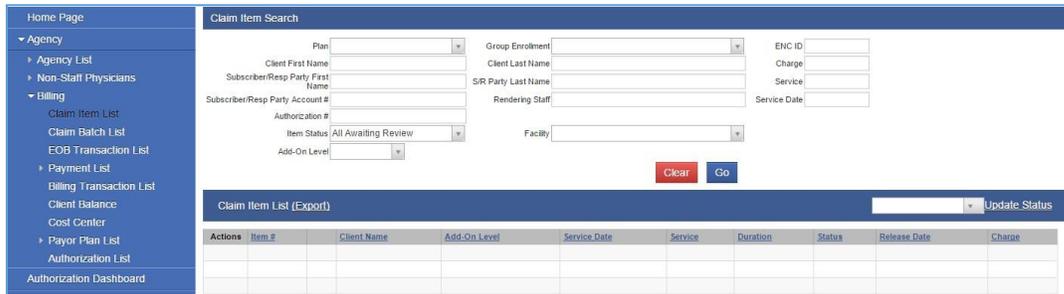


Figure 7-1: Claim Item List screen

2. Use the search fields to find a specific claim item or to filter your results, then click **Go**.

i To view all available claim items, click **Clear** and then click **Go**.

3. The claim item list will display the following information:

Table 7-1: Claim Item List information

Field	Description
Client Name	Name of client record.
Service	Service code.
Status	Status of claim item.
Release Date	Date the claim item was released to billing.
Charge	Total amount billed.

Claim Item Search

Plan: [Dropdown] Group Enrollment: [Dropdown] ENC ID: [Text]
 Client First Name: [Text] Client Last Name: [Text] Charge: [Text]
 Subscriber/Resp Party First Name: [Text] S/R Party Last Name: [Text] Service: [Text]
 Subscriber/Resp Party Account #: [Text] Rendering Staff: [Text] Service Date: [Text]
 Authorization #: [Text] Facility: [Text]
 Item Status: [Dropdown] Add-On Level: [Dropdown]

Claim Item List (Export) [Dropdown] Update Status

Actions	Item #	Client Name	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge
[Edit]	1	Participant, Practice	None	5/11/2015	TR3080/CLBN		Released	5/11/2015	\$1.00
[Profile]	2	Participant, Practice	None	5/12/2015	TR7010	60 Min	Released	5/15/2015	\$12.50

Figure 7-2: Claim Item List screen, Profile link

- Next, click on the **Profile** link located under the Actions column to view the claim item.
- The **Profile for Claim #** screen displays all of the claim information and allows for claim item adjustments to be made if needed. Note you will only be able to edit a few active fields, as the remaining fields will be read-only.

i Tip: The number of units on the Claim Item can be updated in the Billing Units field.

Profile for Claim Item # 2 for Participant, Practice

ENC ID: 2079 Delivered Service: TR7010
 Program: ATR 4 Service Start: 5/12/2015 2:00 PM
 Diagnoses: / / Service End: 5/12/2015 3:00 PM
 Pregnant: Duration: 60 Min
 Status: Released # Sessions/Units: 1
 Rendering Staff: Vendor, Practice

Service Fee

Billing Units **1.00** X Rate / Unit 12.5000 = \$12.50

Cost Center [Dropdown]
 Billing Note [Text]
 Encounter Post Date 5/15/2015
 Created Date 5/15/2015 8:53 PM

Group Enrollment ATR4 [ATR4, ATR4 - Service Vendor]
 Payor Billing Service Peer-to-Peer Services, Mentoring, Coaching (training): TR7010

Service Location [Text]
 Unit Desc 1 unit = [Text]
 Authorization 3-TR7010 Available 187.50
 Available to pay this claim item: 187.5000

Administrative Actions

[Awaiting Review](#) [Hold](#) [Reject \(Back Out\)](#)

Cancel Save Finish

Figure 7-3: Profile for Claim # screen

- Next, you have the option of changing the claim item status. The **Administrative Actions** will vary based on the claim item status. If the claim item is **Released**, choose from the following actions in the **Administrative Actions** box:

Table 7-2: Claim Item Administrative Actions

Action	Description
Awaiting Review	This action link will indicate that the claim is awaiting review and approval to release.
Hold	This action link will indicate that the item is pending and is not ready to be batched and billed.
Reject (Back Out)	This action link will indicate that the claim item may not be billed.

7. After selecting an Administrative Action, the browser window will reload and the claim status is changed. Click **Finish** to save and complete your action.

Note: Reversal and Adjustment

The reversal and adjustment claim items are automatically created with the released status. They will then be batched and billed when the next process runs.

Note: Reject (Back Out) a Claim Item

1. If rejecting a claim, another screen will appear and you will need to provide a reason.

This action will cause this service to be rejected back to the clinician. If you are sure you want to do this, then enter a reason and click confirm.

Rejection Reason: Other

Other Comments: Please update the service date to 5/13/2015.
Thank you!

Cancel Confirm

Reject (Back Out) Claim Item Reason

2. Once the claim is rejected, the encounter will appear in red on the encounter list.

Client: Participant, Practice | 1626IP112585345 | 1 Clear Client

Encounter Search

Start Date: 5/15/2014 End Date: 5/15/2015

Rendering Staff: Service: Encounter Status: Rejected Program:

Clear Go

Encounter List (Export) Add Encounter Record

Actions	Svc Date	Service	ENC ID	Rendering Staff	Program Name	Status
	5/11/2015	Supplemental Needs - Clothing/Personal Hygiene Products (training)	2075	Vendor, Practice	ATR 4	Rejected (Details)

Encounter List, Rejected Item in Red

3. The user will then be able to see the rejection reason by clicking the **“Details”** link. This link will open another window and will provide the user with information to make any changes.

Client: Participant, Practice | 1626IP112585345 | 1

Rejection Reason

Please update the service date to 5/13/2015. Thank you!

Rejection Reason

Create Agency/Facility Claim Item Batches



Where: **Agency > Billing > Claim Item List**

Next, after reviewing all of the claim items, they will need to be batched. Batches can be made either for an agency or for a facility. This ability is assigned through the roles, Create Agency Claim Batch, and Create Facility Claim Batches.

For staff members with either of these roles, the Claim Item List screen will display an Administrative Actions box, with one or both of those links.

The screenshot shows the 'Claim Item Search' interface with various search filters. Below the filters is an 'Administrative Actions' box containing two links: 'Create Agency Batches' and 'Create Facility Batches'. Below this is the 'Claim Item List (Export)' section with a table of claim items.

Actions	Item #	Client Name	Add-On Level	Service Date	Service	Duration	Status	Release Date	Charge
	2	Participant, Practice	None	5/12/2015	TR7010	60 Min	Batched	5/15/2015	\$12.50
	3	Participant, Practice	None	5/14/2015	TR7010	60 Min	Batched	5/15/2015	\$12.50

Claim Item List screen, Create Agency/Facility Batches

1. To create an Agency and/or Facility Batch, click one of those links in the Administrative Actions box.
2. On the **Choose Plan(s) for Batching** screen, select **ATR4** and move it to the "Selected Plans" box, and then click **Go**.

The screenshot shows the 'Choose Plan(s) for Batching' dialog box. It has two columns: 'Available Plans' and 'Selected Plans'. The 'Selected Plans' column contains 'ATR4'. There are 'Cancel', 'Clear', and 'Go' buttons at the bottom.

Choose Plan(s) for Batching screen

3. A message will appear on the screen indicating that the claim items are being batched.

The screenshot shows a message box with the text: "The claim items for the selected 1 plan(s) are being batched. This may take a few minutes to complete." Below the message box is the 'Claim Item Search' header.

Batched Claim Items message

4. Check the Claim Batch by clicking the **Claim Batch List** link in the left menu. *See next section...*

Claim Batch List



Where: [Agency](#) > [Billing](#) > [Claim Batch List](#)

The Claim Batch List screen allows you to review the Claim Batch profile, including all of the claim items associated with that batch, and then submit the claim batch to the payor for payment processing.

1. From the left menu, click **Agency, Billing**, and then click **Claim Batch List**.
2. Click **Clear** to remove pre-filled items in the search fields, and then click **Go** to view all of the claim batches.

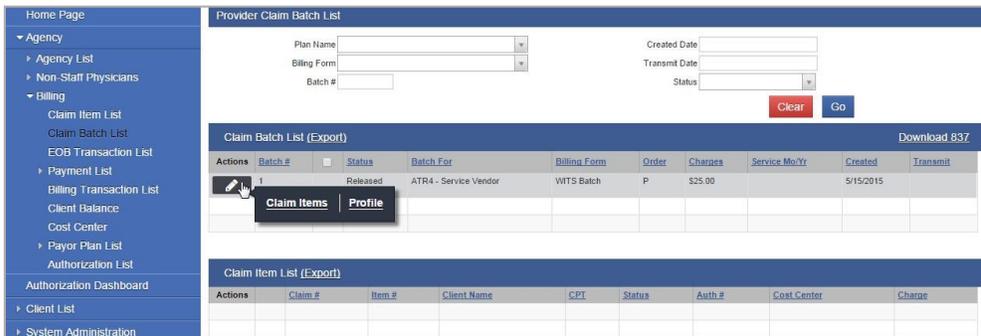


Figure 7-4: Claim Batch List, click Claim Items link

3. Hover over the Actions column of a claim batch, and click the **Claim Items** link.
4. The **Claim Item List** will then display all of the claim items associated with that batch. These can be reviewed before submitting the batch.

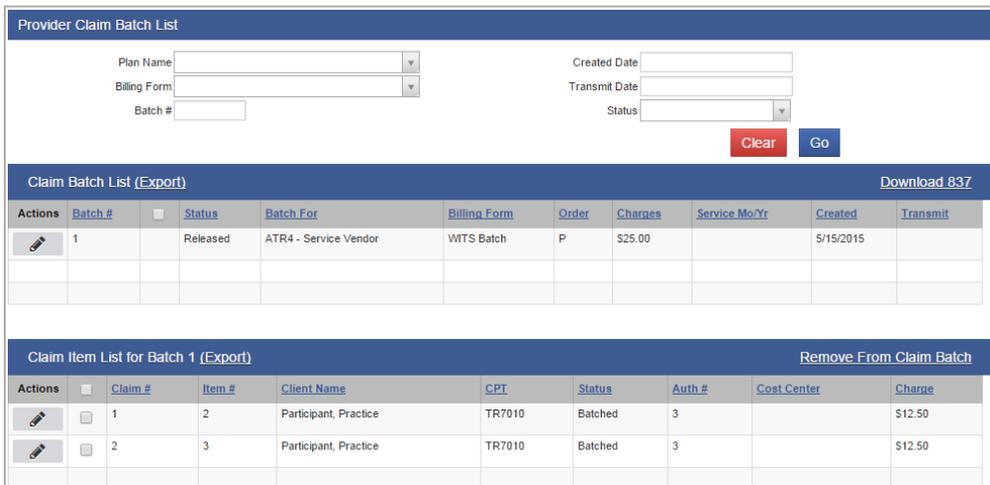
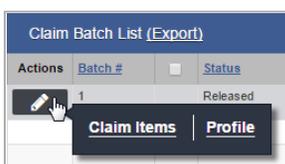


Figure 7-5: Claim Item List for Batch #

5. On the **Claim Batch List**, review the batched claim item by hovering over the Actions column, and select the **Profile** link.



- On the **Profile** screen of a Batched Claim Batch item, the Administration Actions box will display the following links:

Table 7-3: Provider Claim Batch Profile Administrative Actions

Administrative Action	Description
Awaiting Review	Indicates that the batch needs further review.
Hold	Indicates that the batch is pending and is not ready to be billed.
Void	This will void the batch.
Bill It	This will submit the batch for the Contractor agency (payor) for payment processing; the status of the claim batch will be updated once the payor accepts the batch and approves for payment.

Figure 7-6: Provider Claim Batch Profile, Administrative Actions links

- Click any of the links in the Administrative Actions box, and then click **Finish**. This will return to the Claim Batch List screen.
- If viewing the Profile of Batched Claim Item that has been fully adjudicated by the payor, the following actions will be available in the Administrative Actions box:

Table 7-4: Reverse and Adjust Administrative Actions

Administrative Action	Description
Reverse	This selection will create a reverse transaction of the original claim item; The charge will appear as a negative amount on the Claim Item List screen.
Adjust	This selection will create a reverse transaction of the original claim item as well as a new claim corresponding to the adjustment you just entered; The Claim Item List screen will then show two claim items: negative charge and the adjusted amount.

