



SUBSTANCE USE DISORDER MIS

INTRO TO ADMIN FUNCTIONS TRAINING



Live Well San Diego

County of San Diego Behavioral Health Services



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



CONFIDENTIALITY

HIPAA regulations mandate that all client information be treated confidentially.

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

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

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

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

Remember you are personally and legally responsible for maintaining confidentiality. Take it seriously.

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

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

Play it safe – keep in mind how you would want your own PHI handled!





SANWITS SOFTWARE BASICS

- San Diego Web Infrastructure for Treatment Services (SanWITS) is accessed through: <https://sandiego.witsweb.org>
Save this to your favorites or create a shortcut for your desktop.
- NAVIGATE by using a function link, hand icon, pen, arrow key, or button. The back arrow in the internet browser does not pull up the previous screen.
- FUNCTION LINKS are underlined links allowing certain actions to be completed. Function links are usually located on the section headers. A hand icon also functions as a link allowing a user to complete activities.
- SYSTEM REQUIRED FIELDS are in bright or light **yellow**. The bright yellow fields must be completed to save the screen and move forward. The system allows saving of the record with the light yellow fields left blank, but the activity will show the status as In Progress (incomplete).
- OPTIONAL FIELDS are in white. Some white fields may be yellow fields in other pages or screens.
- SYSTEM GENERATED FIELDS are in gray. Nothing can be changed or added in these fields.
- **GO** is the execute button. Click **GO** to change agency or facility, execute a command, load data, or pull up screens.
- **CANCEL** returns to the previous screen without saving the data entered.
- **SAVE** saves the information entered and, in certain screens, adds multiple records of data.
- **FINISH** returns the user to the first screen of the module or Activity List.
- **ARROW** keys or buttons move forward or back from screen to screen.
- Contact information for questions and end user support can be found on the last page of this training manual.

Reminder:

Menu access is set up according to credentials (roles). The menus you have at your program may look different than the menus shown in the screen shots in this packet.



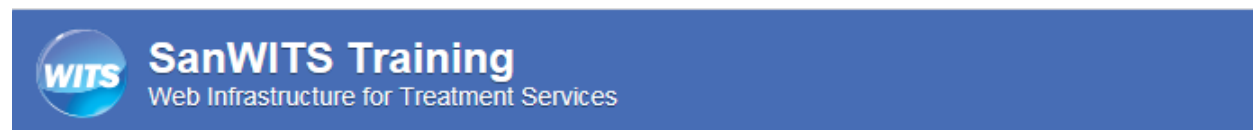
LOGIN INFORMATION

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

Logging in to SanWITS

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

At the Login screen, enter the following: User ID, password, and PIN. Click **Login**.




Login

User ID

Password

PIN

[Forgot Password?](#)

Powered by 

You will be directed to set up your security question with a corresponding answer, password, and PIN if you are a first time SanWITS user.



Note: A system security triggers an automatic email notification to a user account with no login activity within 60 days. A user account is locked if there is no login activity within 90 days.



PASSWORD AND PIN SECURITY

Resetting Credentials

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

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

To confirm credentials, click **Save**.

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



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

SanWITS Training
Web Infrastructure for Treatment Services

Reset Credentials

Display Name

Email

Security Question
1

Answer

Password
2

Confirm Password

Pin
3

Confirm Pin

Show Password/Pin

Changing Credentials (Security Question, Password, and PIN)

Users can change their credentials at any time. To change the security question and answer, password, or PIN, on the right side of the screen:

Click the dropdown arrow (▼) → Change Credentials





HOME PAGE

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

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

Announcements				
Actions	Summary	Posted Date	Start Date	Priority

Alert List							Search in Agency
Actions	Alert Type	Client Name: ID	Applies To Staff	Message	Facility	Date Due	

Changing Facility

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

Click the dropdown arrow (▼) at the New Facility field → Select one from the list → **GO**

Home Page	Change Facility
▶ Agency	
▶ Group List	
▶ Client List	
▶ System Administration	
Reports	

Current Agency	<input type="text"/>
Current Facility	<input type="text"/>
New Agency	<input type="text"/>
New Facility	<input type="text"/>

Cancel **Go**



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



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

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

Most actions are completed through the navigation pane. The navigation pane options vary depending on staff's roles.

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



IMPORTANT: Links for searching, editing or adding client information are usually on the right or at the bottom side of the screen.

Home

Announcements				
Actions	Summary	Created Date	Start Date	Priority

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

Schedule for: Start Date: <input type="text"/> End Date: <input type="text"/> Refresh						
Actions	Start	End	Summary	Status	Search Calendar Edit/Add Schedule	

NOTES



CLIENT SEARCH

A client should have only one client profile per agency. Conduct a careful and thorough search to determine if the client has an existing profile in the agency.

Searching Clients:

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

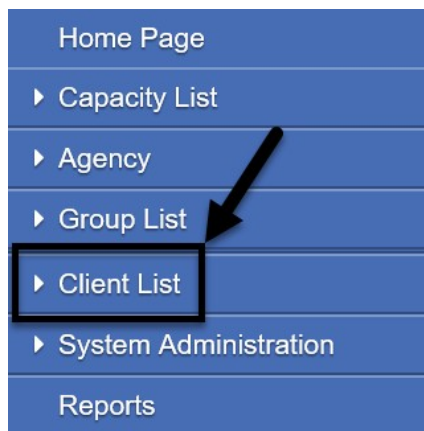
Search the client's profile by using the basic identifiable information, such as:

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

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

Search also by using the client's birth name, current name, and other alternate names (former names and aliases) the client may have used. To search a client from the navigation pane:

Click Client List





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

Client Search

Agency Facility

First Name Last Name

SSN DOB

SanWITS Training Client Id

Unique Client Number Provider Client ID

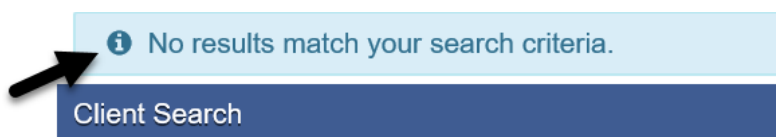
Treatment Staff Primary Care Staff

Case Status Intake Staff

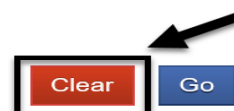
Other Number Number Type

Include Only Active Consents

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



Before entering another client identifiable information, reset the search criteria by clicking the **Clear** button.



2. If a match is identified, the Client List will populate with the matching results. To open an existing client profile:

Hover over the pen under the Actions column → Select **Profile** or **Activity List**

Client List (Export) [Add Client](#)

Actions	Unique Client #	Full Name	DOB	SSN	Gender

Profile | Activity List | Linked Consents



Additional Important Considerations in Searching Clients to Avoid Duplicate Client Records:

1. Always double check the spelling of the client's first, middle, and last names.
2. Search by current and birth names. The current name may be different from the birth name, but the birth name should never change.
3. Search all other alternate names the client uses or may have used.
4. Use the wildcard or asterisk (*).
5. If the client has a two-word name or a hyphenated name, search for one of the names at a time and add the *.
6. If search results show a client with the same identical information on a client photo ID with no middle name, confirm all other identifying information. Do not remove the middle name in SanWITS.
7. Search several times with different combinations of identifiable information.

NOTES



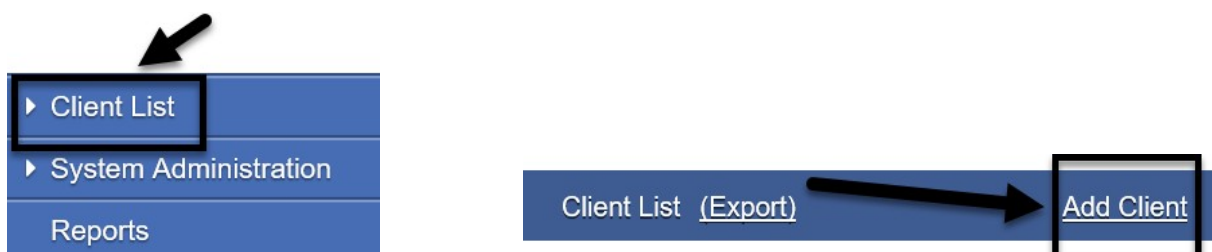
ADD CLIENT



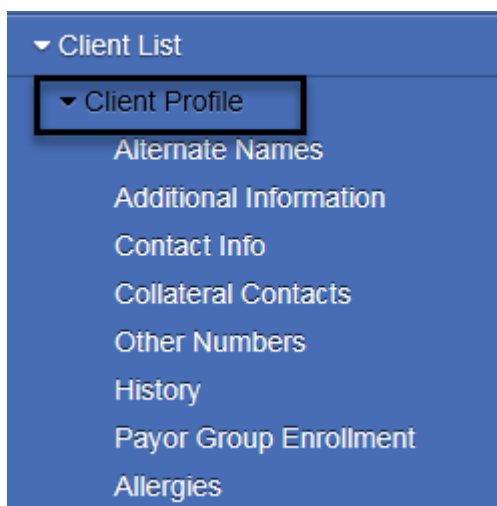
Note: There should be one client record per agency. To avoid duplicate records, it is important to always search several ways to ensure a record for the client does not already exist in the agency. Refer to the “Client Search” tips on the previous pages.

If multiple searches do not show a client profile, the next step is to add a new client profile. Data used to create a new client profile should be obtained directly from the client. To add a client profile:

Click Client List → Add Client



Below is the full content of the Client Profile:



Client Profile, Additional Information- CalOMS required screens

Payor Group Enrollment, Contact Info- Medi-Cal billing required screens

Alternate Names, Collateral Contacts, Other Numbers- Not system required

History- Shows audit trails for viewing

only Allergies- Not currently in use

The **Client Profile** and the **Additional Information** screens are required to save the Client Profile.

IMPORTANT: Notify the County every time the Client Profile is updated as this could cause a CalOMS error. Send email to SUD_MIS_Support.HHSA@sdcounty.ca.gov.



The Client Profile screens require California Outcomes Measurement System (CalOMS) acceptable values. Refer to the [CalOMS TX Data Collection Guide](#) regarding acceptable values for each field.

Client Profile: The Client Profile screen is the first screen in the Client Profile section.

Many of the fields on the Client Profile screen are also on the Client Search screen. It is important to enter complete and accurate client information because inaccurate and incomplete information impacts future users as well as the agency’s submission of reports to the County and the State.

The client’s current name and birth name could be different, but the birth name should never change. If the client has a middle name and the information is available, enter the middle name as well.

Complete the required fields and click the **Right Arrow** button to continue with completing the client profile. The system will display an error message if the Save button is clicked instead of the right arrow button.

Client Profile

Current First Name	<input type="text"/>	State Client ID	<input type="text"/>	State Client No	<input type="text"/>
Middle Name	<input type="text"/>	Provider Client ID	<input type="text"/>		
Current Last Name	<input type="text"/>	SSN	<input type="text"/>		
Birth First Name	<input type="text"/>	Driver's License	<input type="text"/>		<input type="text"/>
Birth Last Name	<input type="text"/>	Medicaid #	<input type="text"/>		
Mother's First Name	<input type="text"/>	Date of Death	<input type="text"/>		<input type="text"/>
Gender	<input type="text"/>	Place of Birth	<input type="text"/>		<input type="text"/>
DOB	<input type="text"/>	Consent on File for Future Contact	<input type="text"/>		
No Readmit Until	<input type="text"/>	Has Paper File	<input type="text"/>		
Record Created By	<input type="text"/>	Created Date	<input type="text"/>		
Last Updated By	<input type="text"/>	Last Updated Date	<input type="text"/>		

Administrative Actions

Important: Click the **Right Arrow** button, rather than the navigation pane, to go to the next screen when completing a new client profile.



Alternate Names: The Alternate Names screen is used to enter other names the client uses or has used in the past. The system is designed to search a client profile by alternate names. To add, click Add Alternate Name. Complete the fields and click Finish. To continue creating the client profile, click the **Right Arrow** button.

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

First Name Middle Name
Last Name Client Alias Type

Cancel Save Finish ⏪ ⏩

To edit an alternate name, hover over the pen under the Actions column and select Review.

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

Review Delete

Reminder: Click the **Right Arrow** button, rather than the navigation pane, to go to the next screen when completing a new client profile.

NOTES



Additional Information: There are several required fields in the Additional Information screen. The preferred language prepopulates on the Encounter screen. Single click on the selected races and disabilities, then single click on the right arrow to complete the Races and Disabilities fields.

Complete the Additional Information screen.

Click **Save** to create a new client profile and click the **Right Arrow** button to add the client's contact information.



Note: After saving the client profile, the system generates a unique client number (UCN) for the client. The UCN consists of the client's initials, gender and date of birth. Include the client's UCN to all forms and communications sent to the County.

Reminder: Notify the County every time the Client Profile is updated as this could cause a CalOMS error. Send email to SUD_MIS_Support.HHSA@sdcountry.ca.gov.



Contact Info: The client's address and telephone numbers are entered in the Contact Info screen. The client's address is required to bill. To add, click **Add Address**.

Contact Info

Home Phone # Preferred Method of Contact

Work Phone #

Mobile #

Other Phone #

Fax #

Email Address

Addresses

[Add Address](#)

Actions	Address Type	Address	Confidential	Created	Updated
---------	--------------	---------	--------------	---------	---------

From the Address Type, select Client Billing and enter your facility's address if the client is homeless. Enter the rest of the information. Click **Finish**. Click **Finish** again.

Address Information

Address Type Confidential

Address Line 1

Address Line 2

County

City State CA Zip

The system validates the address with the United States Postal Service (Postal). If the address entered does not match the Postal address, an Address Validation screen will populate with the original and the suggested addresses. The suggested address must be selected.

Address Validation

There is a problem with the address provided - we've produced a suggestion from the United States Postal Service below. Please Choose which version of the address you want to use.

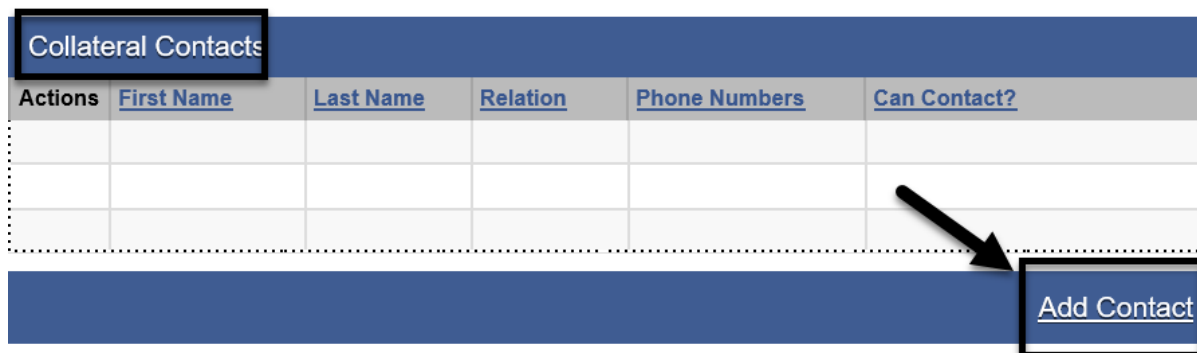
Address	Actions
Original Address: 3255 camino del rio, san diego, California 92108	<input type="button" value="Select"/>
Suggested Address: 3255 CAMINO DEL RIO S, SAN DIEGO, California 92108	<input type="button" value="Select"/>



If all client information has been entered, click **Finish** after saving the Contact Info screen to return to the Client List. To enter additional information such as collateral contacts, click the Right Arrow button instead to go to the next screen.



Collateral Contacts: Complete the Collateral Contacts screen if the client has collateral contacts. To add, click **Add Contact**.



Complete the fields and click **Finish**.



Other Numbers: The Other Numbers screen is for documenting the client’s various court and petition numbers. Court numbers entered in this screen are searchable.

Other Numbers						
Actions	Number Type	#	Start	End	Contact Name	Status

Add Other Number

Complete the fields and click **Finish**.

Other Numbers						
Actions	Number Type	#	Start	End	Contact Name	Status

Add Other Number

Number Type

Number

Start Date

End Date

Status **Active**

Contact

Comments

Cancel **Finish**

This concludes all data entries to complete the Client Profile. Click **Save** to make sure all the information entered is saved in the system. Click **Finish**.



History: The Client History screen shows all entries and changes made to the client’s SanWITS record. This is a read-only screen. No data can be added or deleted on this screen.

Client History (Export)		
Date Changed	System Account	Description of Changes
		<ul style="list-style-type: none"> • Accessed Client Profile Screen •
		<ul style="list-style-type: none"> • Accessed Client Record: • Client added.

The next screen is Payor Group Enrollment screen and is covered on a separate section of this manual.



CONTACTS

The Contacts screen records communication and interactions with a client in order to capture data elements for the Drug Medi-Cal Organized Delivery System (DMC-ODS).

A client profile must exist before a contact record can be created. The contact record will be linked to the intake to start a new episode.

There can be multiple contacts created before an episode is opened. Once a contact record has been linked to an intake, no new contacts will need to be created. To add a contact from the navigation pane:

Click Contacts → Add



Important considerations when completing the Contact Profile fields:

1. The Stop Date, Start Time and Stop Time are system required fields if the contact was made by phone
2. The Call Taker field prepopulated with the name of the staff who is logged in and should be updated to the staff who received the call or had contact with the client
3. Enter the client's medical insurance coverage in the Benefit Type field
4. The 1st Available Intake/Screening Appt, 2nd Available Intake/Screening Appt, 3rd Available Intake/Screening Appt and the 1st Accepted Intake/Screening Appt fields are system required when 'Made an appointment' is selected from the Disposition field. If the client is seen the same day as the visit to the clinic (contact date), the Disposition field should be 'Made an Appointment'.
5. Source of Referral prepopulates on the Intake screen and is also linked to the Admission screen.

The 2nd Available Intake/Screening Appt cannot be the same day as the 1st Available Intake/Screening Appt, and the 3rd Available Intake/Screening Appt must be later than the 2nd Available Intake/Screening Appt.



Complete the Contact Profile screen. Selecting phone as the Contact Method and the 'Made an Appointment' for Disposition will require user to complete additional fields.

Contact Profile

Client Name: [] Age: [] Unique Client Number: [] MPI: []
 DOB: [] SSN: []
 Gender: Male

Initial Contact Date [] Stop Date [] Status: In Progress
 Start Time [] Stop Time [] Duration [] Created Date []
 Contact Reason [] Contact Method: Phone
 If Other, Specify [] Source of Referral []
 Call Taker: Staff, Rendering Requestor Name []
 Location [] Requestor Phone # []
 Contact Made By []
 LMHA []
 Benefit Type []

Appointments

1st Available Intake/Screening Appt []
 2nd Available Intake/Screening Appt []
 3rd Available Intake/Screening Appt []
 1st Accepted Intake/Screening Appt []

Presenting Needs []
 Disposition: Made an appointment
 Unsigned Notes [] Signed Notes []
 Sign Note []

Administrative Actions
[Move Contact](#) [Delete](#)

Cancel Save Finish

A) If the client made no appointment, click **Save** and **Finish**.



The system will take the user to the Contacts List where the Contact Status column will reflect Completed and the Reviewed column will reflect **No**. No additional action is necessary.

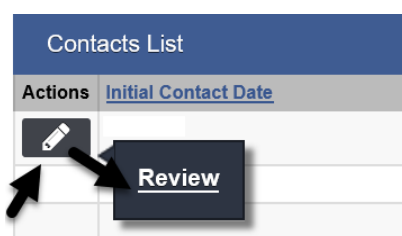
Contacts List							Add
Actions	Initial Contact Date	Call Taker	Contact Reason	Disposition	Contact Status	Reviewed	
			Information	No appointment made	Completed	No	



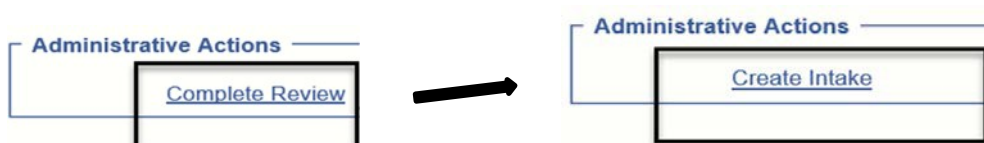
B) If the client was not screened at the time of contact but has made an appointment and accepted one (1) of the three (3) screening appointments, click **Save** and **Finish**.



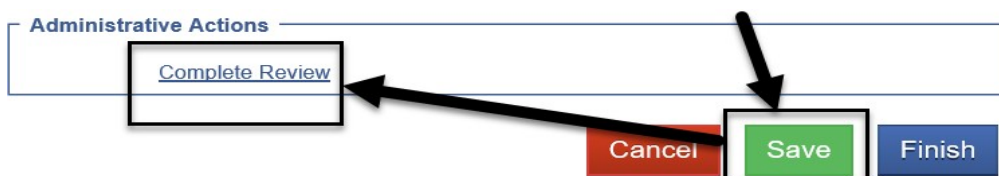
When the client returns for the client intake or screening, re-open the Contact Profile record. To re-open the contact, hover over the pen in Actions, and click **Review**.



In the Administrative Actions field at the bottom left of the screen, click **Complete Review**. A new link is generated on the same spot; click **Create Intake**.



C) If the client is screened at the time of contact, click **Save** to save the contact record. Then in the Administrative Section, click the link **Complete Review**.



The contact is changed to a read-only record and can no longer be modified. The system also generates a link to open an episode/intake.

Click **Create Intake** to start the client intake. Completing an intake screen is addressed in a separate section of this manual.





INTAKE AND EPISODE

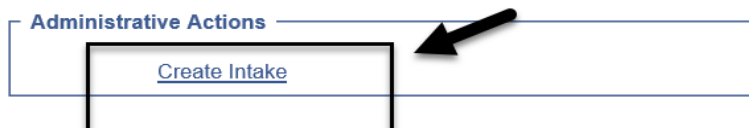
A new client treatment episode begins when a client intake is created. The complete definition of a treatment episode is found in the CalOMS TX Data Collection Guide.

A completed and reviewed contact is required to create an intake. To create an

intake: Click Contacts → Actions → Create Intake



Users may also create an intake within the Contacts screen after completing review of the contact record. At the bottom of the Contact Profile screen and within the Administrative Actions, click **Create Intake**.



The Intake screen prepopulates with data entered from other screens. The Manner of Contact, Initial Contact Date, and Source of Referral prepopulate from the Contact screen and are read-only.

The Intake Staff prepopulated with the name of the staff who is logged in and should be updated to the staff who performed the intake.

The Pregnant field will prepopulate with “No” if the client’s gender is male; the gender designation is made during the completion of the Client Profile.

The Intake screen also has fields that are logically linked to fields in other screens. The Source of Referral field is linked to Criminal Justice field in the Admission screen. If any of the criminal/legal referral sources are selected in Admission, the selected risk categories field must also reflect the Criminal Justice Status.



The 2nd Available Tx Appt cannot be the same day as the 1st Available Tx Appt, and the 3rd AvailableTx Appt must be later than the 2nd Available Tx Appt.

Select the Risk Categories that are applicable to the client for accurate State reporting.

Complete all the fields required to create an intake, then click **Save** and **Finish**.

Intake Case Information

Intake Facility Case #

Intake Staff Case Status

Manner of Contact Initial Contact Date

Residence Intake Date

Source of Referral Pregnant Due Date

Referral Contact Chronic Life Threatening Illness (CLTI)

[Add Collateral Contact](#) Injection Drug User

Referral Date Presenting Problem (In Client's Own Words)

Assessment Date

Appointments

1st Available Tx Appt

2nd Available Tx Appt

3rd Available Tx Appt

1st Accepted Tx Appt

Risk Categories Selected Risk Categories

Date Closed [Save & Close the Case](#)

Closure Reason

The Date Closed field is activated after the intake is saved. Complete all necessary actions first before closing an open case.



Notes: 1) Open a new episode whenever the level of care (LOC) is changed from OS to IOS or vice versa, from OTP courtesy dosing to regular OTP, from Residential 3.2 Withdrawal Management to Residential Service 3.1/Residential Service 3.5. 2) Open a new episode when, after completing a Discharge record, the client is re-admitted for the same LOC.



ACTIVITY LIST

The Activity List launches after the client intake is created, and it lists activities completed for the client.

The Status column shows that an activity is complete or in progress. 'In Progress' status indicates a field is incomplete or has invalid values. Incomplete fields or invalid values prevent submission of data to the Department of Health Care Services (DHCS) or may result in CalOMS error.

A '(Details)' link to the right of the 'In Progress' status shows the records that are incomplete or with invalid values. The link lists on a separate window the fields that must be filled in to complete the activity. Close the window and open the record to complete the activity in order to change the status from in progress to completed.

Home Page	Client Activity List				
▶ Capacity List	Actions	Activity	Activity Date	Created Date	Status
▶ Agency		Client Information (Profile)	12/1/2018	11/20/2018	Completed
▶ Group List		Intake Transaction	12/1/2018	1/9/2019	Completed
Authorization Dashboard		Admission	12/1/2018	1/9/2019	In Progress (Details)
Residential Unit Dashboard					
▶ Residential Unit Mgmt					
Clinical Dashboard					
▼ Client List					
▶ Client Profile					
Linked Consents					
Contacts					
▼ Activity List					
Intake					

To open the incomplete record and resolve incomplete fields or invalid values, hover over the pen in Actions column and click **Review**.

Client Activity List				
Actions	Activity	Activity Date	Created Date	Status
	Client Information (Profile)			Completed
	Intake Transaction			Completed
	Admission			In Progress (Details)
	Review			



PAYOR GROUP ENROLLMENT

A Payor Group Enrollment must be entered for all Substance Use Disorder (SUD) services reported to the County for reimbursement through SanWITS.

Click Client Profile → Payor Group Enrollment → Add Benefit Plan Enrollment



Complete the following fields if client is Drug Medi-Cal (DMC) enrolled and click Save:

1. Payor-Type- Medicaid (Medi-Cal)
2. Plan-Group- This will depend on your facility's certification. Select ODS DMC- Non Peri-Medi-Cal – Non Perinatal or ODS DMC- Peri-Medi-Cal – Perinatal
3. Coverage Start- Enter the first day of the month the client is eligible to Medi-Cal. **Note:** Enter the coverage **End** date when client leaves the agency
4. Aid Code- Enter the aid code shown on the eligibility verification result from the State website. For additional details on billing, refer to the Billing Manual posted on the DMC ODS page of the Optum website at www.optumsandiego.com
5. Relationship to Subscriber/Responsible Party- Select Self. Selecting Self carries over information from the Client Profile screen

Benefit Plan/Private Pay Billing Information

Payor-Type	<input type="text" value="1"/>	Plan-Group	<input type="text" value="2"/>
Payor Priority Order	<input type="text" value="1"/>	Policy #	<input type="text"/>
Coverage Start	<input type="text" value="3"/>	End	<input type="text"/>
Aid Code	<input type="text" value="4"/>	Relationship to Subscriber/ Responsible Party	<input type="text" value="5"/>
		Payment Scale	<input type="text"/>



The Subscriber/Responsible Party section prepopulated with information from the client profile. To prevent claims from being rejected, the information on this section **MUST** match what is on the State website. If the address does not carry over, it was not entered in the client profile. Manually update the information if needed.

- Subscriber#- Enter the client’s Medi-Cal ID issued by the State.

Subscriber/ Responsible Party:

First Name		Middle		Last Name	
Birthdate		Gender		Subscriber #	9-digit Medi-Cal ID 6
Address 1	1255 Imperial Avenue				
Address 2					
City	San Diego	State	California	Zip	92101

PENDING DMC ENROLLMENT OR SITE CERTIFICATION

Complete the following fields if client is awaiting Drug Medi-Cal (DMC) enrollment or the facility is awaiting site certification, and click Save:

- Payor-Type- Medicaid
- Plan-Group- Select ODS DMC- Non Peri-Medi-Cal – Non Perinatal or ODS DMC- Peri-Medi-Cal – Perinatal
- Coverage Start- Enter the first day of the month of Admission
- Aid Code- **00**
- Relationship to Subscriber/Responsible Party- ‘Self’ will prepopulate with client’s contact information. Update address if the address of record is not current
- Subscriber#- **000**

Benefit Plan/Private Pay Billing Information

Payor-Type	Medicaid	Plan-Group	ODS DMC- Non Peri-Medi-...
Payor Priority Order	1	Policy #	
Coverage Start	00/1/2020	End	
Aid Code	00	Relationship to Subscriber/ Responsible Party	Self

Subscriber/ Responsible Party:

First Name		Middle		Last Name	
Birthdate		Gender		Subscriber #	000
Address 1	1255 Imperial Avenue				
Address 2					
City	San Diego	State	California	Zip	92101



COUNTY BILLABLE SERVICES

Complete the following fields if the services are County billable, and click Save:

1. Payor-Type- Other
2. Plan-Group- Select CountyBillable-CountyBillable or CountyBillable-Out of County
3. Coverage Start- Date of Admission
4. Aid Code- Leave the field **BLANK**
5. Relationship to Subscriber/Responsible Party- 'Self' will prepopulate with client's contact information. Update address if the address of record is not current
6. Subscriber#- Leave the field **BLANK**

Benefit Plan/Private Pay Billing Information

Payor-Type	<input type="text" value="Other"/>	Plan-Group	<input type="text" value="CountyBillable-CountyBillable"/>
Payor Priority Order	<input type="text"/>	Policy #	<input type="text"/>
Coverage Start	<input type="text" value=""/>	End	<input type="text" value=""/>
Aid Code	<input type="text"/>	Payment Scale	<input type="text"/>
	Relationship to Subscriber/ Responsible Party	<input type="text" value=""/>	

Subscriber/ Responsible Party:

First Name	<input type="text" value=""/>	Middle	<input type="text" value=""/>	Last Name	<input type="text" value=""/>
Birthdate	<input type="text" value=""/>	Gender	<input type="text" value=""/>	Subscriber #	<input type="text" value=""/>
Address 1	<input type="text" value=""/>				
Address 2	<input type="text" value=""/>				
City	<input type="text" value=""/>	State	<input type="text" value=""/>	Zip	<input type="text" value=""/>

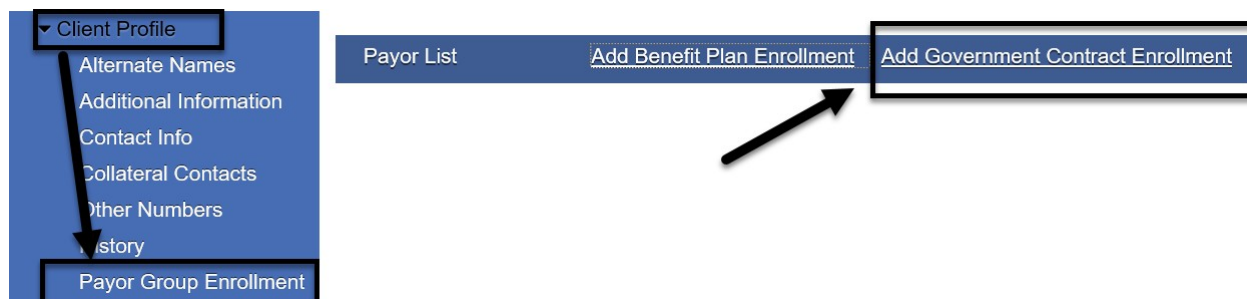
NOTES



RESIDENTIAL PROGRAMS ONLY

In addition to the Benefit Plan Enrollment, residential programs must also add a Government Contract Enrollment. To add a Government Contract Enrollment, from the Client Profile:

Click Payor Group Enrollment → Add Government Contract Enrollment



There are four (4) required fields in the Government Contract Billing Information screen, but two (2) are system generated. Complete the other 2 required fields and click **Save**.

1. Contract- Do **NOT** change the prepopulated information
2. Plan Group- Select ODS Residential-Residential Bed Day, ODS Residential Justice Override Bed Day, or ODS Residential-Out of County Bed Day
3. Subscriber #- Do **NOT** change the prepopulated client's UCN
4. Start Date- Enter the date of admission
5. End Date – Leave it blank. Do **NOT** enter a date

Government Contract Billing Information

Plan Type <input type="text" value="Government Contract"/>	Payor Priority Order <input type="text" value="3"/>
Contract <input style="background-color: yellow; border: 1px solid black; border-radius: 2px; padding: 2px 5px; margin-left: 5px; width: 150px;" type="text" value="559999,559999"/> 1	Start Date <input style="background-color: yellow; border: 1px solid black; border-radius: 2px; padding: 2px 5px; margin-left: 5px; width: 100px;" type="text" value="4"/> 4
Plan-Group <input style="background-color: yellow; border: 1px solid black; border-radius: 2px; padding: 2px 5px; margin-left: 5px; width: 150px;" type="text" value="2"/> 2	End Date <input style="border: 1px solid black; border-radius: 2px; padding: 2px 5px; margin-left: 5px; width: 100px;" type="text" value=""/>
Subscriber # <input style="background-color: yellow; border: 1px solid black; border-radius: 2px; padding: 2px 5px; margin-left: 5px; width: 100px;" type="text" value="3"/> 3	

Administrative Actions:



Note: Enter only one (1) Government Contract Enrollment per client for Residential Bed Day, even when LOC is changed. Leave the Government Contract Enrollment open by leaving the end date blank, even if the client is discharged. Add another GCE if the client is admitted under Justice Override or Out of County and do not end it.



AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

SanWITS has a screen for capturing the American Society of Addiction Medicine (ASAM) criteria assessment for clients. To access ASAM from the navigation pane:

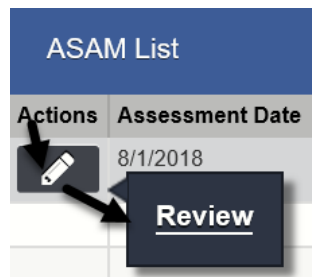
Click Activity List → ASAM



The ASAM List shows all previously entered records. It displays the assessment date, type of assessment, staff name, recommended level of care, status, and updated date.

ASAM List Add ASAM							
Actions	Assessment Date	Type of Assessment	Program	Staff Name	Recommended Level of Care	Status	Updated Date
		Initial LOC Assessment			3.1 - Clinically Managed Low-Intensity Residential Service	Completed	

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



To add a new ASAM, click **Add ASAM** to the right of the ASAM List.





The one-page ASAM screen launches.

ASAM

Type of Assessment

Dimension

1 - Acute Intoxication and/or Withdrawal Potential

Level of Risk Level of Care

Comments

2 - Biomedical Conditions and Complications

Level of Risk Level of Care

Comments

3 - Emotional, Behavioral, or Cognitive Conditions and Complications

Level of Risk Level of Care

Comments

4 - Readiness to Change

Level of Risk Level of Care

Comments

5 - Relapse, Continued Use, or Continued Problem Potential

Level of Risk Level of Care

Comments

6 - Recovery / Living Environment

Level of Risk Level of Care

Comments

Recommended Level of Care

Actual Level of Care

Additional Level of Care

Comments

Reason for Discrepancy

Accessibility
Client Preference
Environment
Financial

Selected Reason for Discrepancy

Court Mandated

Assessment Date

Program

Administrative Actions

[Sign ASAM](#)

A face-to face interaction between the AOD counselor and the LPHA to verify the determination of medical necessity for the client regarding this ASAM LOC Recommendation form occurred and was finalized by LPHA on the date listed.

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

Cancel Save Finish



The Type of Assessment is a required field and is used to identify and categorize when the assessment is administered. The drop-down menu has two options: Initial LOC Assessment and Follow Up Assessment.

ASAM

Type of Assessment

- Initial Assessment
- Followup Assessment

Help texts to score the different levels of risk are available for all six dimensions. Simply hover over the **i** to pull up the help text.

Below are the sample help texts for Dimensions 1 and 6:

1 - Acute Intoxication and/or Withdrawal Potential

Level of Risk **i**

Level of Care

0 - Fully functioning, no signs of intoxication or W/D present.

1 - Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self/others. Minimal risk of severe W/D.

2 - Intoxication may be severe, but responds to support; not posing a danger to self or others. Moderate risk of severe W/D.

3 - Severe signs/symptoms of intoxication indicate an imminent danger to self/others. Risk of severe but manageable W/D; or W/D is worsening.

4 - Incapacitated, with severe signs/symptoms. Severe W/D presents danger, such as seizures. Continued use poses an imminent threat to life (e.g., liver failure, GI bleeding, or fetal death).

6 - Recovery / Living Environment

Level of Risk **i**

Level of Care

0 - Supportive environment and/or able to cope in environment.

1 - Passive/disinterested social support, but not too distracted by this situation and still able to cope.

2 - Unsupportive environment, but able to cope with clinical structure most of the time.

3 - Unsupportive environment and the client has difficulty coping, even with clinical structure.

4 - Environment toxic/hostile to recovery (i.e. many drug-using friends, or drugs are readily available in the home environment, or there are chronic lifestyle problems). Unable to cope with the negative effects of this environment on recovery (i.e. environment may pose a threat to recovery).



Select the level of risk for all 6 dimensions.

Dimension

1 - Acute Intoxication and/or Withdrawal Potential

Level of Risk ▼ ⓘ Level of Care ▼

Comments

2 - Biomedical Conditions and Complications

Level of Risk ▼ ⓘ Level of Care ▼

Comments

3 - Emotional, Behavioral, or Cognitive Conditions and Complications

Level of Risk ▼ ⓘ Level of Care ▼

Comments

4 - Readiness to Change

Level of Risk ▼ ⓘ Level of Care ▼

Comments

5 - Relapse, Continued Use, or Continued Problem Potential

Level of Risk ▼ ⓘ Level of Care ▼

Comments

6 - Recovery / Living Environment

Level of Risk ▼ ⓘ Level of Care ▼

Comments

Select the recommended level of care and the actual level of care.

Recommended Level of Care ▼ ←

Actual Level of Care ▼ ←

Additional Level of Care ▼

Comments



The Reason for Discrepancy field becomes a required field if the actual level of care is not the same as the recommended level of care. After a reason for discrepancy is selected, the Comments section becomes a required field. Select the reason for the discrepancy and enter comments for the selected reason.

The screenshot shows a form with three dropdown menus for 'Recommended Level of Care', 'Actual Level of Care', and 'Additional Level of Care'. The 'Actual Level of Care' is set to '3.5 Clinically Managed High-Intensity Residential Services'. Below these is a 'Reason for Discrepancy' list with options like 'Accessibility', 'Client Preference', etc. The 'Court Mandated' option is selected in a 'Selected Reason for Discrepancy' dropdown. A 'Comments' text area is also visible.

The **Assessment Date** should be the date the client is assessed. Enter the date of assessment.

Assessment Date

There is a hyperlink to sign the ASAM in the Administrative Actions section. It is not required to save before signing the ASAM record, but it is a good practice to save documents. Once it is signed, the document becomes read-only and cannot be modified, except by a licensed practitioner of the healing arts (LPHA).

Click **Save**, **Sign ASAM** and **Finish**. If LPHA, click Finalize ASAM and Finish.

The screenshot shows the 'Administrative Actions' section with a 'Sign ASAM' link highlighted. Below it are three buttons: 'Cancel', 'Save', and 'Finish'. Arrows indicate the sequence of actions: clicking 'Sign ASAM', then 'Save', and finally 'Finish'.

The LPHA will click **Finalize ASAM** and **Finish**, if approving or entering the ASAM.

The screenshot shows the 'Administrative Actions' section with a 'Finalize ASAM' link highlighted. Below it are three buttons: 'Cancel', 'Save', and 'Finish'. An arrow points to 'Finalize ASAM', indicating the action to be taken.

Note: Enter all paper ASAM in SanWITS even when the level of care did not change. The assessment date must be changed to the date the paper ASAM was signed.

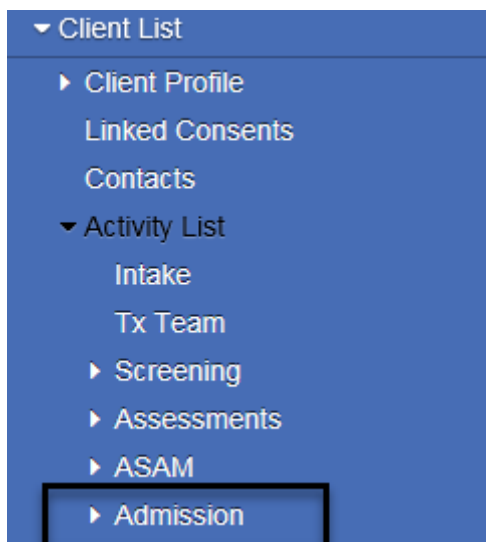


ADMISSION

The Admission process serves to admit the client into the user's facility for treatment services and to build an Admission Profile with CalOMS data for submission to the State. Refer to the CalOMS TX Data Collection Guide regarding acceptable values for each field.

When initiating an admission and there was a prior episode, the system will ask if the user wants to bring forward the client's previous admission record. If the staff selects to bring forward previous admission information, all the necessary fields need to be updated. To complete an admission, from the navigation pane:

Click Activity List → Admission



Below is the full content of the Admission section:



Profile, Administration, Substance Abuse, Tobacco, Family/Social, Employment, and Legal- CalOMS or County of San Diego required screens

Health and Diagnosis- Medi-Cal required screens



Admission Profile: The Admission Profile screen is the first screen in the Admission section. There are several required fields in this screen. Complete the Admission Profile screen. Click **Save** and **Right Arrow** ➡.

Admission Profile

Gender: [Redacted] Age: [Redacted]

Screening

Potential Client for MH [Dropdown] Basis for Decision [Dropdown]
 Potential Client for TBI [Dropdown] [Dropdown]

Admission Date [Yellow] [Calendar Icon] Codependent/Collateral [No] [Dropdown]
 Admission/Transaction Type [Yellow] [Dropdown] CalWORKs Recipient [Dropdown]
 Type of Treatment Service [Yellow] [Dropdown] SA Tx Under CalWORKs [Dropdown]
 Submit to CalOMS [Yes] [Dropdown] Special Services Contract ID [NA] [Text]
 # of Days Waited to Enter Tx [Text] Special Services/Contract County Code [Not Applicable] [Dropdown]
 # of Prior Episodes [Yellow]

Record Status

Record Created By [Redacted] Created Date [Redacted]
 Last Updated By [Redacted] Last Updated Date [Redacted]
 CalOMS Form Serial # [Redacted] Last Upload to State Date [Redacted]
 CADDs Form Serial # [Text]

[Mark as Deleted](#)

Cancel Save Finish [Right Arrow]

The information on the Record Status section is system generated. It includes the name of the staff who created/updated the record, date the record was created/updated, form serial number of the record, and date it was last uploaded to the State.

The CalOMS Form Serial Number (**FSN**) is a unique string of alpha-numeric characters that identifies the client’s record with the State.

Last Upload to State Date: If the *Last Upload to State Date* field is blank, the record has not been sent to the State. If there is a date on this field, the record has been uploaded to the State. If the date on this field is older than the *Last Updated Date*, the update after the *Last Upload to State Date* has not been uploaded to the State.



Note: When the level of care is changed from OS to IOS or vice versa or from IOS to Residential 3.1, select Transfer or Change in Service as the Admission/Transfer Type.



Admission Administration: There are only two (2) required fields in the Admission Administration screen. After completing this screen, click **Save** and **Right Arrow** to continue with the Admission record.

Admission Administration

Program Fees Intake Fees

Drug Testing Participation Testing Level Indicator

Baseline UA Completed Drug Screening Fees

Pictures Taken Encounter Fees

Prop. 36 Start Date End Date JURIS #

Special Population Program

How did you hear about us?

If Other, Specify

Administrative Checklist

- Personal Rights Given
- Emergency Contact release signed
- Property inventory done
- Have the rules been read and signed
- Medical assessment form

Selected Items

Cancel Save Finish



Note: In the Special Population Program field, select "Non BHS Contract" **only IF** the client is paying cash and/or there are other funding sources aside from the County. **DO NOT** enter payor group enrollment and encounter when "Non BHS Contract" is selected, but enter a program enrollment for County and State monitoring purposes.

NOTES



Alcohol and Drug Use: The substance abuse screen for alcohol and drug use has several required fields that need to be completed.

If None is entered for Secondary Drug Type, None or NA should be selected for all required fields under Secondary Drug.

Alcohol & Drug Use

Primary Drug

Drug Type

Drug Name

of Days Used in Past 30

Route of Administration

Age of First Use

Secondary Drug

Drug Type

Drug Name

of Days Used in Past 30

Route of Administration

Age of First Use

of Days Alcohol Used in Past 30

of Days IV Used in Past 30

Used Needles in Past 12 Months

Tertiary Drug

Drug Type

of Days Used in Past 30

Route of Administration

Age of First Use



Note: Under the Secondary Drug Type, if an entry is invalid such as entering the same drug name as the primary drug name, an error message will display at the top of the screen and the system will highlight the incorrect field.



Tobacco/Nicotine: The Tobacco/Nicotine screen is required for the County of San Diego.

Tobacco / Nicotine

Have you ever used Tobacco/Nicotine products?

Smoker Status

At what age did you first use tobacco/nicotine product(s)?

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)?

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

Family/Social: There are several required fields in the Family/Social screen. If a client is identified as **Homeless** in the Current Living Arrangements field, the Current Zip Code field will prepopulate with **00000**. This is accurate. Do not change the value.

Family/Social

of Days Social Support in Past 30

Current Living Arrangements

of Days Living w/User of Alcohol or Drugs in Past 30

of Days Family Conflict in Past 30

of Children Under 18

of Children Age 5 or Less

of Children Living w/Someone Else Because of a Child Protection Order

of Children Living w/Someone Else for whom Parental Rights have been Terminated

Current Zip Code

Abuse Characteristics

Does episode involve physical abuse?

Does episode involve sexual abuse?

Does episode involve domestic abuse?



Employment: There several required fields in the Employment screen. There is no logic linking the field for Graduated from High School and the field for Highest Grade Completed. Both must be completed.

Employment

Employment Status	<input type="text"/>
# of Paid Work Days in Past 30	<input type="text"/>
Enrolled in School	<input type="text"/>
Enrolled in Job Training	<input type="text"/>
Graduated from High School	<input type="text"/>
Highest School Grade Completed	<input type="text"/>

Legal/Criminal Justice: The Legal/Criminal Justice screen has several required fields. There is a logic linking the Source of Referral field in the Intake screen with the Criminal Justice Status field on this screen.

FOTP Parolee is always **No** because it does not pertain to San Diego County.

Legal/Criminal Justice

# of Arrests in Last 30 Days	<input type="text"/>
# of Jail Days in Last 30	<input type="text"/>
# of Prison Days in Last 30	<input type="text"/>
# of Arrests in Last 6 Months	<input type="text"/>
Criminal Justice Status	<input type="text"/>
Type of Sentence	<input type="text"/>
CDC Number	<input type="text"/>
Parolee Services Network (PSN)	<input type="text"/>
FOTP Parolee	<input type="text" value="No"/>
FOTP Priority Status	<input type="text" value="99902-None or not Applicable"/>



Medical/Physical Health: The Medical/Physical Health screen is the last required screen necessary to complete the Admission. The Pregnant at Admission field is read only and is prepopulated from the Intake screen.

Medication Prescribed as Part of Tx- Outpatient and Residential programs will always select **None**. *For OTP, select the medication from the dropdown menu.*

Medical/Physical Health

# of Times Emergency Room in Past 30	<input type="text"/>	Medi-Cal Beneficiary	<input type="text"/>
# of Hospital Overnights in Past 30 Days	<input type="text"/>	Medication Prescribed as Part of Tx	<input type="text"/>
# of Days Medical Problems in Past 30	<input type="text"/>	Communicable Diseases: Tuberculosis	<input type="text"/>
HIV Tested	<input type="text"/>	Communicable Diseases: Hepatitis C	<input type="text"/>
HIV Test Results Received	<input type="text"/>	Communicable Diseases: STD	<input type="text"/>
Pregnant at Admission	0-No		

Mental Health

Mental Illness Diagnosed	<input type="text"/>	
# of Times Outpatient Emergency MH Services in Past 30 Days	<input type="text"/>	
# of 24hr Psychiatric Facility Stays in Past 30 Days	<input type="text"/>	
Mental Health Medication in Past 30 Days	<input type="text"/>	
Suicide Attempts	<input type="text"/>	Was the attempt in the last 30 days? <input type="text"/>

Click **Save** to save the Admission record, then click the **Right Arrow** button to complete the **Diagnosis** and the **Treatment Team** screens.

NOTES



DIAGNOSIS



Note: Enter a client's diagnosis *within the Admission* section. If diagnosis is entered via the *Diagnosis List*, ensure the **effective date** is the **admission date**.

DHCS requires providers to diagnose each client to identify medical necessity in order to bill DMC for treatment services. Completing the diagnosis screen will save time when creating encounters for service claims.

To ensure the diagnosis prepopulates into the encounter screen, enter the diagnosis in the Diagnosis screen within the Admission record. Diagnosis is a subsection in the Admission and is not required to complete an admission. To add a diagnosis, from the Activity List:

Click Admission → Diagnosis



Enter the diagnosis within the Admission record using the **date of admission** as the effective date. The system generated **12:00 AM** time is accurate.



IMPORTANT: Ensure that the **Effective Date** prepopulated with the **admission date** and the **Time** prepopulated with **12:00 AM**.

To add a diagnosis, click **Edit Diagnosis**.

Client Diagnosis **Edit Diagnosis**

Primary Effective Date Time

Select **Behavioral** as the Type of diagnosis. You must select a substance use disorder diagnosis with **DSM-5** Descriptor. Change the Principal Diagnosis to **Yes**. Only one diagnosis can be marked as a principal diagnosis. Click **Save**.

Client Diagnosis

Type

Diagnosis Principal Diagnosis

Comments

At the bottom right of the screen, click **Finish** to go back to the main Diagnosis screen.

Behavioral Diagnosis

Actions	Code	Description	Comments	Principal
				Yes

Medical Diagnosis

Actions	Code	Description	Comments	Principal

Psychosocial Diagnosis

Actions	Code	Description	Comments	Principal

On the Diagnosis screen within the Admission record, click **Save** and **Finish**.



Changing Diagnosis

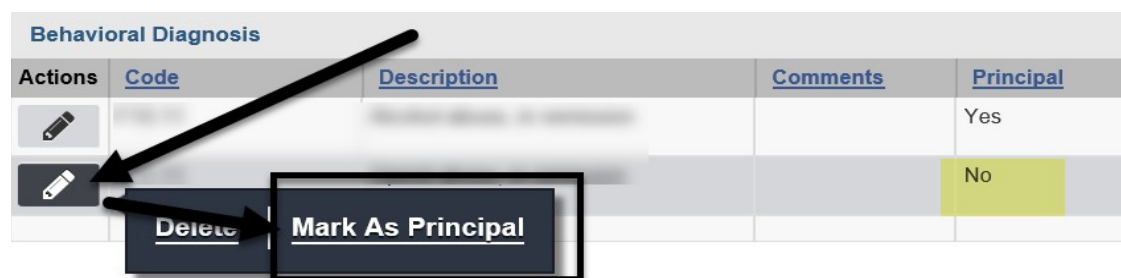
A client's diagnosis should only be changed if an error was made. If corrections are necessary, the user must go to the source of the diagnosis for editing.

Example: If a diagnosis is created in the Admission section, corrections cannot be made to the record via the Diagnosis Summary screen; the user must open the Diagnosis screen in the Admissions section for the Edit Diagnosis function.

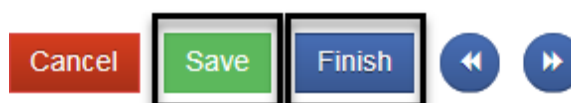
If the client's diagnosis is not identified as the Principal Diagnosis, an edit may be necessary. To edit a diagnosis within the **Admission** record, click **Diagnosis**, and click **Edit Diagnosis**.



From the Actions column, select **Mark As Principal**.



In order to save the updated information, it is necessary to click **Save** and **Finish** again.





TREATMENT TEAM

The Treatment Team in SanWITS is designed to assign program staff members to the client's treatment team.

The client's treatment team may include, at a minimum, a counselor as the primary care member and a case manager, if available. Only one staff member may be designated as the client's primary care staff. To assign a staff member to the treatment team, from the navigation pane:

Click Admission → Treatment Team



Click Add Team Member.



The team member fields are activated and must be completed.



Below are additional considerations in completing the team member screen.

The Staff Name field is not highlighted in yellow, but it is a required field. Click the dropdown menu and select the staff member's name from the table.

Staff Name 

The Start Date is the date the staff member is assigned to the client's treatment team. Enter the start date.

Start Date 

If the staff member is assigned indefinitely to the treatment team, leave the End Date field blank. If the staff member is assigned within a specific date range or the staff is no longer part of the client's treatment team, enter the date the staff assignment ended.

End Date 

The Review Member field defaults to No and should be changed to **Yes** to enable the staff member to review the client record.

Review Member

The Primary Care Staff field defaults to No. If the staff member is the primary care staff, select Yes. If the staff member is not the primary care staff, do not change the prepopulated information. Only one staff may be selected as the primary care staff.

Primary Care Staff

The Deny Access to Client Records field is prepopulated with No. Do **not** change the information in order for the staff member to be able to access and review the client record.

Deny Access to Client Records

Review the completed staff member information for accuracy. Click **Save** and **Finish**.





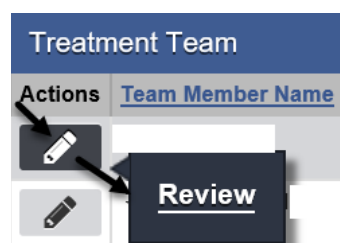
Repeat the same steps to add additional staff members to the client's treatment team.

After adding each staff member, the treatment team screen displays all team members. At a glance, the list shows the staff member, the primary care staff, review staff, role or relationship of member to the client, start date and end date of assignment to the treatment team.

Treatment Team						
Actions	Team Member Name	Is Primary Care Member?	Review Member	Role/Relation	Start Date	End Date
		Yes	Yes	Counselor	8/1/20	
		No	Yes	Case Manager	8/1/20	

To update the staff member's information, hover over the pen in Actions and click **Review**. Make the necessary changes, then click **Save** and **Finish**.

If the staff member changes or a staff member is no longer with your facility, enter an end date for the specific staff member. Add the new staff member as needed.



IMPORTANT: View the Activity List to make sure all activities are marked as Completed. Status must show as completed for the records to upload to the State. If In Progress, follow the steps on the Activity List section of this manual to view missing details and fill in the missing information. If the diagnosis summary is not listed on the Activity List, the entered diagnosis was not marked as primary. Refer to the Changing Diagnosis section of this manual and mark the diagnosis as principal.

Client Activity List				
Actions	Activity	Activity Date	Created Date	Status
	Client Information (Profile) →	4/1/2020	6/17/2020	Completed
	Intake Transaction	4/1/2020	6/17/2020	Completed
	Admission →	4/1/2020	6/17/2020	Completed
	ASAM Summary	4/1/2020	8/23/2020	Not Applicable
	Diagnosis Summary →	6/17/2020	6/17/2020	Not Applicable

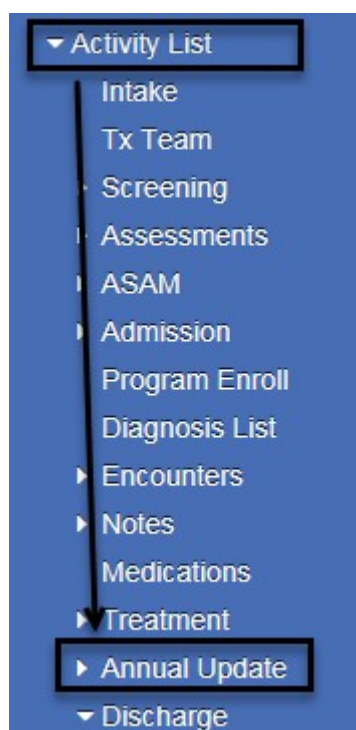


ANNUAL UPDATE

The Annual Update must be completed **no prior** than the **10th** month and **no later** than the **11th** month from the client's admission to the facility.

The steps to complete an annual update are similar to the steps to complete an admission. To add an annual update, from the navigation pane:

Click Activity List → Annual Update




Majority of the screens are the same as the admission screens.





Complete the CalOMS Annual Update/Follow-Up Profile screen by entering the date of the annual update. Click the **Right Arrow** button.


CalOMS Annual Update/Follow-Up Profile

CalOMS Annual Update Date 

CalOMS Annual Update #

Record Status

Record Created By <input type="text"/>	Created Date <input type="text"/>
Last Updated By <input type="text"/>	Last Updated Date <input type="text"/>
CalOMS Form Serial # <input type="text" value="W"/>	Last Upload to State Date <input type="text"/>

[Mark as Deleted](#) **Cancel** **Save** **Finish** 

The remaining Annual Update screens are the same as the Admission record screens. Complete all the screens, then **Save** and **Finish**.

NOTES



DISCHARGE



Note: A program enrollment must be ended prior to completing a client discharge.

Changing Level of Care (LOC)

Complete a Discharge record and open a new episode when there is a change in the level of care (LOC) from:

- 1) OS to IOS and vice versa
- 2) OTP courtesy dosing to regular OTP
- 3) Residential Service 3.1/3.5 to IOS or Recovery Services and vice versa
- 4) Residential Service 3.1/3.5 to Residential 3.2 WM and vice versa

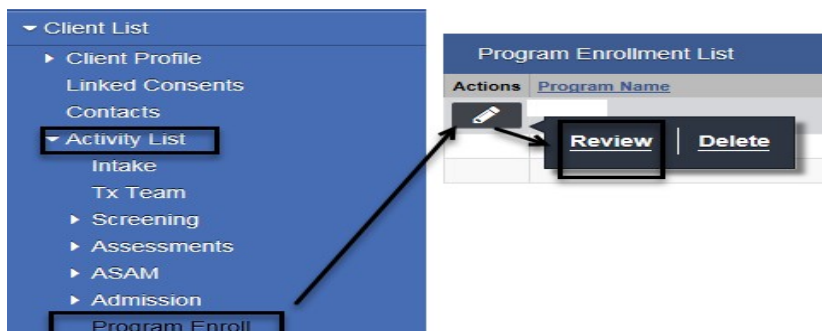
Close the program enrollment prior to completing a Discharge record. After the program enrollment is closed and all client activities have been completed, complete a Discharge record in SanWITS, and then close the treatment episode.

After closing the case, open a new episode for the new LOC. Open a program enrollment for the new LOC under the new episode. Opening a program enrollment is covered in a separate section on the Outpatient and Residential Encounters Training Manuals.

Closing a Program Enrollment

After the client completes the treatment, the client needs to be discharged. However, the program enrollment must be closed first. To close a program enrollment from the navigation pane:

Click Activity List, then click **Program Enroll**. Hover over the pen in Actions and click **Review**.





Enter the date of discharge on the **End Date** field.

Select a **Termination Reason**. Enter comments on the **Notes** field.

Click **Save** and **Finish**.

Program Enrollment Profile

Facility

Program Name

Program Staff

PS Court Phase

Start Date

End Date

Perinatal

Termination Reason

Notes

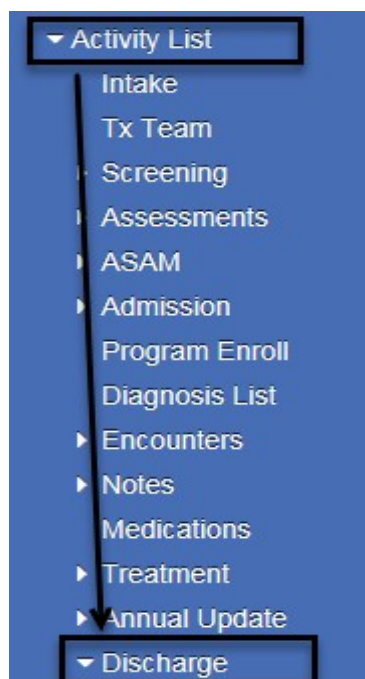
Administrative Actions

Cancel Save Finish

Completing a Discharge

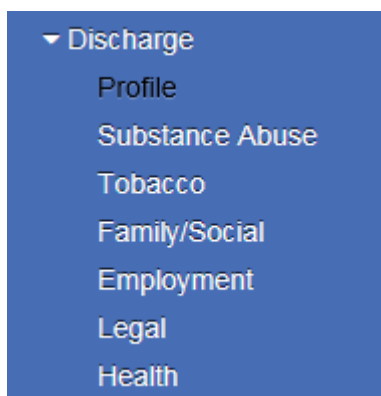
After the client is discharged and all activities have been completed, discharge the client in SanWITS. To complete a discharge from the navigation pane:

Click Activity List → Discharge






Majority of the screens are the same as the admission and annual update screens.



Complete the Discharge Profile screen and click the **right arrow** button.

Discharge Profile

Discharge Date  Admission Date

Discharge Status

Ancillary Services Referral Ancillary Services
0-None/No Other
1-Education/Literacy
2-Mental Health
3-Medical


Selected Ancillary Services

Record Status

Record Created By Created Date

Last Updated By Last Updated Date

CalOMS Form Serial # Last Upload to State Date

[Mark as Deleted](#) 

Complete the other screens and click **Save**.

After fully completing the Discharge record, click **Finish**.

The system displays the message: "Client is discharged. Do you want to close this case also?"



The episode should be closed once the billing has been completed. Select **Yes** or **No**.

Client is discharged. Do you want to close this case also?

Yes	No
-----	----



Reminder: *1) Complete a Discharge record when the level of care (LOC) is changed from OS to IOS and vice versa, from Residential Service 3.1/3.5 to IOS or Recovery Services and vice versa, or from Residential 3.2 WM to Residential Service 3.1/3.5 and vice versa. After a Discharge record is completed, open a new episode for the new level of care. 2) After a Discharge record is completed and the client returns to the program, open a new episode for the re-admission, even if the level of care is the same as the prior admission.*

NOTES



CAPACITY LIST

The Capacity List provides a list of all ODS Programs in San Diego County. To view the Capacity List from the navigation pane:

Click Capacity List



The Capacity List displays the number of available program slots to help locate availability in the appropriate program for a client.

Capacity List Search

Modality	<input type="text"/>	Program Name	<input type="text"/>
Facility GeoCode	<input type="text"/>	Beds/Slots Available	<input type="text"/>
Agency Name	<input type="text"/>	Facility Name	<input type="text"/>
Age Group	<input type="text"/>	Gender Specific	<input type="text"/>

Capacity List							
Actions	Agency/Facility	Facility City	Program	Modality	Available Program Slots	# on Readiness List	Age/Gender
	...	San Diego	ODS RES 3.1	ODS RES 3.1	62	0	Adult/Male and Female
	...	San Diego	ODS RES 3.1	ODS RES 3.1	50	0	Adult/Female
	...	San Diego	OS	ODS OS	0	0	None/Female
	...	san diego	IOS	ODS IOS	19	0	None/None
	...	san diego	OS	ODS OS	20	0	31-40/Male and Female
	...	san diego	OS	ODS OS	30	0	None/None
	...	san diego	OTP	ODS OTP	29	0	None/None



CONSENT AND REFERRALS

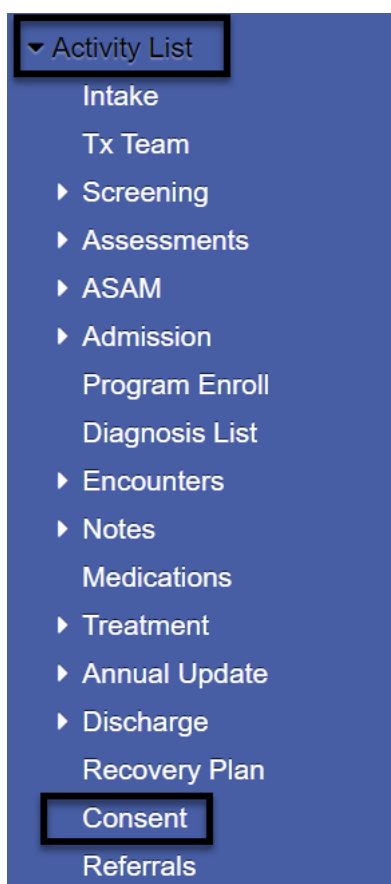
The Consent and Referrals Modules in SanWITS are designed for two entities to share client information. Disclosure agreements must first be signed by the two entities, and, for the features to work, there must be a client episode.

The electronic Consent and Referrals work in tandem. However, Consent is independent of Referrals, whereas Referrals are dependent on Consent.

A. Consent

The Consent Module allows a facility to share specific client information to another facility. In addition to the entities signing disclosure agreements, a client must also sign a consent form authorizing the information to be disclosed to a specific agency and facility. To create a consent in SanWITS, from the navigation:

Click Activity List → Consent





To the right of the Consent screen, click the link **Add New Client Consent Record**.

Client Consent List				
Actions	Start Date	Disclosed To	Status	Signed?

Add New Client Consent Record

On the question 'Is this related to a readiness list record?', select **No**.

Is this related to a readiness list record?

The Client Disclosure Agreement screen launches.

Client Disclosure Agreement

Note: Consented information may not be redisclosed.

Client Name: [Redacted]
 Unique Client Number: [Redacted]
 Disclosed From Agency: [Redacted]

Entities with Disclosure Agreements: [Dropdown]
 System Agency: Yes

Disclosed To Agency: [Dropdown] Facility: [Dropdown]

Disclosed To Entity (Non System Agency): [Dropdown]

Purpose for disclosure: Treatment [Dropdown]

Earliest date of services to be consented: [Date Picker]

Has the client signed the paper agreement form: No Date client signed consent: [Text]

Client Information To Be Consented

Expiration Type: [Dropdown]

*Expiration type is required for disclosure activities.

Client Information Options

- Admission
- ASAM
- Client Information (Profile)
- Client Screening
- Consent
- CONTINUUM™
- Court Cage Assessment

Disclosure Selection

Comments: [Text Area] Other Disclosures: [Text Area]



On the Disclosed to Agency field, select from the dropdown menu the agency the client information is being disclosed to. The selected agency will then prepopulate on the Entities with Disclosure Agreements field. After selecting the agency name, the Facility field prepopulates with 'All Facilities'. The user may leave the information as is or select a specific facility from the dropdown menu.

Entities with Disclosure Agreements

System Agency Yes

Disclosed To Agency → Facility

Disclosed To Entity (Non System Agency)

Select the purpose for the disclosure of client information.

Purpose for disclosure

Enter the earliest date of record that is being disclosed to the entity. For example, the client admission is being shared and the admission date is 02/02/2020, then 02/02/2020 should be entered on this field. If the date entered is later, such as 02/03/2020, the receiving agency/facility will not be able to view the admission.

Earliest date of services to be consented

If the client signed the agreement in paper form, select **Yes**. Enter the date and the reason the paper form was signed. If the client will sign electronically, select **No**. Electronic signatures will be covered after the Consent form is completed and saved.

Has the client signed the paper agreement form Date client signed consent

Electronic signature skip reason

Select the Expiration Type, and enter the number of days to set the consent expiration date.

Client Information To Be Consented

Expiration Type + Days

*Expiration type ies

Discharge(UD)
Date Signed(DS)
Other Event(OE)
Crim Just Cond (CJC)

Disclosure Selection



After completing the consent form, click **Save**.



If the client did not sign a paper form, the system opens the electronic signatures page. Allow the client to affix his electronic signature in the Signature of participant section, and click **Accept Signature**. To complete the witness signature, click the link **Enable Signature Capture** and sign. Click **Finish**.

Signature of participant:

Signature of witness:

[Enable Signature Capture](#)

The disclosure agreement becomes read only.

If the client is being referred to the same facility, click the link **Create Referral Using this Disclosure Agreement**. Referral is covered in a separate section of this manual.

Client Disclosure Agreement

Note: Consented information may not be redisclosed.

Client Name: [Redacted]

Unique Client Number: [Redacted]

Disclosed From Agency: Residential Train

Entities with Disclosure Agreements: [Redacted]

System Agency Yes

If a client referral is not completed at this time, click **Finish** to return to the main navigation pane.

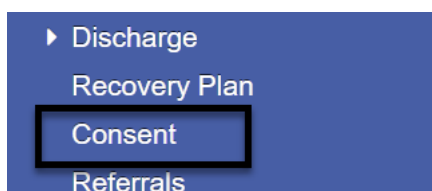




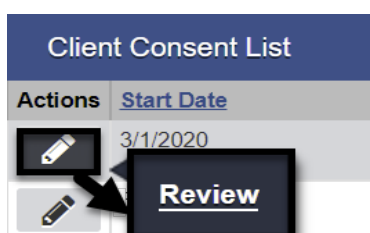
Revoking a Consent

A completed consent can be revoked. A revoked consent stops sharing of newly created records. However, it does not stop the receiving agency or facility from viewing the records that were previously consented. To revoke a consent, from the navigation pane within the Activity List:

Click **Consent**.



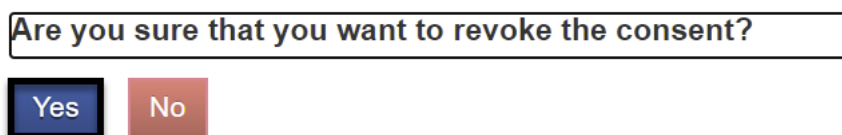
Hover over the pen in Actions and click **Review**.



At the bottom of the disclosure agreement, click **Revoke**.



Another page opens up, displaying at the top of the screen a confirmation question. To confirm revocation of the consent, click **Yes**.



On the Client Consent List, the status of the consent is updated as Revoked.

Client Consent List					Add New Client Consent Record
Actions	Start Date	Disclosed To	Status	Signed?	
	3/1/2020	San Diego County	Revoked	Yes	



Viewing a Consent

A receiving agency or facility must have completed the required agreements before viewing consented client records. To view a consented record, from the navigation pane:

Click **Client List**.

- Dashboard
- Clinical Dashboard
- ▶ Client List

Enter the client information in the Client Search section. Click **GO**.

Client Search

Agency <input type="text" value="OTP Training"/>	Facility <input type="text"/>
First Name <input type="text"/>	Last Name <input type="text"/>
SSN <input type="text"/>	DOB <input type="text"/>
SanWITS Training Client Id <input type="text"/>	Provider Client ID <input type="text"/>
Unique Client Number <input type="text"/>	Primary Care Staff <input type="text"/>
Treatment Staff <input type="text"/>	Intake Staff <input type="text"/>
Case Status <input type="text" value="All Clients"/>	Number Type <input type="text"/>
Other Number <input type="text"/>	
Include Only Active Consents <input type="text" value="Yes"/>	

Clear
Go

At the bottom of the Client Search screen, the system displays the name of the disclosing agency and the client's identifying information.

Client List [\(Export\)](#) [Add Client](#)

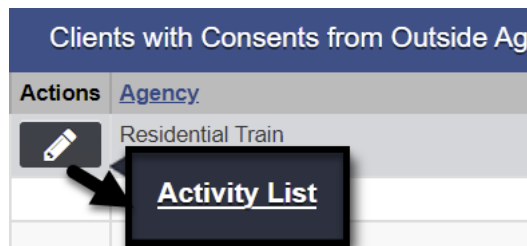
Actions	Unique Client #	Full Name	DOB	SSN	Gender
				99902	Female
				99902	Female

Clients with Consents from Outside Agencies

Actions	Agency	Unique Client #	Client Name	DOB	SSN	Gender
	Residential Train		Optum, Consent		99902	Male



To open and view the consented records, hover over the pen in Actions and click **Activity List**.

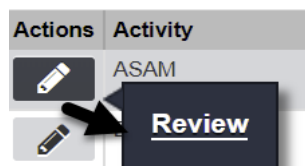


The read-only records are displayed in the Consented Activity List.

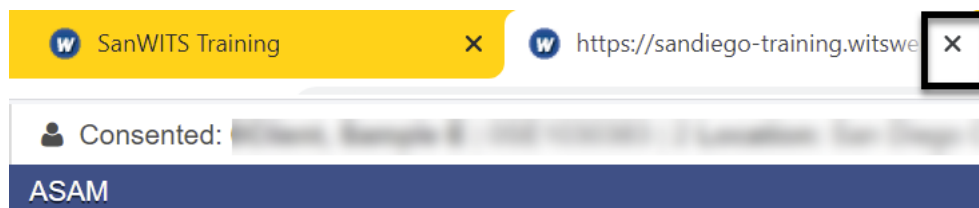
Consented Activity List					
PROHIBITION ON REDISCLOSURE OF INFORMATION CONCERNING CLIENT IN ALCOHOL OR DRUG ABUSE TREATMENT					
This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.					
Actions	Activity	Case #	Activity Date	Created Date	Status
	ASAM	2	5/1/2020	6/4/2020	Completed
	Diagnosis List	1	1/17/2020	1/17/2020	Completed
	Client Information (Profile)	2	1/1/2020	3/19/2019	Completed

IMPORTANT: The system opens a new tab for each consented record. In order for the feature to work and be able to open the records, the browser's pop up blocker must be turned off. If the program's security system does not allow the pop up blocker to be turned off, add the SanWITS website as a trusted site. If unable to view the consented records, email SUD_MIS_Support.HHSA@sdcounty.ca.gov.

Select the record to be viewed, then hover over the pen in Actions and click **Review**.



The record is launched on a new tab. After reviewing the record, click the **x** at the top right corner of the tab to close it and return to the Consent screen.





To view the next consented record, click the link **Return to Consented Activity List** and repeat the same steps.

Consented Activity View

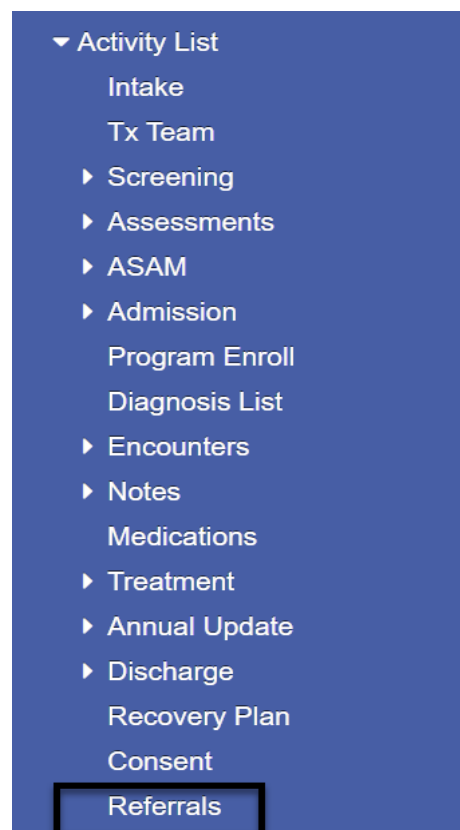
Note: Consented information may not be redisclosed.

[Return to Consented Activity List](#)

B. Referrals

Referrals reduce data entry by automatically creating a new client profile when the referral is accepted. After an electronic Consent is completed, an electronic Referral can be created. To create a referral, from the navigation pane:

Click Activity List → Referrals



To the right of the Referral screen, click the link **Add New Client Referral Record**.





It is important that an electronic consent must be completed first in order for an electronic referral to be generated.

Another path in creating a referral is within the completed consent record. To the right of the screen, click Create Referral Using this Disclosure Agreement.



The Referral screen launches showing two main sections. The Referred By on the left refers to the referring agency. The Referred To on the right refers to the agency or facility receiving the client referral.

Complete the electronic referral form following the policies and guidelines set forth by the County and the entities involved.

After completing the form, click **Save** and **Finish**.

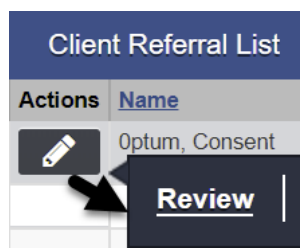




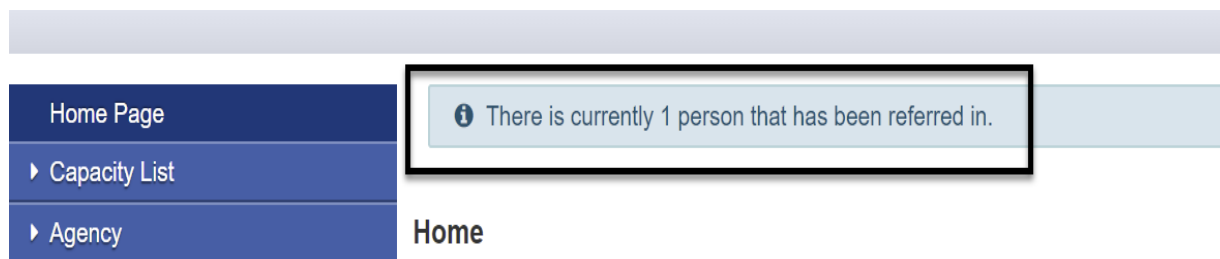
The system returns to the Referral screen displaying the completed referral as pending.

Client Referral List						Add New Client Referral Record
Actions	Name	Referred To Agency	Referred To Facility	Non System Agency	Referred To Modality	Referral Status
		OTP Training	OTP Facility		ODS OTP	Referral Created/Pending

To review the referral completed, hover over the pen in Actions and click **Review**. A referral may be updated while it is on a pending acceptance status. After the referral is accepted, it may not be edited.



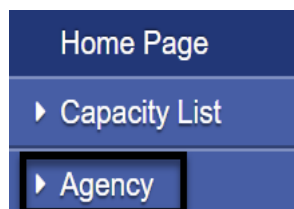
After the referral is completed and saved, the system automatically sends an alert to the receiving agency that a client has been referred. The alert is displayed at the top of the Home Page screen.



Locating Referrals

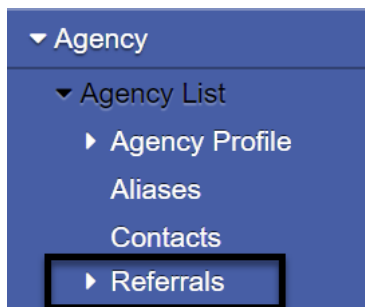
To locate an electronic referral, from the navigation pane:

Click **Agency**.

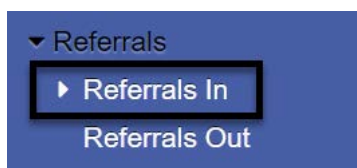




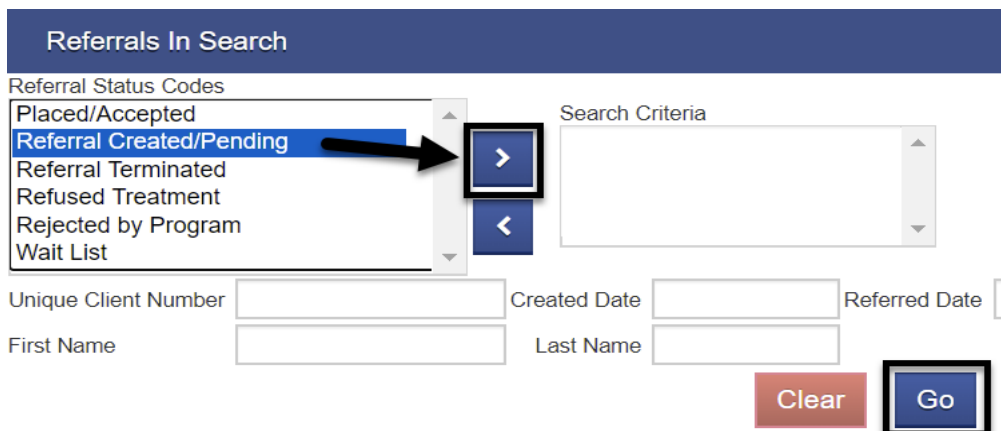
Click **Referrals**.



Click **Referrals In**.



On the Referrals In Search screen, select **Referral Creating/Pending**. Click **GO**.



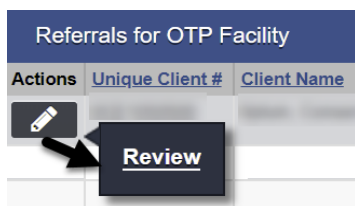
The system displays a list of referrals showing the client identifying information.

Referrals for OTP Facility									(Export)
Actions	Unique Client #	Client Name	DOB	Created Date	Referring Agency/Facility	Referred To Modality	Referral Status	Ref to Facility	Referral Comments
		Optum, Consent		8/6/2020	Residential Train/RES Train 2	ODS OTP	Referral Created/Pending	OTP Facility	



Accepting Referrals

After locating the referral, review the referral. To accept, hover the pen in Actions and click **Review**.



The completed Referral screen launches. Complete the two required fields and click **Finish**.

Referral

Referred By

Agency Residential Train

Facility RES Train 2

Staff Member [Redacted]

Program RES Train 2/ODS 3.1 RES : 3/1/2020 -

State Reporting Category NOT APPLICABLE

Reason Service not available at this facility

If Other [Redacted]

Is Consent [Redacted]

Is Conso [Redacted]

Continue This Episode [Redacted]

Comments [Redacted]

Referral Status **Referral Created/Pending**

Projected End Date [Redacted]

Created Date 8/6/2020 3:59 PM

Referred To

Signed Consents OTP Training

Agency OTP Training **Kept appointment**

Facility OTP Facility **No Show**

Staff Member [Redacted] **Not kept appointment**

Program OTP (1.0 - OTP) **Other**

State Reporting Category NOT APPLICABLE **Rescheduled**

Non-System Agency [Redacted] **Reserved For Contracting Agency**

Non-System Modality [Redacted] **Scheduled**

Non-System Specifier [Redacted]

Appt Date [Redacted] **Undetermined**

Consents Granted

Consent Date: 8/1/2020

Disclosure Domains: Admission (DS, +365)

Cancel **Finish**

IMPORTANT: Once a referral is placed/accepted, the action may not be reversed and a new client profile is automatically created.

NOTES



UNFINISHED CLIENT ACTIVITIES REPORT

The Unfinished Client Activities Report may be utilized for monitoring client activities that have been completed. Only designated staff in each program will have access to the report that they are authorized to use.

Run this report twice a month, prior to the 1st and 15th of the month.

Home Page

▶ Agency

Authorization Dashboard

Residential Unit Dashboard

▶ Residential Unit Mgmt

▶ Client List

▶ System Administration

Reports

Report Title Contains: **Go**

Report Catalog

Title	Access
Admissions: Client Demographics	
Agency Client Movement	
Client Demographic by Substance	
Program Client Movement	
Referrals in by Agency	
Referrals out by Agency	
Waitlist by Agency, Facility & Program	
	QA/QC
Program Enrollment Counts	
Client List by Program	
Agency/Facility Client Terminations	
Unfinished Client Activities	

Unfinished Client Activities

Choose Agency(s)...

Agency

Choose Facility(s)

Available Facilities Selected Facilities

Choose Case Status

Choose Activity(s)

Available Activities: Annual Update, ANSA Assessment, ASAM, ASAM Summary

Selected Activities: Admission, Client Information (Profile)

Select the primary care staff name

On Screen **Export** **Cancel**

1. Click on "Reports" from the Navigation Pane
2. Click "Unfinished Client Activities"
3. Select your facility(ies)
4. From Available Activities, select "Admission" and "Client Information (Profile)"
5. Select "On Screen" to view the information on screen
6. Select "Export" to view on an Excel spreadsheet



TIMELINESS OF RECORDS

ASAM		
Due Date	OS/OTP	Residential
Initial Assessment	At Intake	At Intake
Follow up Assessment	90 days	30 days

ADMISSION		
Due Date	OS/OTP	Residential
Initial	7 days	24 hours
Re-admission	7 days	24 hours

ANNUAL UPDATE	
Due Date	10th month - 11th month

DISCHARGE		
Due Date	OS/OTP	Residential
Planned	7 days	24 hours
Unplanned	37 days	24 hours

NOTES



GLOSSARY

ASAM	American Society of Addiction Medicine
BHS	Behavioral Health Services
CalOMS	California Outcomes Measurement System
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
EBP	Evidence Based Practices
FSN	Form Serial Number
HHSA	Health and Human Services Agency
ODS	Organized Delivery System
OTP	Opioid Treatment Program
SanWITS	San Diego Web Infrastructure for Treatment Services
SUD	Substance Use Disorder
TX	Treatment
UCN	Unique Client Number



CONTACT INFORMATION

CalOMS, SanWITS, End User Support

SUD_MIS_Support.HHSA@sdcounty.ca.gov

Phone: 619-584-5040

Fax: 1-855-975-4724

Clinical Processes and Documentation

QIMatters.HHSA@sdcounty.ca.gov

General Billing and Training on Billing

ADSBillingUnit.HHSA@sdcounty.ca.gov

SanWITS Training Registration

www.regpacks.com/DMC-

ODS 1-800-834-3792 x3

CalOMS Tx Data Collection Guide & Dictionary, Manuals, and Forms

www.optumsandiego.com

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

