



# SUBSTANCE USE DISORDER MIS TREATMENT PLAN TRAINING



LIVE WELL  
SAN DIEGO

*Live Well San Diego*

**County of San Diego  
Behavioral Health Services**



## TABLE OF CONTENTS

TABLE OF CONTENTS.....	2
CONFIDENTIALITY.....	3
SANWITS SOFTWARE BASICS.....	4
CLINICAL DASHBOARD.....	5
FLY-OUT MENU.....	7
TREATMENT PLANS IN SANWITS.....	9
Overview of Treatment Plans.....	9
Design of Treatment Plans.....	10
CREATING INITIAL TREATMENT PLANS.....	11
Printing Treatment Plans.....	15
Panels.....	16
Completion Requirements.....	17
Profile.....	17
Diagnosis.....	19
Client Information.....	20
Problems, Goals, and Action Steps.....	23
Interventions.....	28
Client Signature.....	30
Staff Signatures.....	34
RESOLVING GOALS AND ACTION STEPS.....	36
UPDATING TREATMENT PLANS.....	37
WITHDRAWAL MANAGEMENT TREATMENT PLANS.....	40
ACCESSING TREATMENT PLANS.....	42
Searching Treatment Plans.....	43
Viewing Treatment Plans.....	46
TIMELINESS OF RECORDS.....	48
BHS SUD INSTRUCTIONS FOR COMPLETING TREATMENT PLANS.....	49
Initial Treatment Plan Instructions.....	49
Updated Treatment Plan Instructions.....	53
Withdrawal Management Treatment Plan Instructions.....	57
GLOSSARY.....	61
CONTACT INFORMATION.....	62

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



---

## **CONFIDENTIALITY**

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

**HIPAA regulations mandate that all client information be treated confidentially.**

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

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

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

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

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

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

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

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





---

## **SANWITS SOFTWARE BASICS**

- San Diego Web Infrastructure for Treatment Services (**SanWITS**) is accessed through <https://sandiego.witsweb.org>. **Save this address to your favorites or create a shortcut for your desktop.**
- **NAVIGATE** by using function links, icons, ellipses, buttons, signs, or arrow keys.
- **BACK < BUTTON** pulls up the previous screen, usually a search screen. The back arrow in the internet browser does not pull up the previous screen.
- **CLIENT LIST** allows a client search or activates/hides the **Fly-Out** menu.
- **FUNCTION LINKS** are underlined links allowing certain actions to be completed. Most function links are preceded by a plus sign (+) and are usually near the upper corner of the page.
- **SYSTEM REQUIRED FIELDS** are indicated with a solid  or striped  orange bar on the left side of the field. The solid orange fields must be completed to save the screen and move forward. The system allows saving of the record with the striped fields left blank, but the activity will display as incomplete (In Progress).
- **SYSTEM GENERATED FIELDS** are in gray. Nothing can be changed or added in these fields.
- **GO** executes a change in agency or facility.
- **SEARCH** loads data and/or launches new screens.
- **CANCEL** returns to the previous screen without saving the data entered.
- **SAVE** stores the information entered and, in certain screens, adds multiple records of data.
- **FINISH** returns the user to the first screen of the module or activity.

### **Reminder:**

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

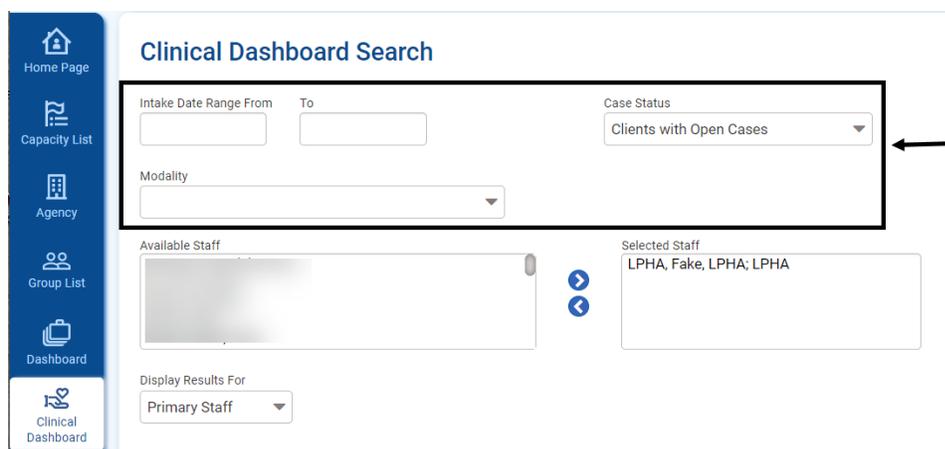


## CLINICAL DASHBOARD

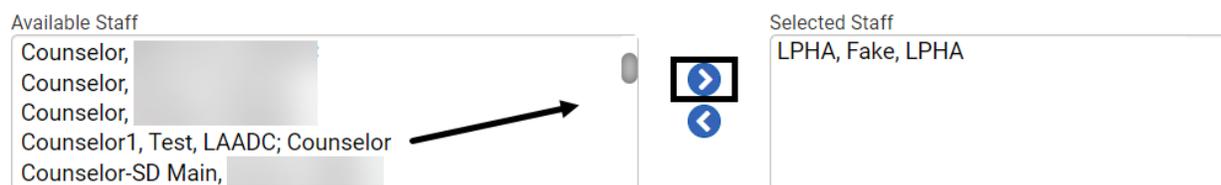
The Clinical Dashboard displays clients who are assigned to a primary staff or to a treatment team. The counselors can view their assigned clients and can also launch a client's electronic chart directly from the clinical dashboard. To open the Clinical Dashboard from the navigation pane, click **Clinical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



To search and pull up a specific set of clients, complete the Clinical Dashboard Search parameters. The Case Status field defaults to Clients with Open Cases.

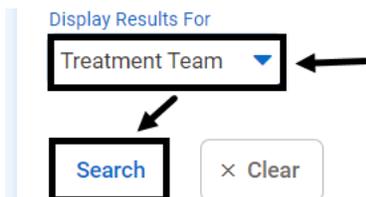


The Selected Staff defaults to the staff who is logged in. Clinicians can access their own caseloads only. Clinical supervisors may access the clinical dashboards of all clinicians within the facility. Select the staff and click the right arrow key.





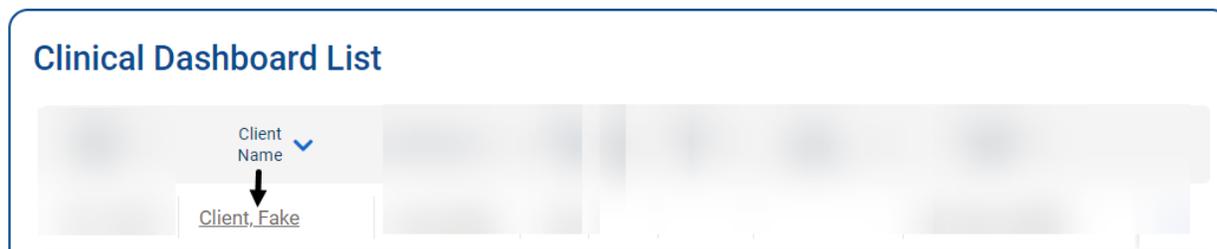
The Display Results For field defaults to Primary Staff. For best results, change it to **Treatment Team**, and click **Search**.



The Clinical Dashboard List can be sorted by any of the column titles, such as Intake Date, Client Name, ASAM Date, DDN Date, Admission Date, Treatment Plan Finalization Date, and so forth.

Intake date	Client Name	ASAM Date	DDN Date	Admission Date	Treatment Plan Finalization Date	Modality	Last Encounter Date	Discharge date	Case Closed	Primary Staff
4/7/2022	<a href="#">Client, Fake</a>			4/7/2022		,ODS OS,				Counselor, Fake, CAADE
3/10/2022	<a href="#">Optum, Test</a>	3/15/2022	3/21/2022	3/10/2022	3/21/2022	,ODS OS,				Counselor, Fake, CAADE
12/10/2021	<a href="#">Super, Treatment</a>	12/10/2021	12/10/2021	12/10/2021		,ODS OS,				LPHA, Fake, LPHA LPHA

In the Client Name column, click the **client's name** to pull up the client record.



Make sure that all treatment records are completed in a timely manner.

The client is removed from the clinician's dashboard as soon as the episode is closed or when the clinician is removed from the client's treatment team.

## **NOTES**



## FLY-OUT MENU

Additional information in the Client Profile and the Activity List can be accessed through the Client List Fly-Out Menu.

The screenshot shows the 'Client Profile Workspace' interface. On the left is a vertical navigation menu with icons and labels: Home Page, Capacity List, Agency, Group List, Dashboard, Clinical Dashboard, Client List, and System Administration. A fly-out menu is open from the 'Client List' icon, listing: Client List, Client Profile (expanded), History, Payor Group Enrollment, Authorization, Allergies, Linked Consents, Contacts, Activity List, and Episode List. The main content area is titled 'Client Profile Workspace' and contains a 'Profile' form with the following fields:

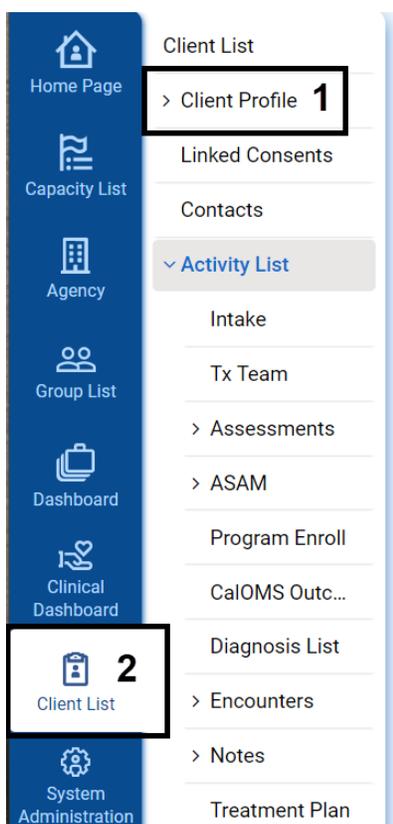
Current First Name: Fake	Middle Name:	Current Last Name: Client	Birth First Name: Fake
Birth Last Name: Client	Mother's First Name:	Sex:	Gender Identity:
DOB:	No Readmit Until:	Provider Client ID:	SSN:
Driver's License #:	Driver's License State:	Medicaid #:	Date of Death:
Place of Birth County:	Place of Birth State:	Consent on File for Future Contact:	Has Paper File:
State Client No:	State Client ID (UCN):		
Record Created By:	Created Date Time:	Last Updated By:	Last Updated Date Time:

A client record must be opened first to access the Fly-Out menu. To access the Fly-Out menu from the Profile screen, click **Client List**.

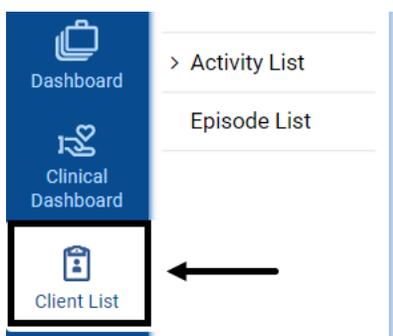
This close-up shows the 'Client List' fly-out menu. The 'Client List' option at the bottom of the menu is highlighted with a black box, and a black arrow points to it from the right. The menu items are: Profile (expanded), Additional Information, Alternate Names, Contact Information, Collateral Contacts, and Other Numbers.



To view the additional options under Client Profile while the Activity List is on expanded view or if any record in the Activity List is open, first click **Client Profile** and then click **Client List**.



To hide or unhide the Fly-Out menu or to toggle between Activity List and Client Profile, click **Client List**.





## TREATMENT PLANS IN SANWITS



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

### Overview of Treatment Plans

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

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

After the client profile and contact records are completed and medical necessity has been determined through the Initial Level of Care (ILOC) and Diagnosis Determination Note (DDN), the client is assigned to a treatment team and enrolled in a treatment program. The CalOMS (California Outcome Measurement System) admission record must also be completed as part of the client treatment plan process.

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



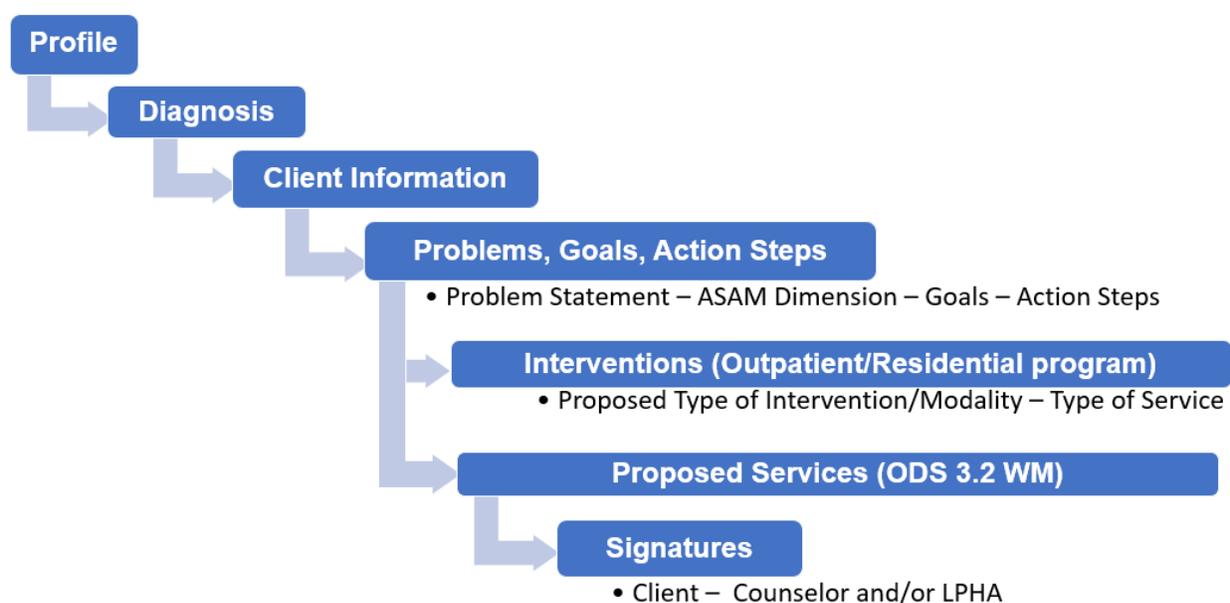
The **SUD QM resources**, such as SUDPOH, SUDURM, tip sheets, and important announcements for detailed instructions for completing a treatment plan, can be accessed through the Drug Medi-Cal Organized Delivery System (DMC-ODS) page of the Optum website at [www.optumsandiego.com](http://www.optumsandiego.com).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



## Design of Treatment Plans

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

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



A treatment plan goes through different stages as it is developed in SanWITS.

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

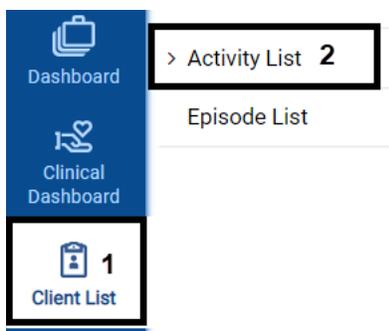
The signature buttons are hidden when the plan is *In Progress*. After the plan is completed and the client signature is collected, the plan is *Pending Signature*. If the completed plan was signed by a counselor, the plan is *Pending Finalization*, and the system notifies the LPHA for review and finalization. After the plan is reviewed and signed by the LPHA, it is in a *Finalized* stage.



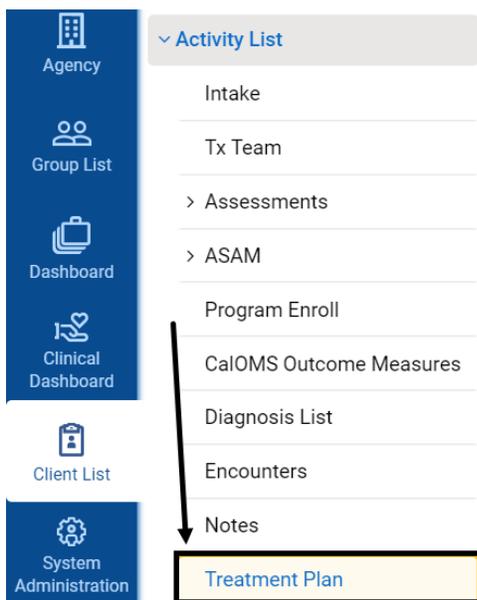
## CREATING INITIAL TREATMENT PLANS

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

An initial treatment plan is completed for a client admitted to Outpatient and Residential Programs. To create an initial treatment plan after the Client Profile is launched, click **Client List** from the navigation pane. The Fly-Out menu opens. Click **Activity List**.



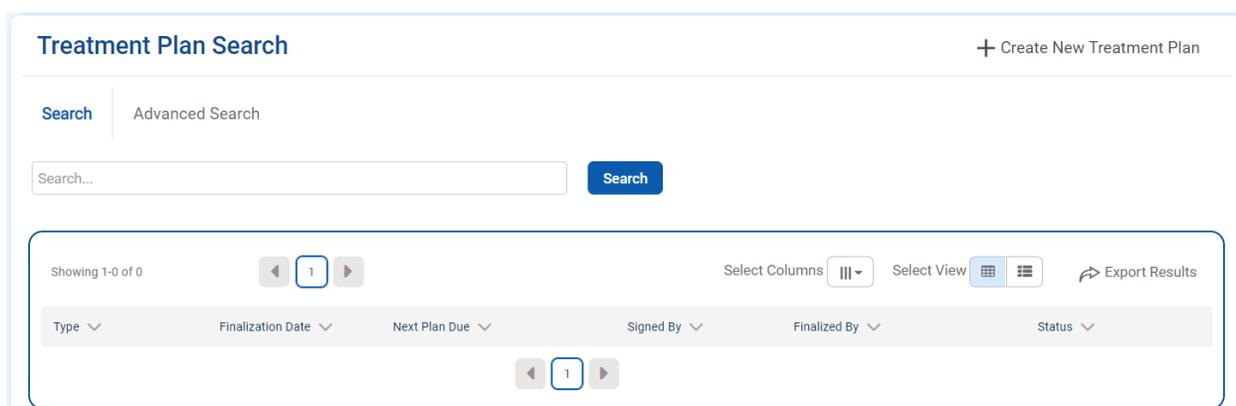
Under the expanded Activity List, click **Treatment Plan**.



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



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

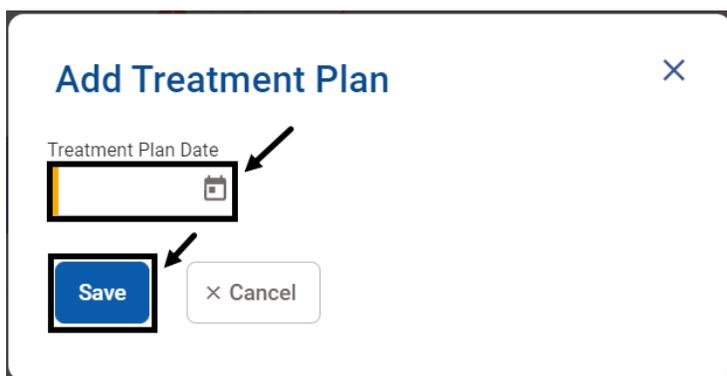


To continue creating the initial treatment plan, click **Create New Treatment Plan**.



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

To continue adding a treatment plan, enter the Treatment Plan Date and click **Save**.



The treatment plan date should be on or after the client's program enrollment. It cannot be earlier than the program enrollment and cannot be a future date.



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

The Treatment Plan Date must be on or after the program enrollment date ✖

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

Treatment Plan Date cannot be a future date. ✖

The Treatment Plan workspace launches if there is no error message, and it is ready for completion.

The screenshot shows the 'Treatment Plan' workspace. At the top left is a back arrow and the text 'Treatment Plan' with a refresh icon. To the right is a yellow button that says 'DONE EDITING' and a set of utility icons (print, download, add, remove, info). Below this is a sidebar menu with 'Profile' selected. The main content area is divided into two columns. The left column is titled 'Profile' and contains a table with the following data:

Status	Type	Treatment Plan Date
In Progress	Initial	4/4/2022
Team Member Name	Role	
Counselor, Fake, CAADE	Counselor	
LPHA, Fake, LPHA	LPHA	

The right column is titled 'Completion Requirements' and contains a list of items: 'Client Information', 'Problems, Goals, and Action Steps', 'Interventions', and 'The plan requires a finalized DDN'.

To return to the Treatment Plan Search screen, click the **Back** button.

This screenshot is identical to the previous one, but a black box highlights the back arrow icon in the top left corner, with a black arrow pointing to it.

To reopen the treatment plan workspace, hover over the ellipsis and click **Edit**.

The screenshot shows a table with the following columns: Type, Finalization Date, Next Plan Due, Signed By, Finalized By, and Status. The first row has the following values: Initial, (empty), 07/02/2022, (empty), (empty), and In Progress. A dropdown menu is open over the 'In Progress' status cell, showing three options: 'Delete', 'Edit', and 'View'. The 'Edit' option is highlighted with a black box and a black arrow.



There are several action buttons in the top right of the treatment plan.



The system automatically saves responses to questions. If there are interruptions and it is necessary to pause from completing the form, it is best to click **Done Editing** to lock the treatment plan from editing.



Click **Edit** to enable editing of the treatment plan.



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



## NOTES

---

---

---

---

---

---

---

---



## Printing Treatment Plans

The standard print button opens the print window. However, it is best to click the **Generate Report** button, then select **Treatment Plan Report** to convert the treatment plan to an Acrobat Adobe document before printing it.



Below is a sample of the upper section of an initial treatment plan converted to an Acrobat Adobe format.

Client Name: Client, Fake

UCN:

### Initial Treatment Plan

CLIENT INFORMATION			
<b>Name:</b> Fake Client		<b>UCN:</b> <input type="text"/>	<b>Admission Date:</b> 04/04/2022
<b>Team Member Name:</b>	<b>Role:</b>		
Counselor, Fake, CAADE	Counselor		
LPHA, Fake, LPHA	LPHA		
Diagnosis List			
Diagnosis	Effective Date	Principal	Provisional
			Diagnosis Clinician
			Source

### NOTES

---



---



---



---



---



**Note:** For best printing results, select the **Generate Report** button instead of the standard print option.



## Panels

The Treatment Plan is divided into 3 sections. The left side contains the panel headers, the right side shows the completion requirements, and the middle section is the actual treatment plan form.

The screenshot shows the 'Treatment Plan' interface. On the left is a sidebar with a 'Profile' panel selected. The main area displays the 'Profile' form with fields for Status (In Progress), Type (Initial), Treatment Plan Date (4/4/2022), Team Member Name (Counselor, Fake, CAADE), Role (Counselor), and LPHA (Fake, LPHA). On the right, the 'Completion Requirements' sidebar is visible, listing Client Information, Problems, Goals, and Action Steps, and Interventions. A 'DONE EDITING' button is at the top right.

Select a panel title to navigate to a particular panel.

This screenshot shows the 'Client Information' panel selected in the sidebar. The main form area contains a dropdown for 'Was a physical exam completed in the last 12 months?', a section for 'Assessments Reviewed' with checkboxes for ASI or YAI, ASAM LOC Recommendation, Risk Assessment, Health Questionnaire, and Other, and another dropdown for 'If client's preferred language is not English, were linguistically appropriate services provided?'. The 'Client Information' item in the 'Completion Requirements' sidebar is highlighted with a black box.

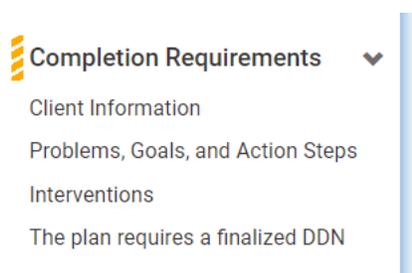
## NOTES



## Completion Requirements

The Completion Requirements section validates the proper completion of the treatment plan. This section also alerts the counselors and LPHAs which panels are incomplete. When a panel is completely filled in, it is cleared from this section.

A treatment plan can be created even if there is no finalized DDN in the system. However, the Completion Requirements will indicate that the plan requires a finalized DDN. The LPHA must complete and finalize a DDN before a treatment plan can be finalized.



The client and staff signatures are hidden when there are panels listed in the Completion Requirements.

## Profile

The Profile panel displays the Status, Type, Treatment Plan Date, and Team Member Names.





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

**Type-** For the first plan that is created, the type is Initial.

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

**Team Member Name-** A Treatment Team must include, at a minimum, a counselor (or an LPHA) and must be entered before creating a treatment plan because the team member names are pulled from the Treatment Team screen and cannot be changed in the treatment plan.



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



To add or remove a team member, a staff with administrative roles and/or full access to the Treatment Team screen will make the changes in the Treatment Team screen. If the *pending* treatment plan is open, exit out of the plan and then re-open it to refresh the team member names.

Changes to the Treatment Team screen do not pull forward into a *finalized* treatment plan. Refer to the SUDPOH for more information.

### Diagnosis

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

Diagnosis						
Diagnosis	Effective Date	Expiration Date	Principal	Provisional	Diagnosing Clinician	Source
F10.10 - Alcohol use disorder, Mild	04/04/2022		Yes	No		Diagnosis Determination Note

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

## NOTES

---



---



---



---



---



---



## Client Information

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

▼ **Client Information**

Was a physical exam completed in the last 12 months?

Assessments Reviewed

ASI or YAI

ASAM LOC Recommendation

Risk Assessment

Health Questionnaire

Other

If client's preferred language is not English, were linguistically appropriate services provided?

What does the client want to change on this updated treatment plan from the previous treatment plan? (Use client's own words.)

Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals)

**Was a physical exam completed in the last 12 months?**- If a physical examination has not been completed in the last 12 months, select **No**. The Related Goal field is then activated and must be completed.

▼ **Client Information**

Was a physical exam completed in the last 12 months?

→ × ▼

Related Goal



The Related Goal field starts out blank, displaying the error message 'No matches found'. A goal to obtain a physical examination under the Biomedical Conditions and Complications ASAM Dimension must be added. *Refer to the Problems, Goals, and Action Steps Panel section for the steps to adding a goal.*

Related Goal

No matches found

After a Biomedical Conditions and Complications goal is entered, return to the Related Goal section to select it.

Related Goal

Client will obtain a physical examination within 30 days

If a physical examination has been completed within the last 12 months, select **Yes**. The Date of physical exam field is then activated. Enter the **Date of physical exam**.

Was a physical exam completed in the last 12 months?

Yes

→

Date of physical exam

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

Has client provided a copy of the results?

No

→

Related Goal

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

- Assessments Reviewed
- ASI or YAI
  - ASAM LOC Recommendation
  - Risk Assessment
  - Health Questionnaire
  - Other



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

If client's preferred language is not English, were linguistically appropriate services provided?

Explanation

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

What does the client want to achieve from treatment? (Use client's own words)

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

Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals)

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

 Completion Requirements ▾

Problems, Goals, and Action Steps

Interventions

## NOTES



## Problems, Goals, and Action Steps

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

▼ Problems, Goals, and Action Steps

**Problem # 1**

Problem Statement

ASAM Dimensions

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional, Behavioral, or Cognitive Conditions and Complications
- Readiness to Change
- Recovery/Living Environment
- Relapse, Continued Use, or Continued Problem Potential

**Goals**

Goal (Specific & Quantifiable)	Target Date	Resolution Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

+ Add Goal

**Action Steps**

Action Step	Target Date	Resolution Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

+ Add Action Step

+ Add Problem

## NOTES



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

To add an additional problem statement, click **Add Problem**.

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

To delete a problem, click **Remove**.

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



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

The treatment plan must contain at least one Problem. **x**

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

**Goals**

Goal (Specific & Quantifiable) Target Date Resolution Date

**Resolution Date-** For the initial treatment plan, leave the Resolution Date field blank and do not enter a resolution date.

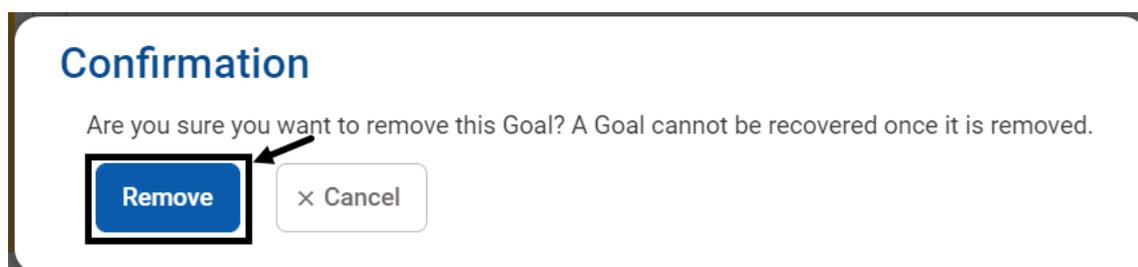
Resolution dates are discussed in this manual but in a separate section- **RESOLVING GOALS AND ACTION STEPS.**

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

To remove a goal, click **Remove**.



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



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



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



**Resolution Date-** For the initial treatment plan, leave the Resolution Date field blank and do not enter a resolution date.

Resolution dates are discussed in this manual but in a separate section-  
**RESOLVING GOALS AND ACTION STEPS.**

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





To remove an action step, click **Remove**.

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

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



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

## NOTES

---

---

---



## Interventions

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

▼ Interventions

Proposed Type of Intervention / Modality for Successful Goal Completion (include proposed frequency)

Outpatient Services (OS)  Weekly

Additional MAT

Type of Services

Individual Counseling

Group Counseling

Case Management

Collateral Services

Patient Education

Other

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

Proposed Type of Intervention / Modality for Successful Goal Completion (include proposed frequency)

Outpatient Services (OS)

Weekly ←



Enter the frequency of services if the CPE is Intensive Outpatient Services (IOS)

Proposed Type of Intervention / Modality for Successful Goal Completion (include proposed frequency)

Intensive Outpatient Services (IOS)

Weekly ←

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

Proposed Type of Intervention / Modality for Successful Goal Completion (include proposed frequency)

Daily Residential Treatment

3.1 - Clinically Managed Low-Intensity Residential Service

Proposed Type of Intervention / Modality for Successful Goal Completion (include proposed frequency)

Daily Residential Treatment

3.5 - Clinically Managed High-Intensity Residential Service

Enter the additional MAT services, if any.

Additional MAT

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

Type of Services

Individual Counseling

Group Counseling

Case Management

Collateral Services

Patient Education

Other

↓



## Client Signature

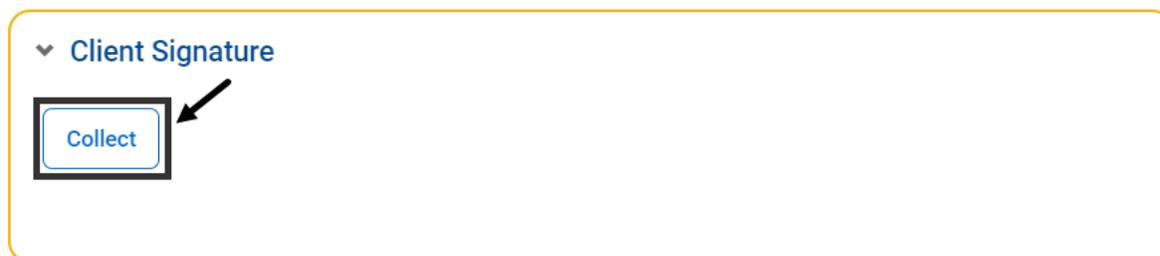
The client signature button is hidden when the treatment plan is pending completion. The Completion Requirements section displays the panels that are incomplete.

### Completion Requirements

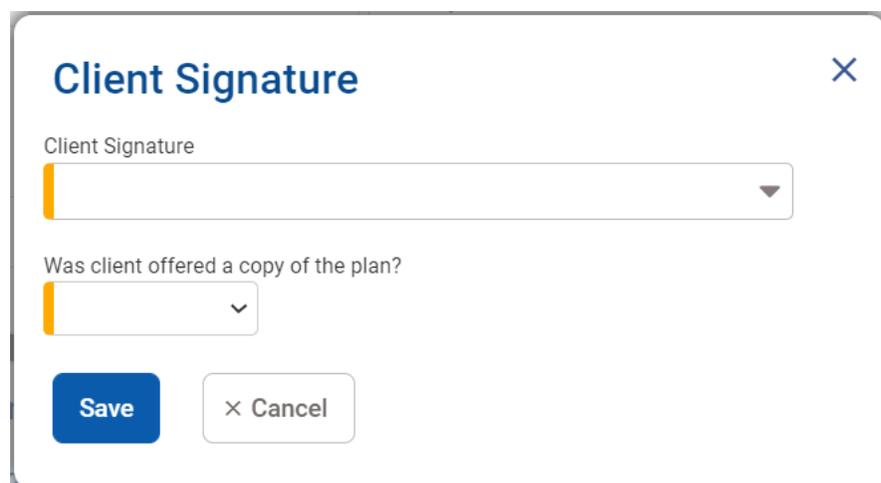
Client Information

Problems, Goals, and Action Steps

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



The Client Signature window launches.



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



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

Client Signature

Electronic  
Paper  
Refused

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

## Client Signature

Client Signature

Electronic

Signature

Sign here

Sign Clear

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

Was client offered a copy of the plan?

Yes

Save

Cancel



If the client was not offered a copy of the treatment plan, select **No**. Explain in the **Reason** field, and click **Save**.

Was client offered a copy of the plan?

No

Reason

Save × Cancel

**Paper Signature-** Select **Paper** if the client signed on paper and explain in the **Reason** field. Refer to the SUDPOH and the treatment plan instructions for guidelines. Respond to the question, 'Was client offered a copy of the plan?' Click **Cancel** to clear the answers. Click **Save** to accept the answers.

**Client Signature** ×

Client Signature

Paper

Reason

Was client offered a copy of the plan?

Save × Cancel

## NOTES

---

---

---



**Refused to Sign-** Select **Refused** if the client refused to sign. In the **Reason** field, explain and also indicate the strategy that will be used to engage the client in completing the treatment plan. Refer to the SUDPOH and the treatment plan instructions for guidelines. Respond to the remaining question and click **Save**.

**Client Signature** [X]

Client Signature  
Refused [X] [v]

Reason  
[Text Area]

Was client offered a copy of the plan?  
[Dropdown]

[Save] [X Cancel]

**Confirmation-** The Confirmation message provides one last opportunity to clear or accept the client signature. Select **Cancel** to clear the client signature. Click **Ok** to accept and lock the treatment plan for changes, except for the resolution dates on goals and action steps.

**Confirmation**

Are you sure you want to collect the client's signature? This cannot be undone, and you will no longer be able to edit the treatment plan, except for goal and action step resolution dates.

[Ok] [X Cancel]



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



The system automatically stamps the signature date and time.

▼ Client Signature

Client Signature  
Electronic

*Client*

Was client offered a copy of the plan?  
Yes

Signature Date/Timestamp  
04/14/2022 11:07 AM ←

After the Client Signature panel is completed, the status of the treatment plan changes to *Pending Signature*.

▼ Profile

Status  
Pending Signature ←

### Staff Signatures

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

**Counselor-** If a counselor prepared the treatment plan, click **Sign**. The system will notify the LPHA that the signed plan is ready for review and finalization.

▼ Staff Signatures

**Sign** ←



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



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



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



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

Type	Finalization Date	Next Plan Due	Signed By	Finalized By	Status
Initial	04/14/2022	07/02/2022	Counselor, Fake, CAADE	LPHA, Fake, LPHA	Finalized

## NOTES



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



## RESOLVING GOALS AND ACTION STEPS

Document the actual completion dates of established goals and action steps using the **Resolution Date** fields in the Problems, Goals, and Action Steps panel. Follow the treatment plan instructions and SUDPOH guidelines on resolution dates.

To enter the resolution dates from the Treatment Plan Search screen, locate the finalized treatment plan. Hover over the ellipsis and click **Edit**.



Scroll down to the Problems, Goals, and Action Steps panel.

In the **Resolution Date** fields, enter the dates the goals and action steps were completed. The system automatically saves the dates.

### Goals

Goal (Specific & Quantifiable)  
Client will learn at least 3 aspects of relapse prevention.

Target Date  
05/03/2022

Resolution Date

Goal (Specific & Quantifiable)  
Client will participate in relapse prevention groups to reduce cravings of use by 50%.

Target Date  
05/03/2022

Resolution Date

### Action Steps

Action Step  
SUD counselors will provide client with relapse prevention workbook and practice with client at least 2 times per week.

Target Date  
05/03/2022

Resolution Date

Action Step  
Client will participate in relapse prevention group at least once per week.

Target Date  
05/03/2022

Resolution Date

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





## UPDATING TREATMENT PLANS

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

The steps in adding an updated treatment plan in SanWITS are the same as creating an initial treatment plan.

This section covers only the sections that are different for updated treatment plans.

### **Add Treatment Plan**

The Add Treatment Plan window includes an additional question for updated plans.

Select **Yes** to pre-fill the problems, goals, action steps, and interventions with information from the most recent finalized plan. Select **No** to open a blank treatment plan.

**Add Treatment Plan** ×

Treatment Plan Date

Pull forward problems, goals, action steps, and interventions from the most recent finalized plan?

No

Yes

**Save** × Cancel



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



## Profile

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

▼ Profile

Status  
In Progress

Type  
Updated

Treatment Plan Date  
4/14/2022

## Client Information

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

▼ Client Information

Was a physical exam completed in the last 12 months?  
[Dropdown menu]

Assessments Reviewed

- ASI or YAI
- ASAM LOC Recommendation
- Risk Assessment
- Health Questionnaire
- Other

If client's preferred language is not English, were linguistically appropriate services provided?  
[Dropdown menu]

What does the client want to change on this updated treatment plan from the previous treatment plan? (Use client's own words.)  
[Text area]

Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals)  
[Text area]



## Problems, Goals, and Action Steps

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

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

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

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

**Goals**

Goal (Specific & Quantifiable)	Target Date	Resolution Date
Client will learn at 3 aspects of relapse prevention.	<input type="text"/>	<input type="text"/>
Client will participate in relapse prevention groups to reduce cravings of use by 50%.	<input type="text"/>	<input type="text"/>

+ Add Goal

**Action Steps**

Action Step	Target Date	Resolution Date
SUD counselors will provide client with relapse prevention workbook and practice with client at least 2 times per week.	<input type="text"/>	<input type="text"/>
Client will participate in relapse prevention group at least once per week.	<input type="text"/>	<input type="text"/>

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



## WITHDRAWAL MANAGEMENT TREATMENT PLANS

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

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

### Profile

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

▼ Profile

Status  
In Progress

Type  
Withdrawal Management

Treatment Plan Date  
4/14/2022

### Client Information

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

▼ Client Information

Was a physical exam completed in the last 12 months?

Assessments Reviewed

- Initial LOC Assessment
- Health Questionnaire
- Risk Assessment
- Observation Log
- Other



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



## Proposed Services

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

**Proposed Services**

*At least one proposed service must be entered.*

Observation

**Daily**

Medication Services

**Daily**

Individual Counseling

Group Counseling

Case Management

Collateral Services

Patient Education

Other

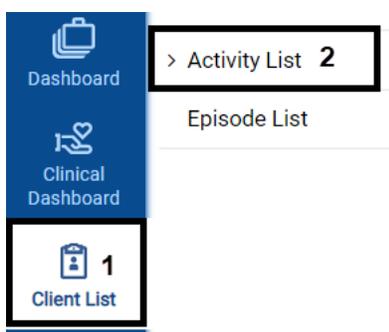
Review the treatment plan for accuracy, and then complete the signatures.



## ACCESSING TREATMENT PLANS

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

To access an entered treatment plan after the Client Profile is launched, click **Client List** from the navigation pane. The Fly-Out menu opens. Then click **Activity List**.



Find the Treatment Plan Summary in the Client Activity List. Hover over the ellipsis and click **Review**.

Activity	Activity Date	Created Date	Status	
Client Information (Profile)			Completed	⋮
Intake Transaction			Completed	⋮
Adult Initial Level of Care			Finalized	⋮
Diagnosis Summary			Completed	⋮
ASAM Summary			Not Applicable	⋮
Diagnosis Determination Summary			Not Applicable	⋮
Client Program Enrollment (ODS OS)			Completed	⋮
Treatment Plan Summary			Not Applicable	⋮

A box highlights the 'Treatment Plan Summary' row. A callout box with an arrow points to the ellipsis icon in the 'Treatment Plan Summary' row, containing the text 'Review'.



## Searching Treatment Plans

The Treatment Plan Search screen launches.

Treatment Plan Search + Create New Treatment Plan

Search Advanced Search

Search... Search

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

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

**Search** Advanced Search

Search... Search

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

Search **Advanced Search**

Search... Search

Click **Add Search Criteria**.

My Saved Searches ▼ | Manage Saved Searches

**+ Add Search Criteria**



Select the primary search filter from the dropdown menu.

Complete the remaining search specifications.

When a primary filter is selected, a secondary filter populates with a default value. To change the default value, click the dropdown menu and select one from the list.

To add an additional search filter, repeat the same steps.

To remove the search criteria, click **X**.

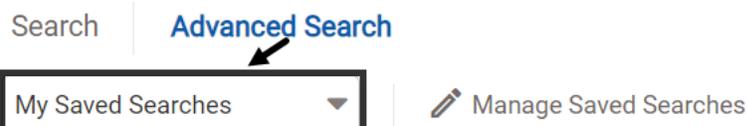
To complete the advanced search, click **Search** or **Advanced Search** again.

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

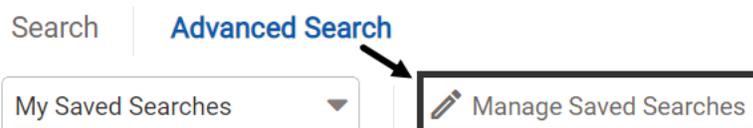
Enter the name of the search template and click **Save**.



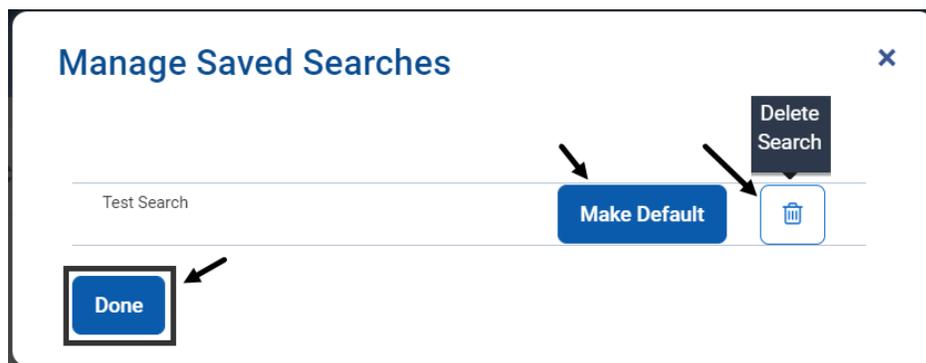
To use a saved search template, click **My Saved Searches** and select the saved template.



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



Click **Make Default** to make a saved template the default search or click **Delete Search** to remove it. Click **Done**.



## NOTES

---

---

---

---

---

---

---

---



## Viewing Treatment Plans

To view an existing treatment plan from the Treatment Plan Search screen, hover over the ellipsis and click **View** to review or **Edit** to update the plan.

Type	Finalization Date	Next Plan Due	Signed By	Finalized By	Status	
Updated		07/12/2022			In Pro	
Initial	04/14/2022	07/02/2022		LPHA, Fake, LPHA	Finaliz	

Navigation: < 1 >

Context Menu: Delete, Edit, View

The Delete option is active while the plan is in progress. If the Delete button is not available, then the treatment plan has been signed or the staff has no access to delete a treatment plan.

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

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

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

If View or Edit was selected, the system launches the treatment plan. If view was selected, click **Edit** to make changes to a pending plan.

**< Treatment Plan** 

 **EDIT**     

**Profile**

Diagnosis	Status	Type	Treatment Plan Date
Client Information	In Progress	Updated	04/14/2022
Problems, Goals, and Action Steps	Team Member Name	Role	

**Completion Requirements**

- Client Information
- Problems, Goals, and Action Steps





## TIMELINESS OF RECORDS

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

### NOTES

---



---



---



---



---



---



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



## **BHS SUD INSTRUCTIONS FOR COMPLETING TREATMENT PLANS**

The following instructions may also be downloaded from the DMC-ODS, SUDURM page on the Optum website at [www.optumsandiego.com](http://www.optumsandiego.com).

### Initial Treatment Plan Instructions

#### REQUIRED FORM:

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

#### WHEN:

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

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

#### COMPLETED BY:

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

#### **REQUIRED ELEMENTS (do not leave any blanks):**

##### **CLIENT INFORMATION**

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



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

**PROBLEM'S #1, #2, #3**

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



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

4. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.
- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
    1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
    2. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
    3. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.
  - **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).
  - **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

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

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

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

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

**TREATMENT PLAN SIGNATURES**

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



---

## Treatment Plan Training

- **For Residential:** All signatures must be in place within 10 days from the date of admission.
- If client **refuses to sign** the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.
- **Counselor/LPHA Name, Signature, and Date:** LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
  - **For Outpatient:** Counselors must sign the treatment plan within 30 days from the date of admission.
  - **For Residential:** All signatures must be in place within 10 days from the date of admission.
  - The date of LPHA/Counselor signature is considered the treatment plan completion date.
- **\*LPHA or MD Printed Name, Signature, and Date:** LPHA or MD legibly printed or typed name, signature with credentials and date of signature.
  - **For Outpatient:** The MD or LPHA has up to 15 days after the counselor's signature date to sign the treatment plan.
  - **For Residential:** All signatures must be in place within 10 days from the date of admission.



### Updated Treatment Plan Instructions

#### REQUIRED FORM:

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

#### WHEN:

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

- Outpatient Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 90 calendar days after signing the initial treatment plan, and not later than every 90 calendar days thereafter. (Note: Remember to complete the ASAM Level of Care form whenever completing an Updated Treatment Plan)
- For Residential Programs - when a change in problem identification or focus of recovery or treatment occurs, or no later than 30 calendar days after signing the initial treatment plan, and not later than every 30 calendar days thereafter. (Note: Remember to complete the ASAM Level of Care form whenever completing an Updated Treatment Plan)
- Level of Care Changes - If the client is assessed to meet criteria for a new level of care in the same program, the treatment plan must be updated within 7 calendar days (date of assessment + 6) to match the Actual Level of Care indicated on the LOC Recommendation Form, or as part of the next service attended by the client if no service is attended in 7 calendar days
- DDN Updates - If the DDN is updated, the treatment plan must be updated within 7 calendar days (date of assessment + 6) or as part of the next service attended by the client if no service is attended in 7 calendar days

#### COMPLETED BY:

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

#### REQUIRED ELEMENTS (do not leave any blanks):

- Client Name: Legibly print or type client's full name. (NOTE: to be entered on each page of the Treatment Plan)
- Client ID#: Legibly print or type client's SanWITS Unique Client Number (UCN). (NOTE: to be entered on each page of the Treatment Plan)
- Admission Date: Date client was admitted to program.
- Primary Counselor Name: Primary LPHA/Counselor's name.
- Case Manager Name: Case manager's name.
- DSM-5 Diagnosis(es): Enter the DSM-5 diagnosis. More than one diagnosis can be entered, but the Primary diagnosis must be a Substance Use Disorder.



- *The SUD diagnosis (or diagnoses) as documented by the MD or LPHA on the DDN must match on the treatment plan(s) and language shall be identical.*
- *ICD-10 codes are not required on the treatment plan; however, if ICD-10 codes are added to a treatment plan with the DSM-5 language for the diagnosis(es), they must match the verbiage of the DSM (and both language and codes must match the DDN).*
- **Date of the Last Treatment Plan:** Enter date of initial or previous Treatment Plan.
- **Date of Treatment Plan Update:** Enter date this treatment plan was completed.
- **Was a physical exam completed within the last 12 months?** Check the appropriate box.
  - If 'Yes' is checked, provide the date of the physical. Inform client that results of physical exam shall be submitted to program.
  - If 'No' is checked, then the goal to obtain a physical exam shall remain on the treatment plan.
- **If Yes, has client provided a copy of physical exam results?**
  - If 'Yes' is checked, MD must review results per SUDPOH requirements.
  - If 'No' is checked, then goal to obtain a physical exam must remain on treatment plan until provided and MD has reviewed results.
  - Check 'N/A' if client has not had a physical exam in the last 12 months and has not provided a copy
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?** Check the appropriate box; if No, explain in detail.
- **What does the client want to change on their current treatment plan from the previous treatment plan?** Attempt to obtain client's expectations regarding continuing treatment services and document using the client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.
- **Current Needs at Time of Treatment Plan Update:** Check the appropriate box after assessing the client's progress on their treatment plan goals and appropriate level of care. Then, enter client's Recommended Level of Care and Actual Level of Care based on the information from the ASAM Level of Care form that was completed with this treatment plan update.

**PROBLEM'S #1, #2, #3**

- **Select related ASAM Dimension:** Check appropriate box(s). Review all 6 ASAM Dimension criteria to assess which box(s) to check.
- **Problem Statement:**
  - Personalize problem(s) unique to the client.
  - Write problems in client language and *prioritize* (emergent, realistic for completion, what is needed to prevent relapse?)
  - If a physical health concern is identified (e.g., pregnancy or lack of a physical in the last 12 months), this needs to be addressed in one of the problem areas on the plan.
  - Multiple related issues may be combined into one problem statement that fall under the same ASAM dimension(s). For example, a client may have multiple Bio-medical issues, such as needing a physical exam, follow up care on diabetes, and dental work



which could all be incorporated into one problem as they are all related to ASAM dimension 2.

- If the client cannot demonstrate having had a physical exam within 12 months prior to admission to treatment, problem must identify lack/need for a physical exam.
- Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; then a problem may be that the client needs to address appropriate treatment for the illness and a goal to address the health need must be included on the treatment plan.
- **Goal(s):** What do the client and program want to accomplish? Use “SMART” acronym (Specific, Measurable, Attainable, Realistic, Time-Related):
  1. Goals must be measurable and achievable.
  2. If multiple problems are grouped together, then include a specific goal to resolve each of the specific problems.
  3. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
  4. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.
- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
  1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
  1. Include specific actions the client will do to reach their goals (e.g., Client will identify a list of potential doctors and contact at least 1 to schedule an appointment to complete a physical).
  2. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.
- **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).
- **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

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

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



frequency of each service.

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

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

#### TREATMENT PLAN SIGNATURES

- Client was offered a copy of the plan: Check Yes or No; if No, document why.
- Client Printed Name, Signature, Date: Client must legibly print name, sign, and date.
  1. The client must be present and participate in the treatment plan to bill for treatment plan services.
  2. Client signature provides evidence of client participation and agreement with the Individual Recovery/Treatment Planning process.
    - For Outpatient: Client must sign within 90 days from the previous treatment plan's completion date.
    - For Residential: All signatures must be in place within 30 days from the previous treatment plan.
    - If client refuses to sign the treatment plan, please document reason for refusal and the strategy that will be used to engage client for participation in treatment plan. Future attempts to obtain the client's signature on the treatment plan should be documented in progress notes.
- Counselor/LPHA Name, Signature, and Date: LPHA/Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of completed Individual Treatment Plan.
  - For Outpatient: Counselors must sign the treatment plan within 90 days from the previous treatment plan's completion date.
  - For Residential: All signatures must be in place within 30 days from the previous treatment plan.
  - The date of LPHA/Counselor signature is considered the treatment plan completion date.
- \*LPHA or MD Name, Signature, and Date: LPHA or MD legibly printed or typed name, signature with credentials and date of completed Individual Treatment Plan.
  - For Outpatient: The MD or LPHA has up to 15 days after the counselor's signature date to sign the treatment plan.
  - For Residential: All signatures must be in place within 30 days from the previous treatment plan.



### Withdrawal Management Treatment Plan Instructions

#### REQUIRED FORM:

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

#### WHEN:

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

- Withdrawal Management – within 72 hours of admission to program
  
- Level of Care Changes - If the client is assessed to meet criteria for a new level of care in the same program, the treatment plan must be updated **within 7 calendar days (date of assessment 6)** to match the Actual Level of Care indicated on the LOC Recommendation Form, or as part of the next service attended by the client if no service is attended in 7 calendar days
  
- DDN Updates - If the DDN is updated, the treatment plan must be updated **within 7 calendar days (date of assessment + 6)** or as part of the next service attended by the client if no service is attended in 7 calendar days

#### COMPLETED BY:

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

#### REQUIRED ELEMENTS (do not leave any blanks):

##### CLIENT INFORMATION

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



- If 'No' is checked, then goal to obtain a physical exam must remain on treatment plan until provided and MD has reviewed results.
  - Since WM programs are short term in nature, and the physical exam goal may not be met while client is enrolled, the goal may also include language about linkage for physical exam as part of discharge planning. Please individualize the goal to each specific client's needs.
- Check 'N/A' if client has not had a physical exam in the last 12 months and has not provided a copy
- **Assessments/Forms Reviewed:** Check the appropriate boxes; if other, provide details.
- **If client's preferred language is not English, were linguistically appropriate services provided?**  
Check the appropriate box; if No, explain in detail.
- **What does the client want to obtain after Withdrawal Management services:** Document the client's expectations regarding treatment services and what the client hopes to gain from receiving services at the program. You may use client's own words.
- **Client Strengths/Resources/Abilities/Interests (to be used to reach treatment plan goals):** Use Motivational Interviewing techniques to obtain strengths-based client information to use when creating treatment plan goals.

**Goals Short Term and Long Term:**

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



specific problems.

3. If client has been identified as having a medical condition, a goal must be included for the client to address the condition.
  4. If the client has not received a physical exam within 12 months prior to admission to treatment, a goal that the client completes a physical examination must be included.
  5. Should a client demonstrate completion of a physical exam within 12 months prior to admission to treatment, and a significant medical illness has been identified; a client goal to obtain appropriate treatment for the illness must be included.
- **Action Steps:** Action steps to be taken by the LPHA/Counselor and/or client to accomplish identified goals:
    1. Include specific actions the LPHA/counselor will do while providing treatment services to the client (e.g., individual counseling, group, etc.) to help the client reach their goals. Include the use of evidence-based treatment interventions (e.g., Motivational Interviewing, Relapse Prevention) to be utilized, if applicable.
    2. Include specific actions the client will do to reach their goals (e.g., Client will follow medical advice during withdrawal and take medication as prescribed).
    3. If multiple problems are grouped together, then include a specific action step to accomplish each of the specific problem goals.
  - **Target Date(s):** Estimated date of completion per action step. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 target dates).
  - **Resolution Date(s):** Actual task completion date to be documented on the treatment plan after the treatment plan has been developed. Remember to document if the client did not complete a goal or action step when carrying over the same goal/action to the next plan. Dates to reflect each of the specific goals and action steps (i.e., if there are 3 goals, there will be 3 resolution dates).

#### **WITHDRAWAL MANAGEMENT PROPOSED SERVICES (INCLUDE FREQUENCY)**

(Observation should be every 30 minutes for at least 24 hours and then based on medical necessity)

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

#### **TREATMENT PLAN SIGNATURES**

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



plan.

- **Counselor Name, Signature, and Date:** Counselor's legibly printed or typed name, signature with degree and/or credentials, and date of signature.
  - **For Withdrawal Management:** Counselor must sign within 72 hours of client's admission to the program.
  - The date of Counselor signature is considered the treatment plan completion date.
- **\*LPHA or MD Name, Signature, and Date:** MD/LPHA legibly printed or typed name, signature with credentials and date of signature.
  - **For Withdrawal Management:** All signatures must be in place within 72 hours of client's admission to the program.

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



## **GLOSSARY**

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



---

## **CONTACT INFORMATION**

### **SanWITS System and End User Support**

[SUD MIS Support.HHSA@sdcounty.ca.gov](mailto:Support.HHSA@sdcounty.ca.gov)

Phone: 619-584-5040 (for password resets)

Fax: 1-855-975-4724

### **Clinical Processes and Documentation**

[QIMatters.HHSA@sdcounty.ca.gov](mailto:QIMatters.HHSA@sdcounty.ca.gov)

### **BHS SUD Instructions, Manuals, and Forms**

[www.optumsandiego.com](http://www.optumsandiego.com)

### **SanWITS Training Registration**

<https://www.regpack.com/reg/dmc-ods>

1-800-834-3792 x3

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

