ADMH SAIS

WITS Treatment User Guide

Version 1.0

Prepared by FEI Systems

Date 04/03/2024

FEI Systems

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Record of Changes

Table 1: Record of Changes

Version Number	Date	Author/Owner	Description of Change
0.1	5/13/2025	Scott Wilson	Initial Draft

1. INTRODUCTION

1.1. Purpose

This document covers the standard functionality of the WITS Treatment module for the state of Alabama's end users. This particular version of the WITS Treatment End User Guide covers workflows for agencies that do not need to complete the ADMH Placement Assessment during the client enrollment process.

This alternate workflow is determined by an attribute that is added to a provider agency. If an agency should have this attribute but does not, contact your WITS administrator for assistance.

Users will know their agency has this attribute because they will not be prompted to complete the ADMH Placement Assessment when trying to add a new outcome measure for the client.

1.2. Audience

The intended audience for this WITS User Guide is users tasked with managing client records in WITS. Users will need the appropriate clinical roles assigned to their WITS user accounts to perform the processes and actions described in this document.

2. GETTING STARTED

2.1. System Requirements

WITS is a web-based application that is accessible through the most up-to-date versions of the following web browsers:

- Google Chrome
- Microsoft Edge
- Apple Safari
- Mozilla Firefox

2.2. Pop-Up Blocker

Certain features in WITS, such as Snapshot and Scheduler, will open in a separate browser window. Ensure the browser allows pop-ups for the WITS application to avoid functionality issues.

For more information on how to disable the pop-up blocker, reference the smart guide *Disable Pop-Up Blocker*.

2.3. URL Links

2.3.1. Testing/Training Environment

NOTE: It is recommended that the user bookmark the following links for quick access to the WITS environments.

To access the testing/training environment, use the following link:
https://al-uat-sts.witsweb.org

As with all training and testing environments, the following rules apply.

- User account credentials will match that of the user's actual role unless otherwise specified.
- Only fictitious data should be entered into the system. DO NOT use data from an actual client.
- Keep all entered data professional.
- If adding an email address to a fictitious account, the domain should be set to @test.com.

2.3.2. Production Environment

To access the production environment, use the following link:

https://al.witsweb.org/

3. TREATMENT WORKFLOW

When a client comes into a treatment facility and requests services, there are multiple actions that must be completed and data that must be captured. To help facilitate step completion and accurate data collection, there is a workflow for navigating the WITS Treatment module.

NOTE: The workflow presented below is for provider agencies that do not need to complete the ADMH Placement Assessment. If your agency must complete the assessment, contact your AITS Administrator and have them provide you with the correct user guide (ADMH Treatment End User Guide).

Differences in this user guide include the following:

- ADMH Placement Assessment is not required. It will not display as a menu option under the Client Activity List.
- On the Outcome Measures screen, all fields will need to be completed for TEDS reporting.
    - Questions regarding tobacco use are optional and do not need to be completed.
- A diagnosis needs to be recorded for the client. This does not display as a required screen, but a primary diagnosis is required before service encounters can be recorded against a client record.

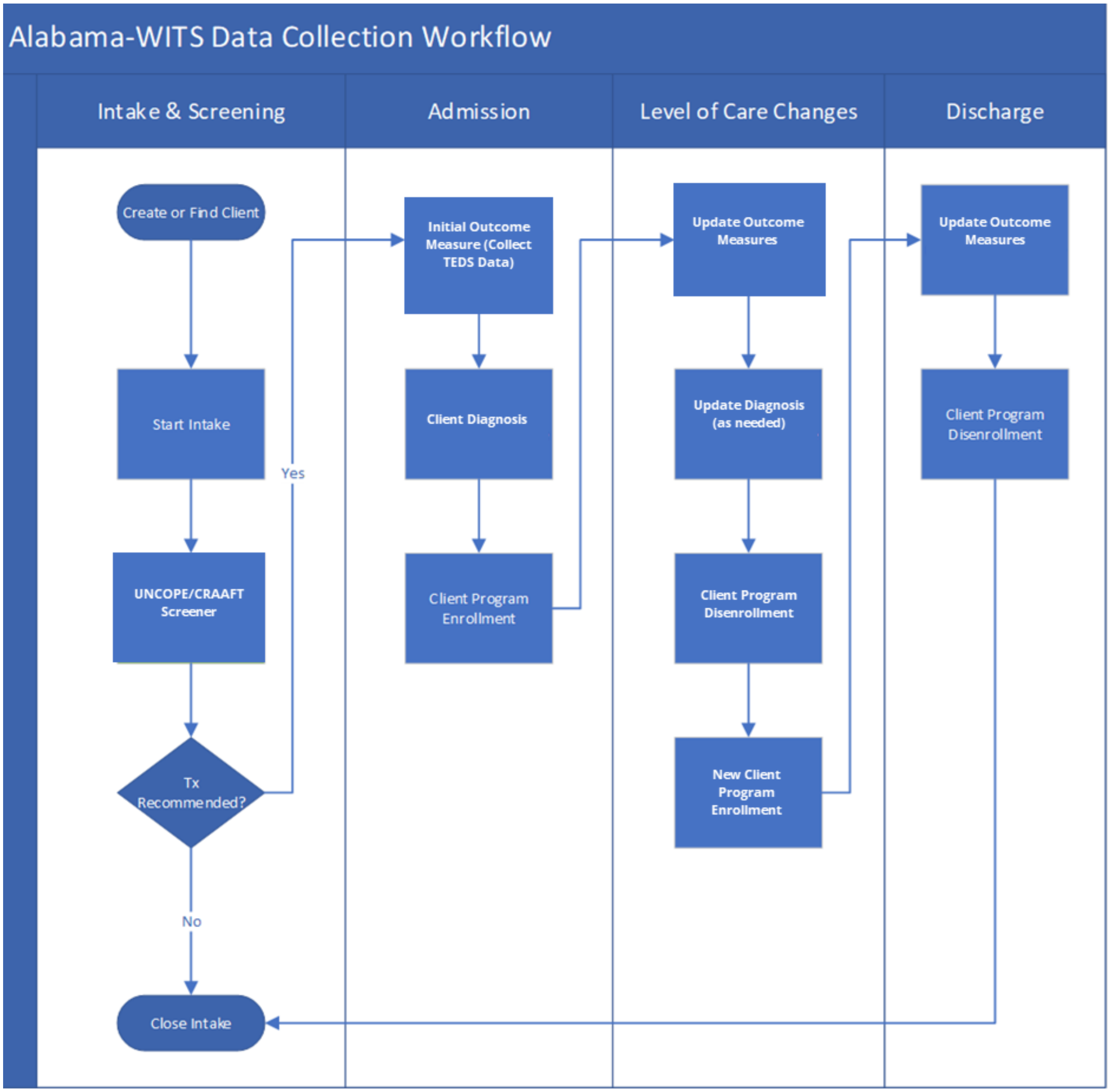


Figure 1: Treatment Workflow

The steps for completing each step of the treatment data collection workflow are covered in detail in the proceeding sections.

As the different screens are navigated in WITS, the user will have the opportunity to capture various data. Some data fields are required and are indicated by the yellow or yellow striped bar on the left side of the field. Fields without these bars are optional to completing the form or workflow. However, it is recommended that the user capture as much data as necessary for complete and accurate reporting.

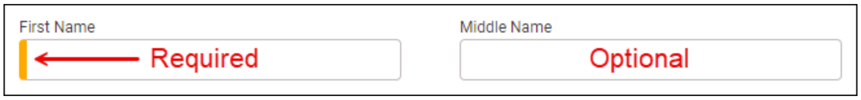


Figure 2: Required vs Optional Fields

Some fields will have an alternating yellow and white striped bar to the left. These fields are required for TEDS reporting. While you can save data and leave a screen without completing these fields, records will not show as Complete on the Activity List screen until these fields are completed.

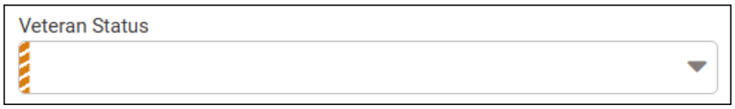


Figure 3: Required for Completion and/or TEDS Reporting

3.1. Client Records

The first step towards treating a client is the creation and management of their client record.

3.1.1. Client Search

Before creating a client record, the user should always perform a search for an existing client record. This prevents duplicate records from being created for the provider.

To search for a client record:

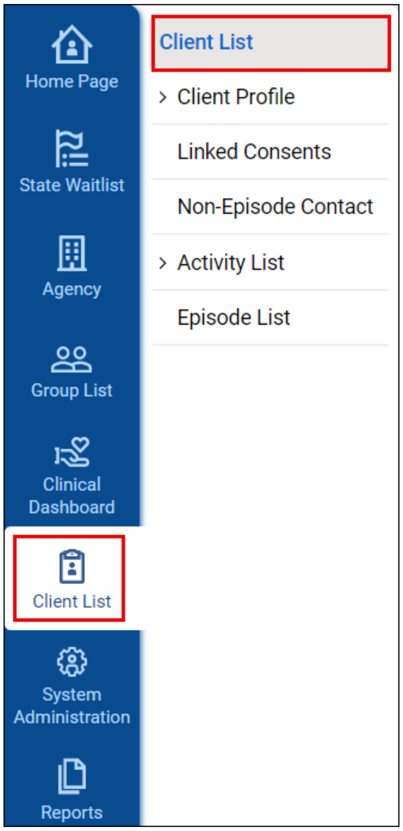


Figure 4: Accessing Client Records

1. From the left navigation menu, click **Client List**.
2. The Client Search screen displays with basic search functionality immediately available.
3. If other criteria besides those under basic search will be used to locate the client record, then click **Advanced Search**.
4. Enter search criteria, and then click **Search**.
5. Search results will be listed under the Client List section.

3.1.2. Add Client

If a search for a client record does not produce results, then the client has not been added to WITS for this agency. A record will need to be created.

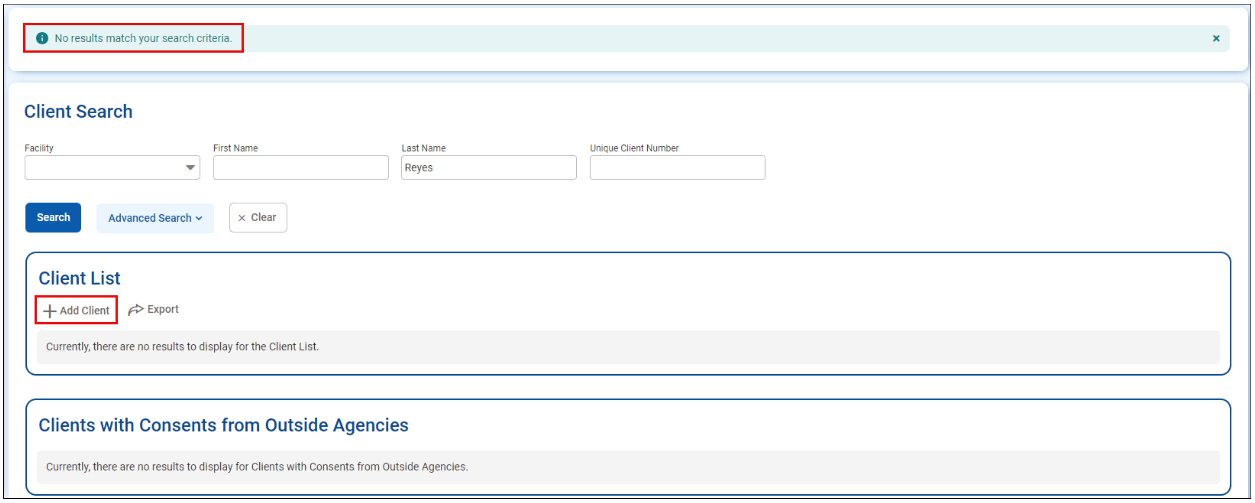


Figure 5: Client Search - No Results

1. In the Client List section, click **+Add Client**.
2. The Client Profile screen will display.
3. At the least, complete the required fields.

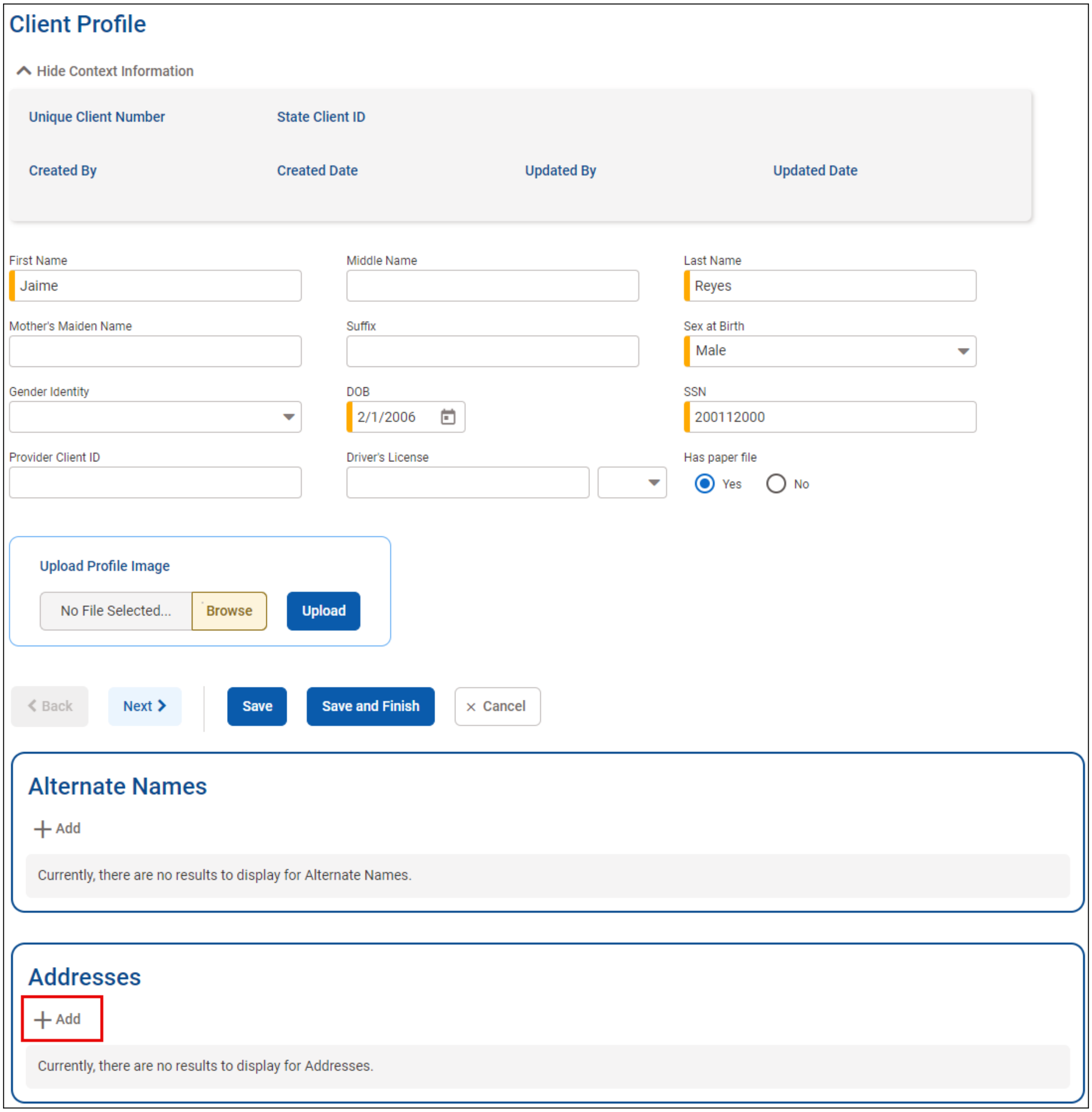


Figure 6: Client Profile

4. Scroll down the screen and then click **+Add** under the Addresses section.

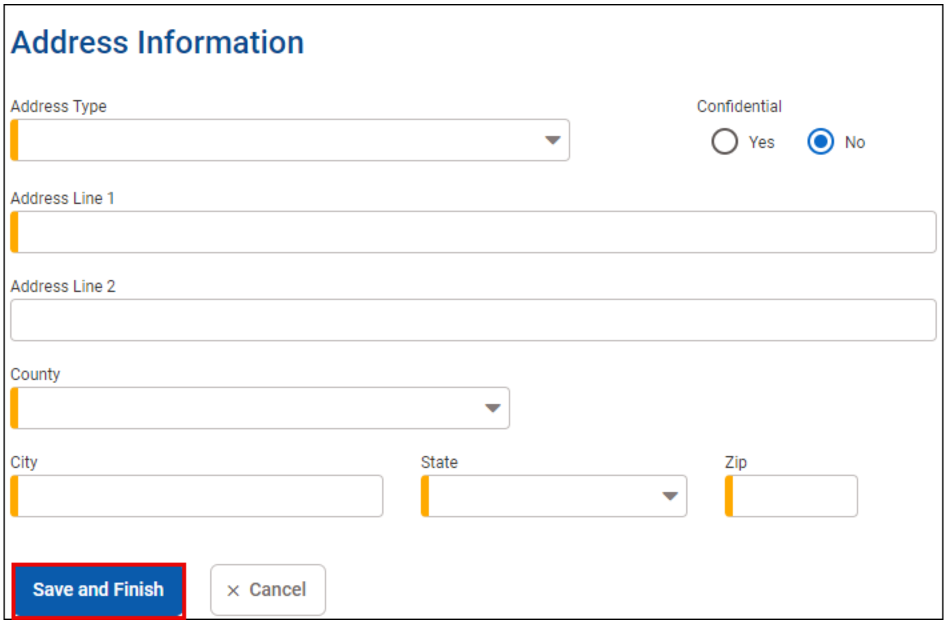


Figure 7: Address Information

5. Complete the required fields, and then click **Save and Finish**.
6. The address information entered will be validated against the US Postal Services database. If no match is found, an informational message will display informing the user of a possible error.
    a. To edit the address information, click **Edit**.
    b. To accept the address information as is, click **Select**.

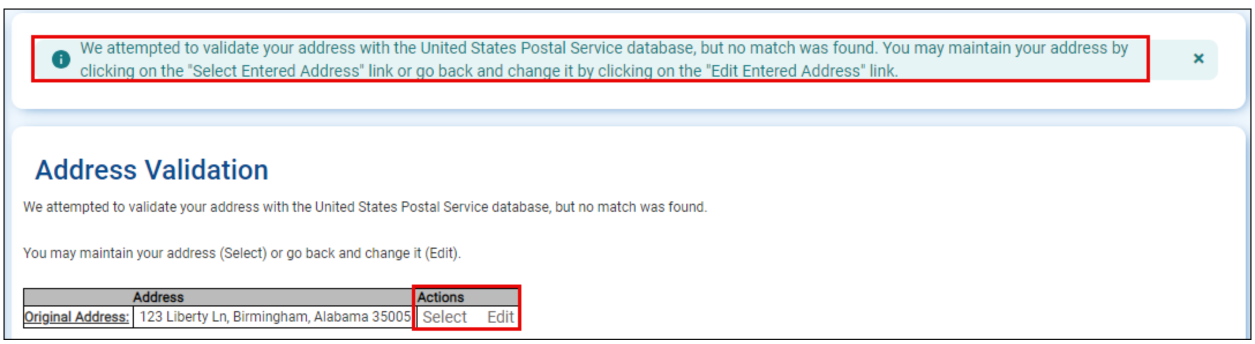


Figure 8: Address Validation Error

7. Once the address is verified or no errors are found, the Contact Info screen displays.
8. Capture at least one Method of Contact for the client and choose the Preferred Method of Contact.

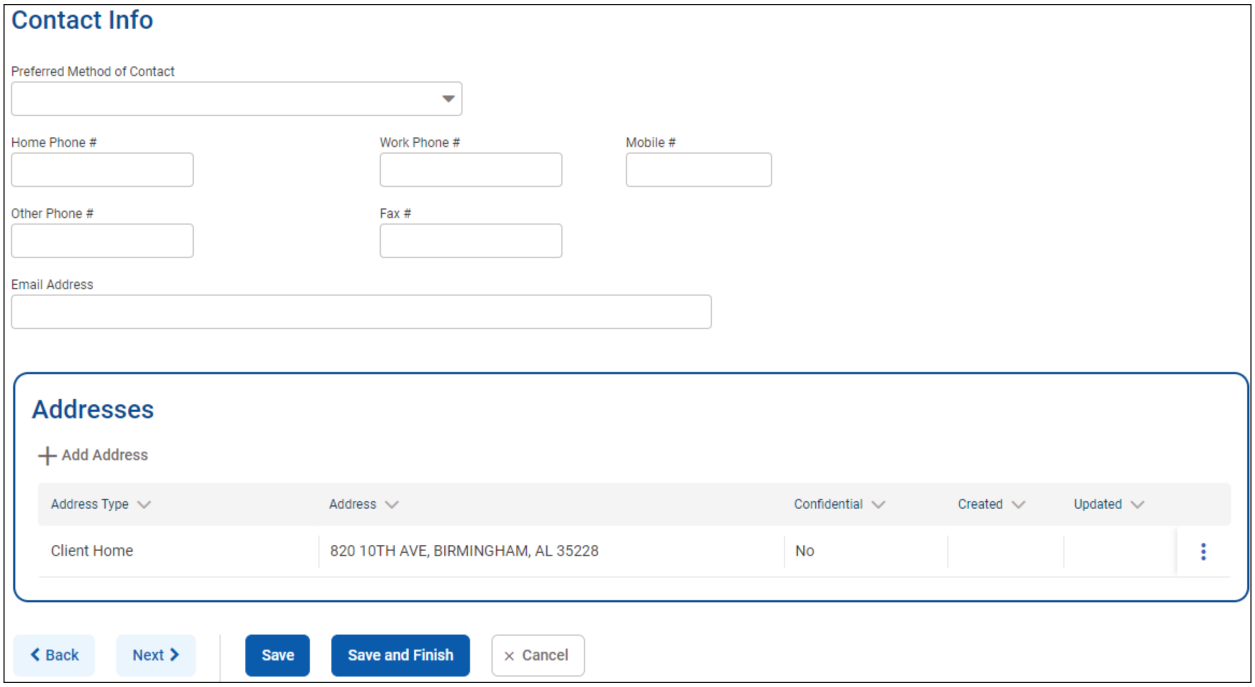


Figure 9: Contact Info

9. Click **Save and Finish**.

Once these steps are completed, the user needs to complete the required fields on the Additional Information screen to satisfy requirements for the Client Intake and TEDS reporting.

3.1.3. Updating a Client Profile

1. Should a client record need to be updated, search for the client record.
2. To the right of the client in question, click the **vertical ellipsis**.

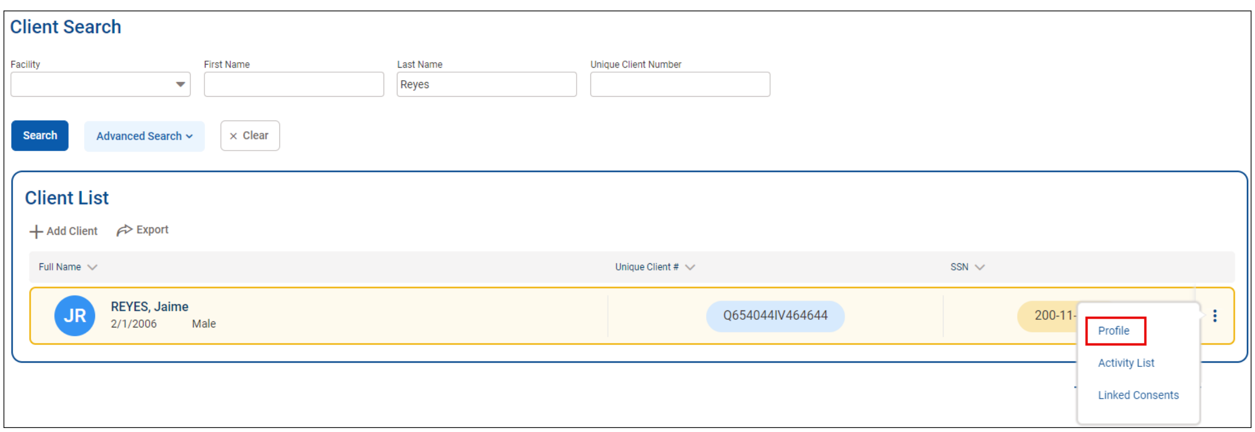


Figure 10: Accessing Client Profile

3. Click **Profile**.

4. Once within a client's profile, several submenu actions become available under Client List > Client Profile.

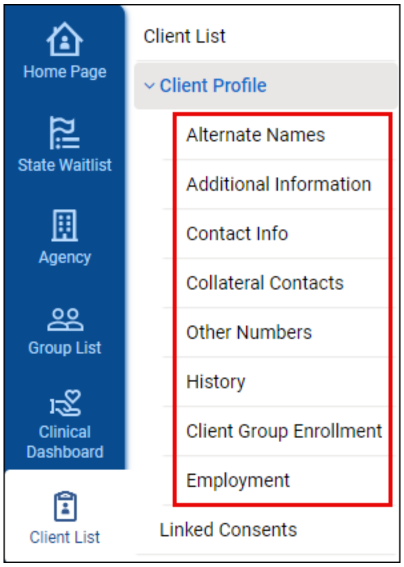


Figure 11: Client Profile Submenu Actions

Each section is covered below.

3.1.3.1. Alternate Names

If the client has alternate or preferred names that differ from their legal name, they can be captured here. The client search will take these names into consideration when performing a search.

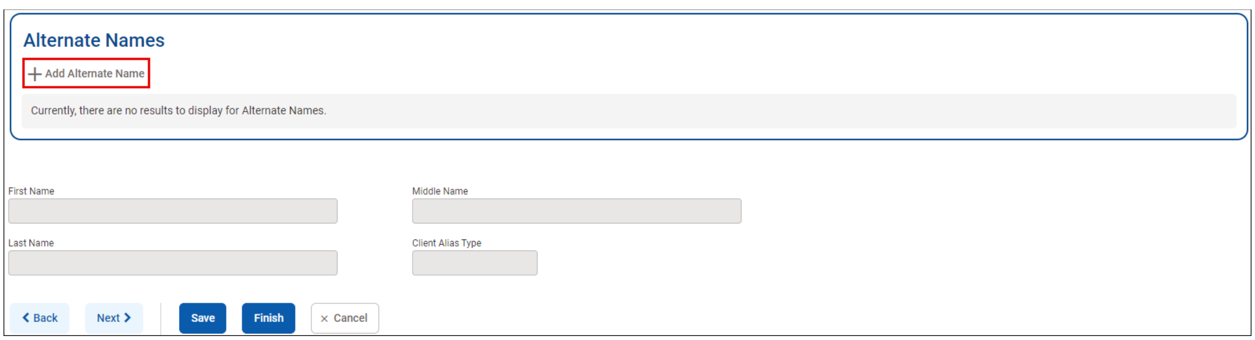


Figure 12: Alternate Names

1. Click **+Add Alternate Name**.
2. Complete the required and relevant fields.

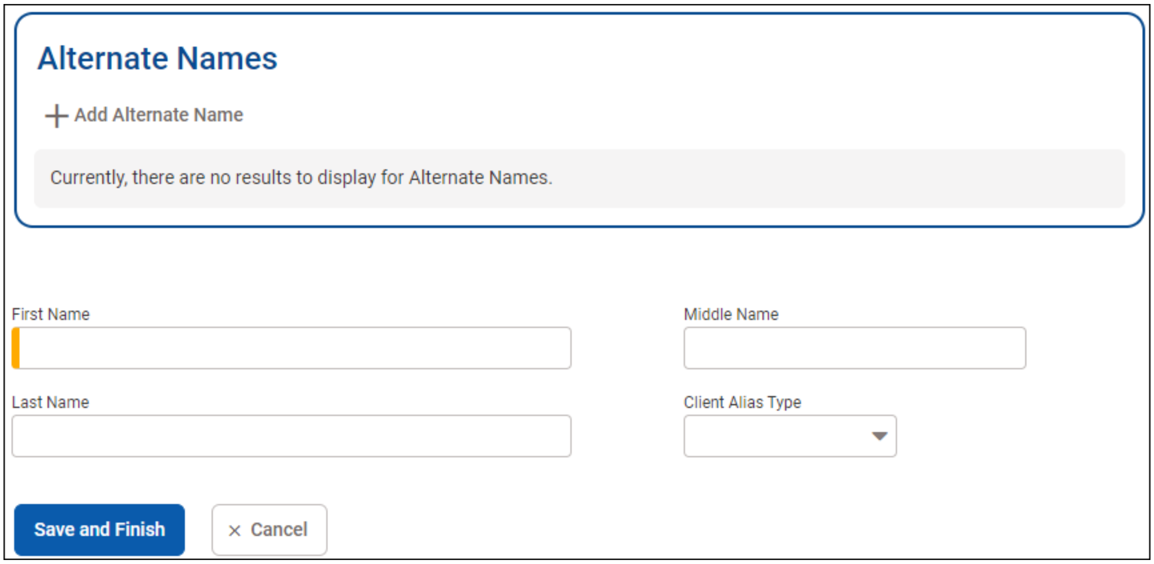


Figure 13: Add Alternate Name

3. Click **Save and Finish**.

3.1.3.2. Additional Information

Clicking **Additional Information** under the Client Profile submenu to access client demographic information. Complete the required and relevant fields, and then **Save and Finish**.

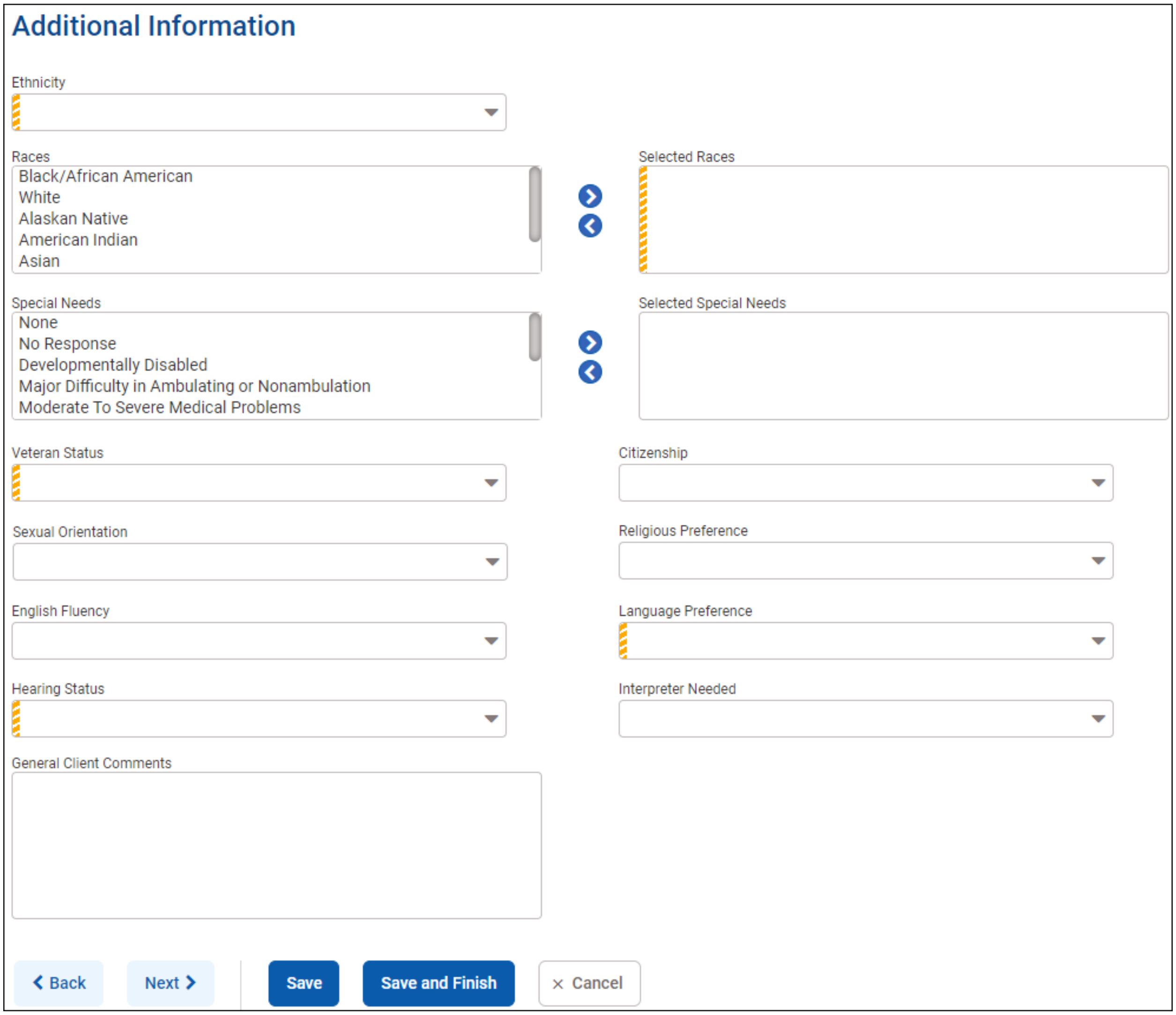


Figure 14: Additional Information

3.1.3.3. Contact Info

To add phone and address information to the client's record, click **Contact Info** from the Client Profile submenu.

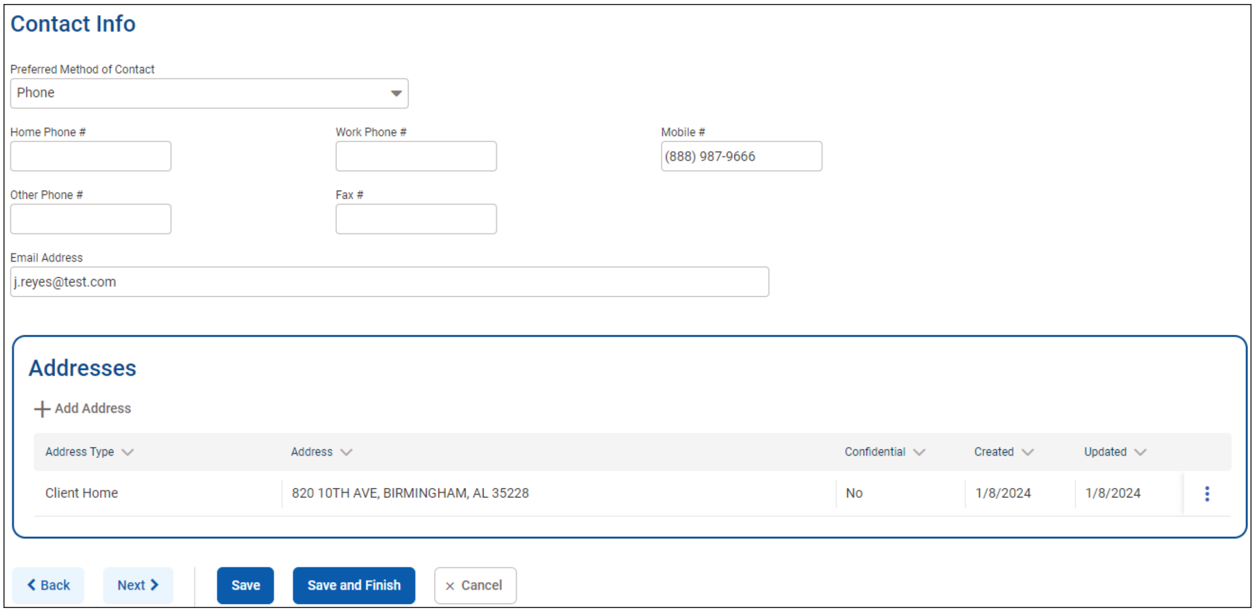


Figure 15: Adding to Contact Info

3.1.3.4. Collateral Contacts

To add contacts to a client's record:

1. While the client's record is active, click **Collateral Contacts** under the Client Profile submenu.
2. The Collateral Contacts screen displays. Fields that are gray cannot be edited.

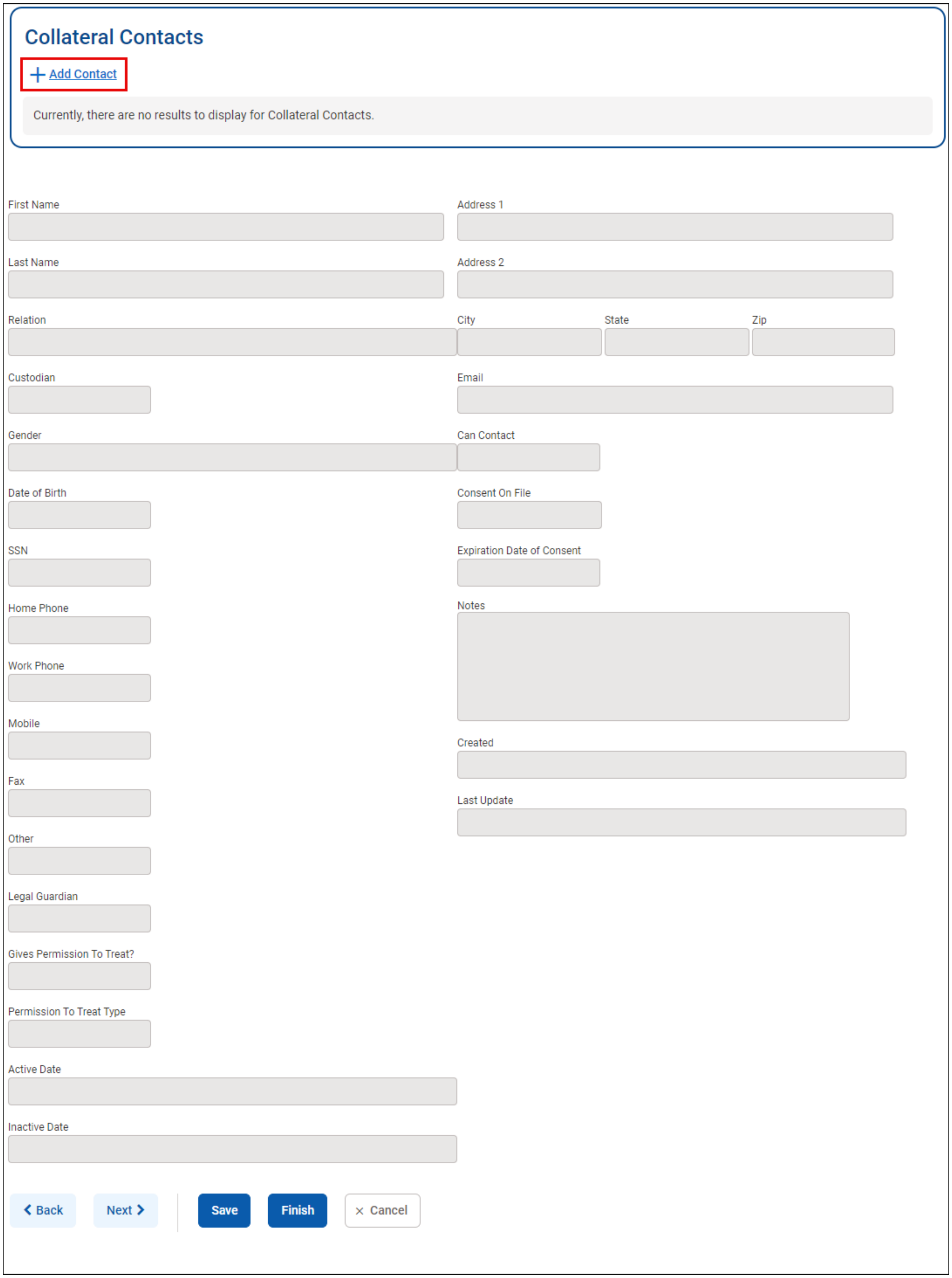


Figure 16: Collateral Contact

3. Click **+Add Contact** to make the fields active.
4. Complete required and relevant fields.

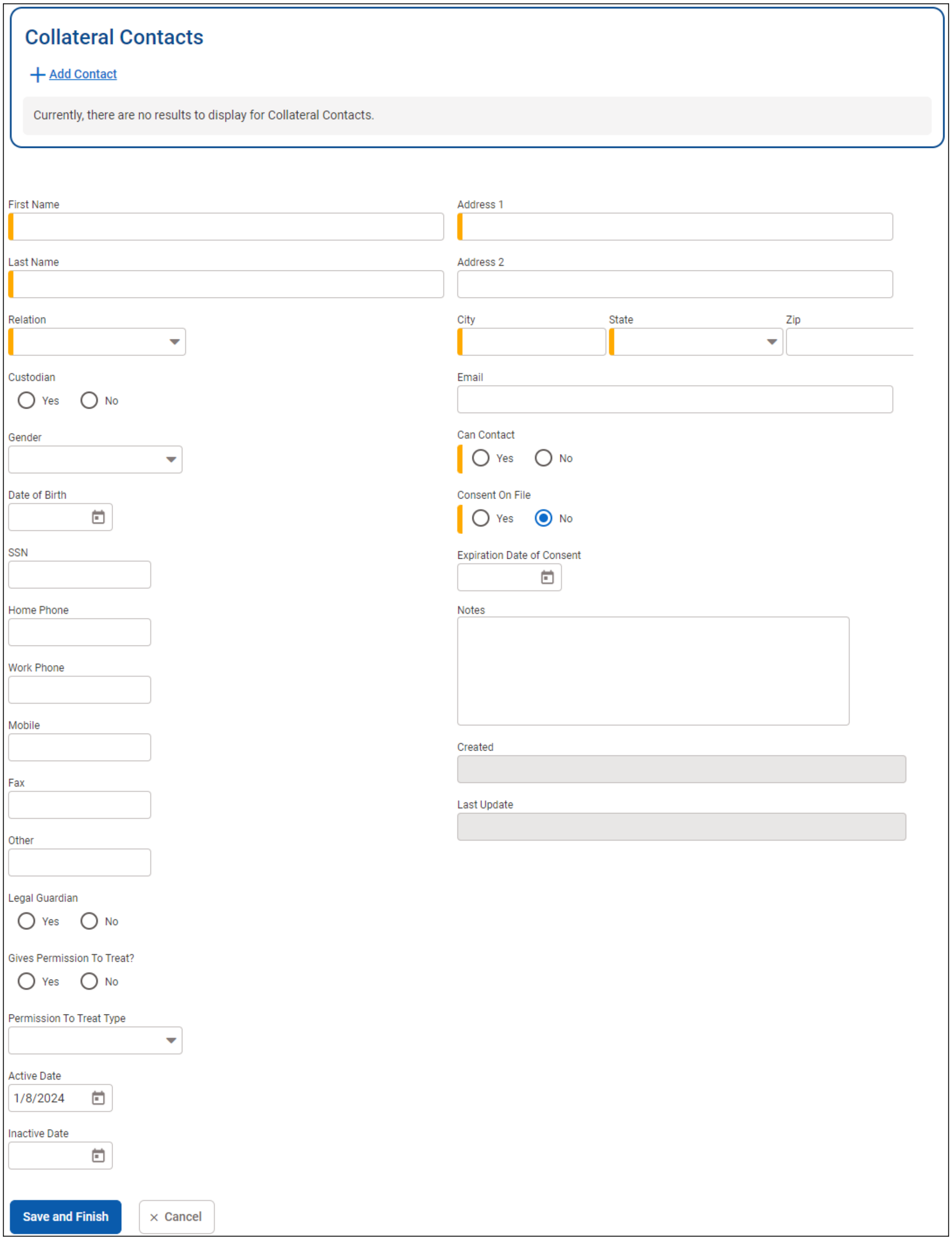


Figure 17: Add Collateral Contact

5. Click **Save and Finish**.

If needed, more than one contact can be added. Repeat steps as needed for each contact.

3.1.3.5. Other Numbers

This screen is used to capture other numbers related to state and court documents not captured in the client's profile.

1. While the client's record is active, click **Other Numbers** under the Client Profile submenu.
2. The Other Numbers screen displays. Fields will be gray and cannot be edited.
    a. Existing numbers will be listed under the Other Numbers List section.

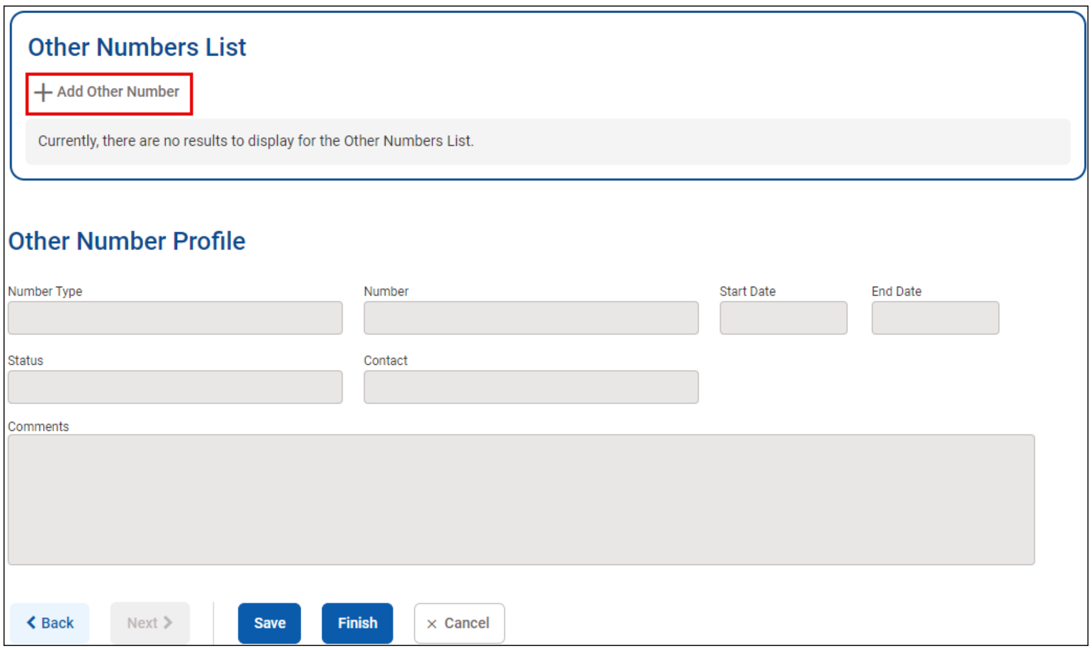


Figure 18: Other Numbers

3. Click **+Add Other Number**. The Other Number Profile section will become editable.
4. The types of information that can be recorded here may include:
    a. ASAIS ID
    b. External Record ID – This is created for clients created imported into WITS.
    c. Court case numbers
    d. State issued IDs
5. Complete the required and relevant fields.

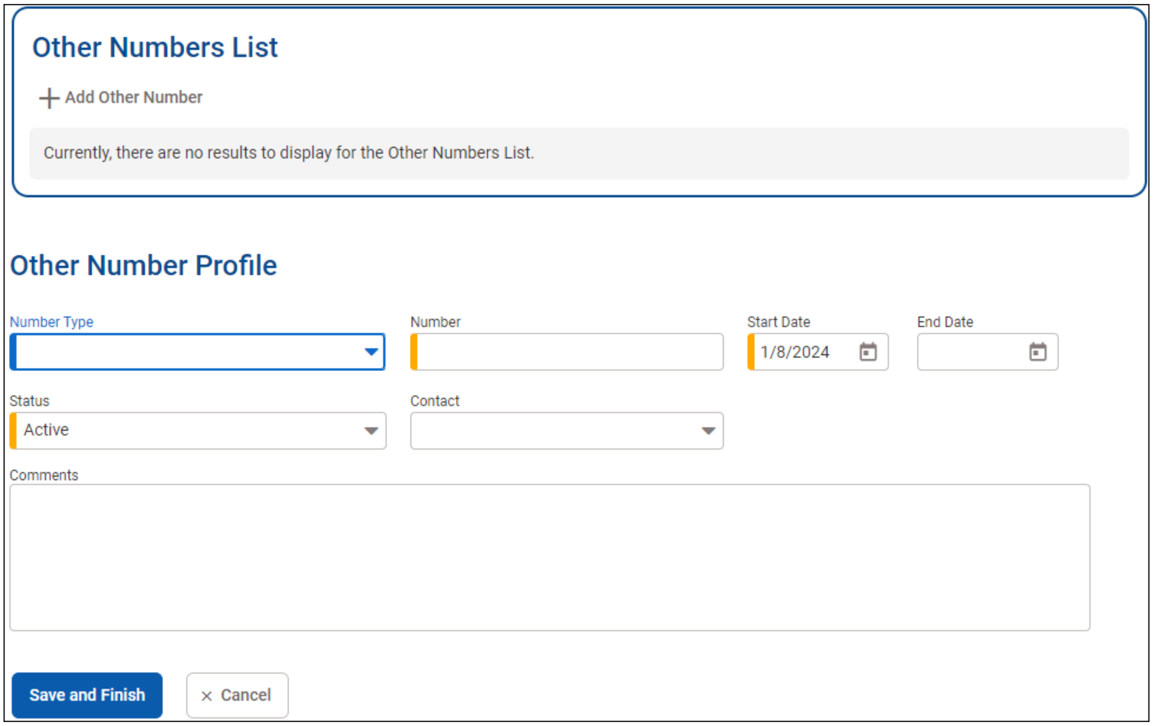


Figure 19: Adding Additional Number

6. Click **Save and Finish**.

These steps can be repeated as needed to capture additional numbers.

3.1.3.6. History

History tracks the changes made to the client's record across all screens under the Client Profile.

If needed, the history can be exported to an Excel file.

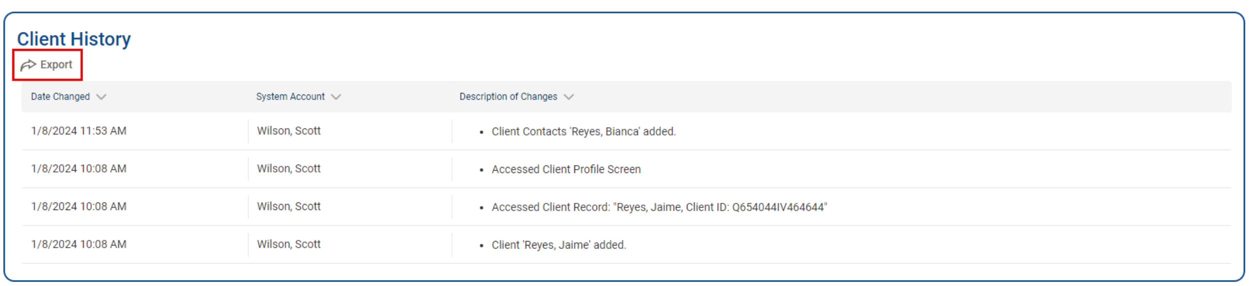


Figure 20: Client Profile History

3.1.3.7. Client Group Enrollment

Client Group Enrollment (CGE) contains information regarding a client's benefits.

Only Third Party Liability (TPL) information will need to be manually added to a client's record.

Medicaid eligibility will be auto-generated. A 270 is submitted to Medicaid when a client record is created. Medicaid then returns a 271 response on the client's Medicaid eligibility, which is then used to update the CGE.

Any government contracts between the provider and Alabama Department of Mental Health (ADMH) will be added to the CGE automatically after the client intake is created.

Existing enrollments will display under the Client Enrollment List. If needed, the Client Enrollment Search section can be used to filter the results in the Client Enrollment List.

To add a benefit or insurance:

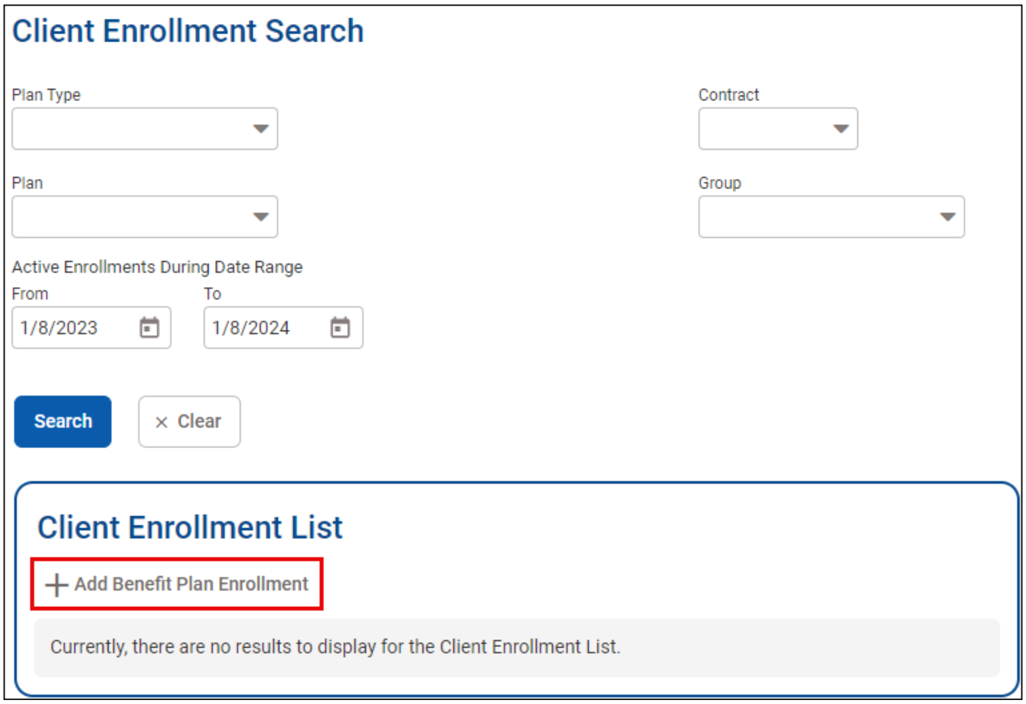


Figure 21: Client Group Enrollment

1. Click **+Add Benefit Enrollment Plan**.
2. The Benefit Plan/Private Pay Billing Information will display below the Client Enrollment List section.
3. Complete all required and relevant fields.

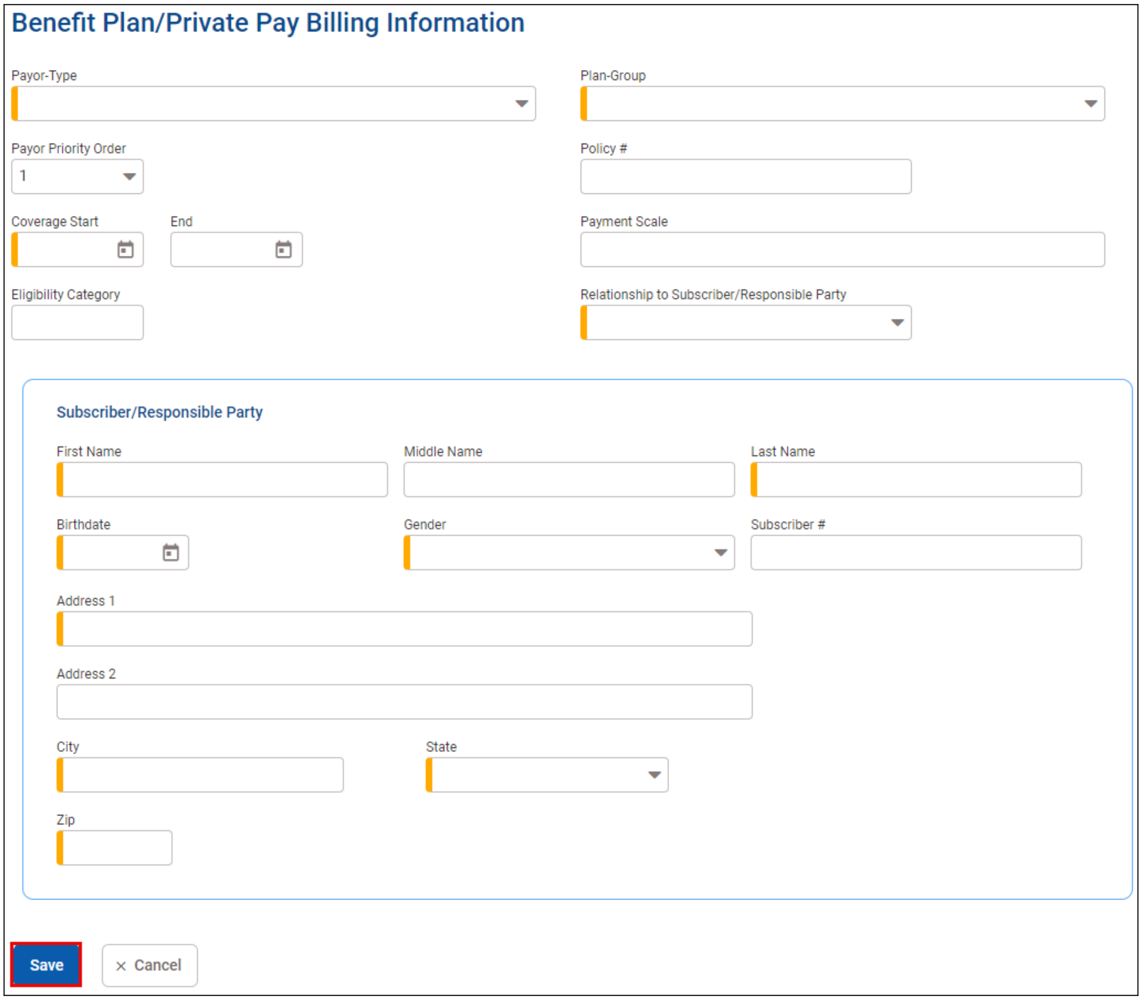


Figure 22: Benefit Plan/Private Pay Billing Information

4. Click **Save**.

These steps can be repeated as necessary to capture additional benefit plans.

3.1.3.8. Employment

This section can be used to capture the client's employment history.

To add employment history:

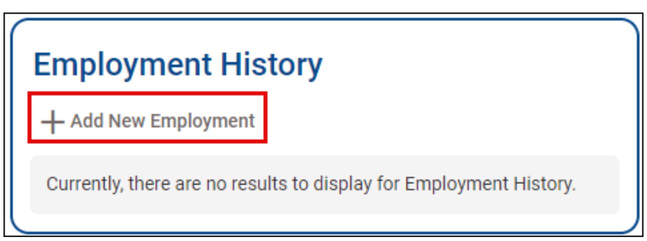


Figure 23: Add Employment

1. Click **+Add New Employment**.
2. The Employment Profile screen will display.
3. Complete all required and relevant fields.

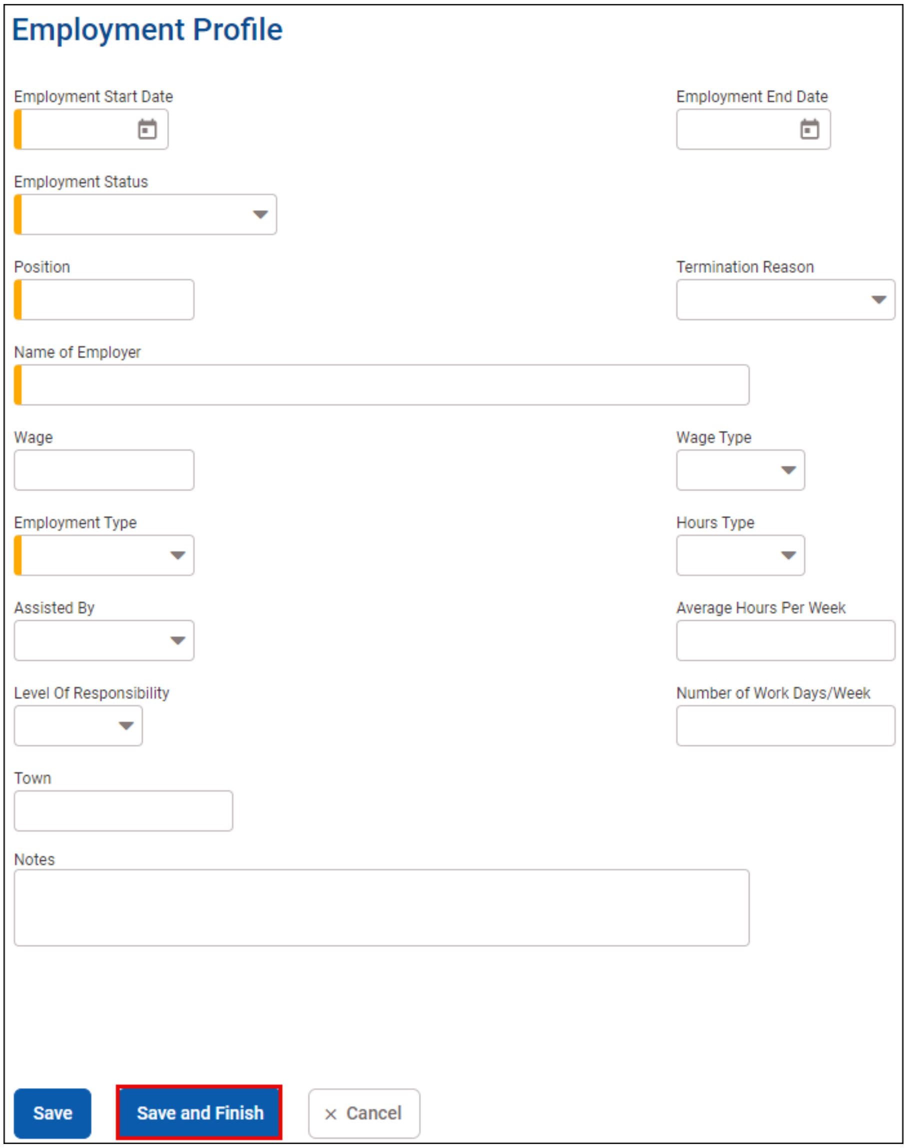


Figure 24: Employment Profile

4. Click **Save and Finish**.

To edit an existing employment record:

1. To the right of the employment record, click the **vertical ellipsis**.

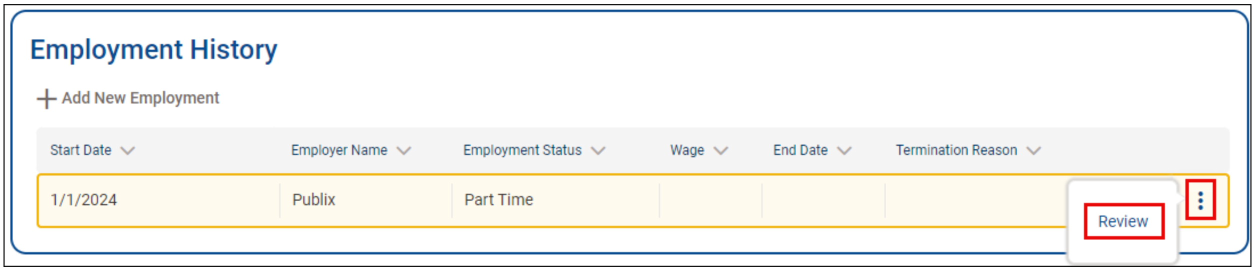


Figure 25: Edit Employment History

2. Click **Review**.
3. Make necessary edits, and then click **Save and Finish**.

3.2. Client Intake

Once the client's profile has been created, the intake process can begin.

NOTE: The active client record is indicated by the ribbon at the top of WITS.

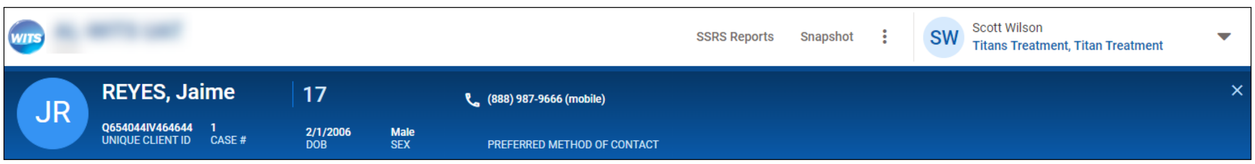


Figure 26: Active Client Record

1. From the Client List, click submenu item **Activity List**.
2. The Episode List screen displays.
    a. Any previously recorded episodes will display here.

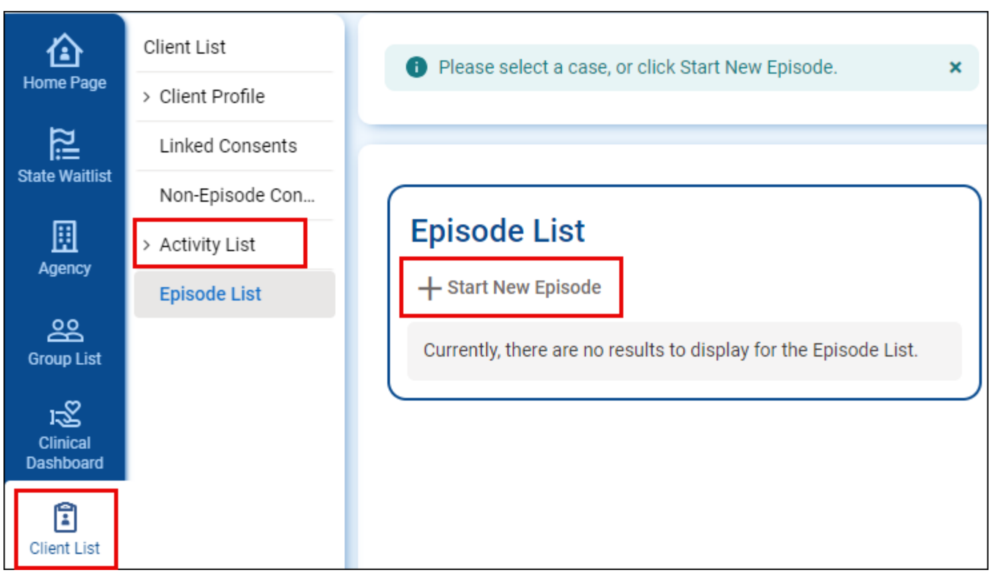


Figure 27: Create Intake

3. To begin the intake, click **+Start New Episode**.
4. The Intake Case Information screen displays.
5. Complete all required and relevant fields.
    a. While not a required field, Presenting Problems needs to be completed.

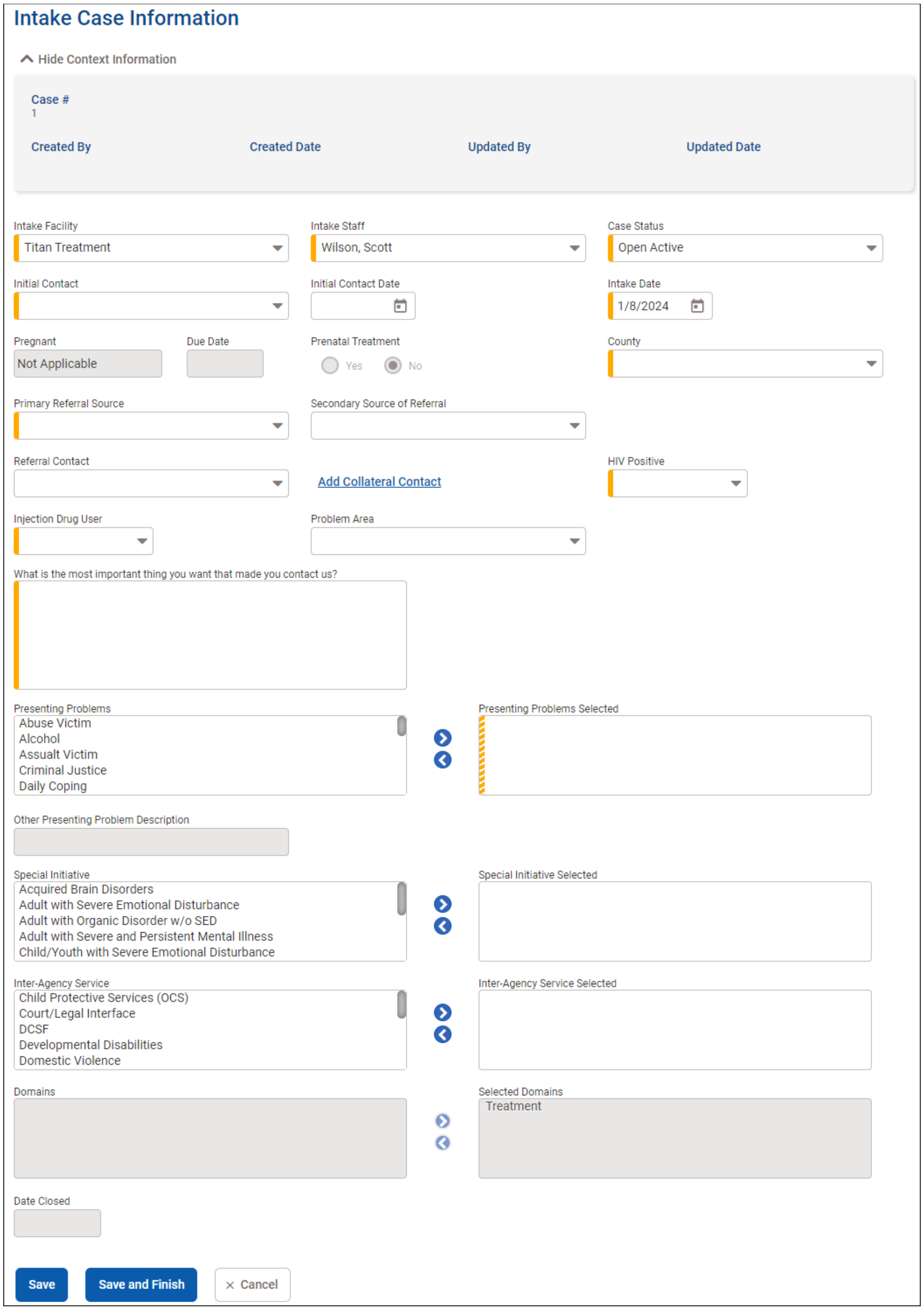


Figure 28: Intake Case Information

6. Click **Save and Finish**.
7. The Client Activity List screen displays. As specific actions are completed against a client record, they will display here.
    a. The client profile information will have a status of In Progress until all required information has been collected.

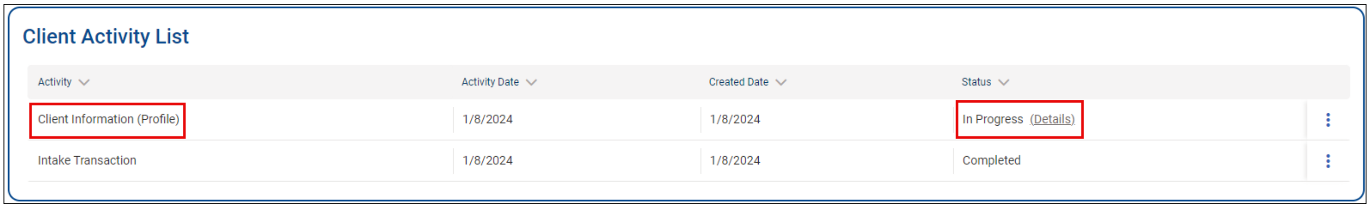


Figure 29: Activity List

8. Click **Details** to the right of In Progress.

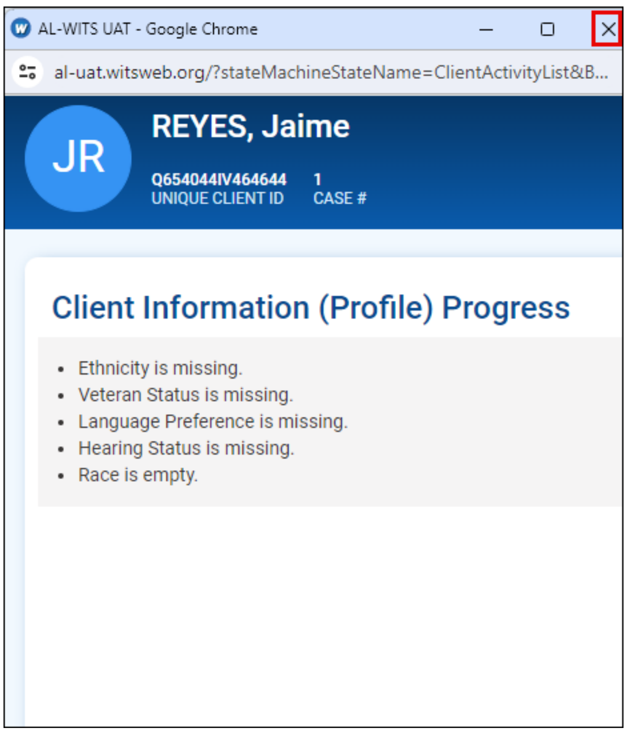


Figure 30: Client Information Profile Progress

9. The Client Information Profile Progress window will pop up, informing the user of the information that still needs to be captured.
    a. The missing information will likely be from the [Additional Information] screen under the Client Profile.
    b. Click the **X** in the top right corner of the window to close.
10. Navigate to [Additional Information] and complete the required and relevant fields.

3.3. Screening

To perform a screening, the user will need to navigate to Screening and then choose the appropriate screening form.

NOTE: To begin the Intake process, the user must have the client record active. The active record is indicated by the ribbon at the top of WITS.

1. From the Client List, click submenu item **Activity List** and then click **Screening**.
2. The available screenings will be listed under Screening.
3. Click the appropriate form to access it.

3.3.1. UNCOPE

Once this form is selected, the user can search for existing UNCOPE screenings for the client, or they can create a new one.

NOTE: UNCOPE is for clients that are over the age of 18.

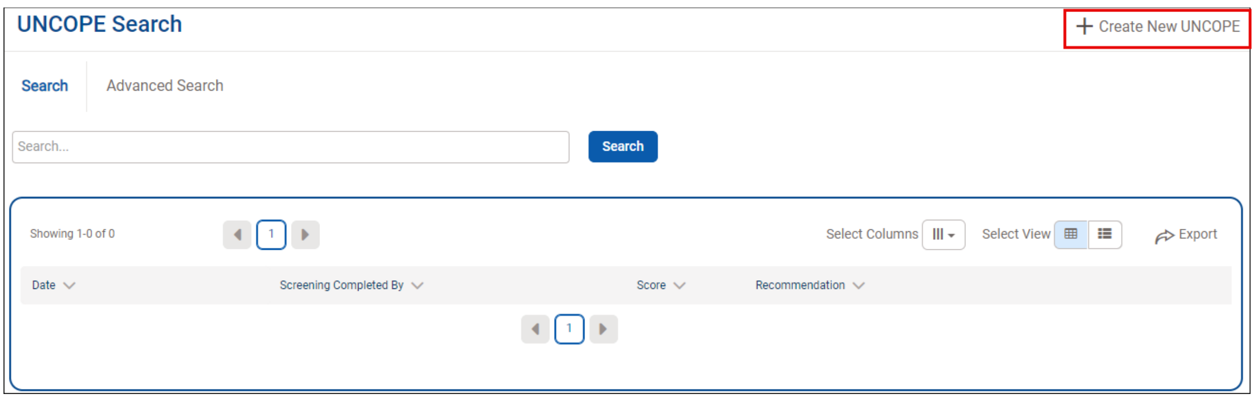


Figure 31: Create UNCOPE

1. Click **+Create New UNCOPE**.
2. The Add UNCOPE window will open.

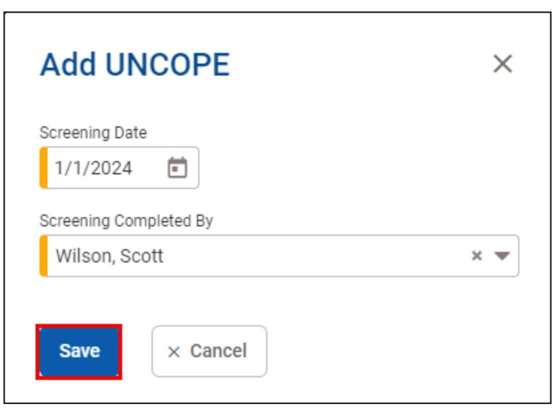


Figure 32: Add UNCOPE

3. Complete the fields and then click **Save**.
    a. If the client is under the age of 18, a confirmation will open confirming the creation of the form.

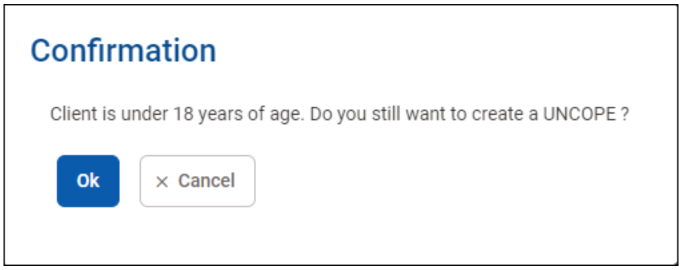


Figure 33: Age Restriction Confirmation

4. The UNCOPE Workspace screen displays. To edit the fields, click **Edit**.

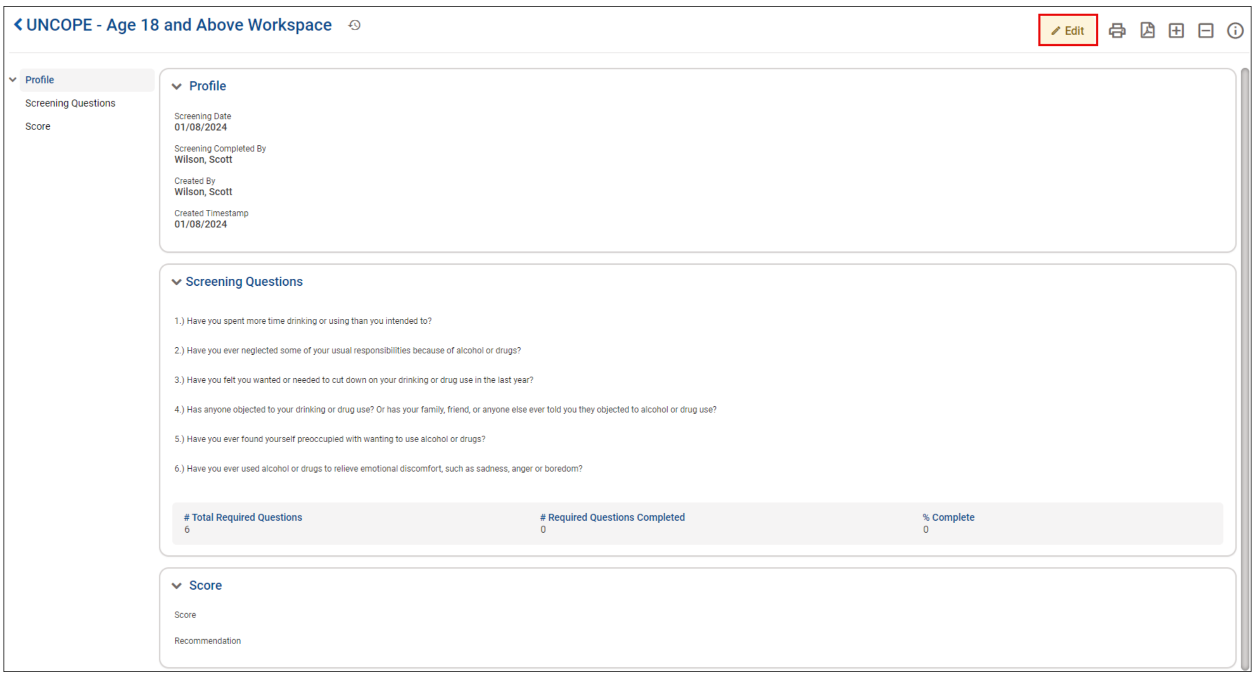


Figure 34: UNCOPE Workspace

5. The Screening Questions section will become editable.
6. Complete all questions.

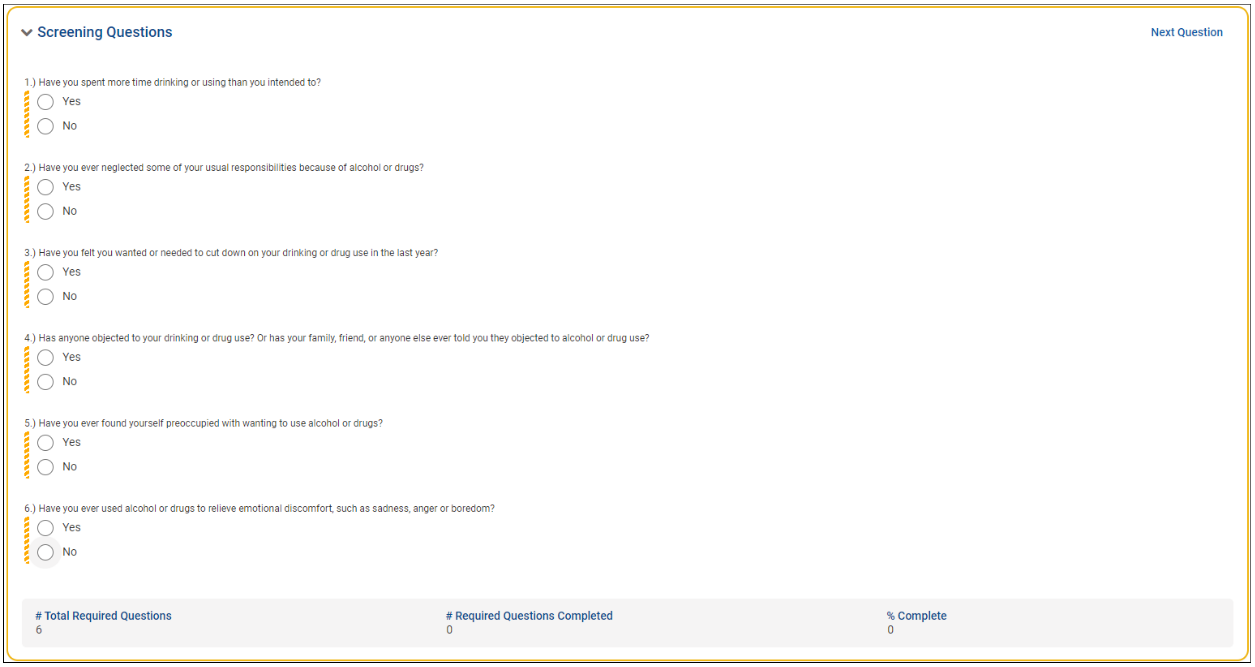


Figure 35: UNCOPE Questions

7. As questions are completed, the Score section will update and provide a recommendation based on answers to the questions.

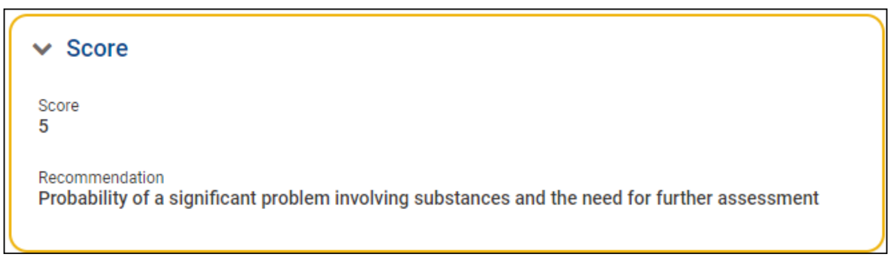


Figure 36: UNCOPE Score

8. Once the form has been completed, click **Done Editing**.

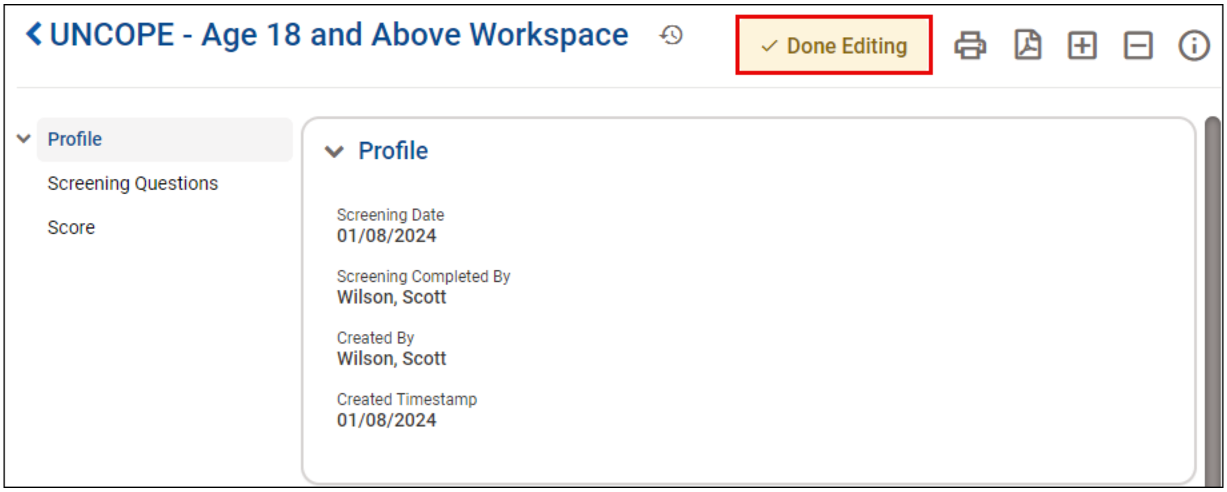


Figure 37: UNCOPE Done Editing

3.3.2. CRAFFT

Once this form is selected, the user can search for existing CRAFFT screenings for the client, or they can create a new one.

NOTE: CRAFFT is for clients that are under the age of 18.

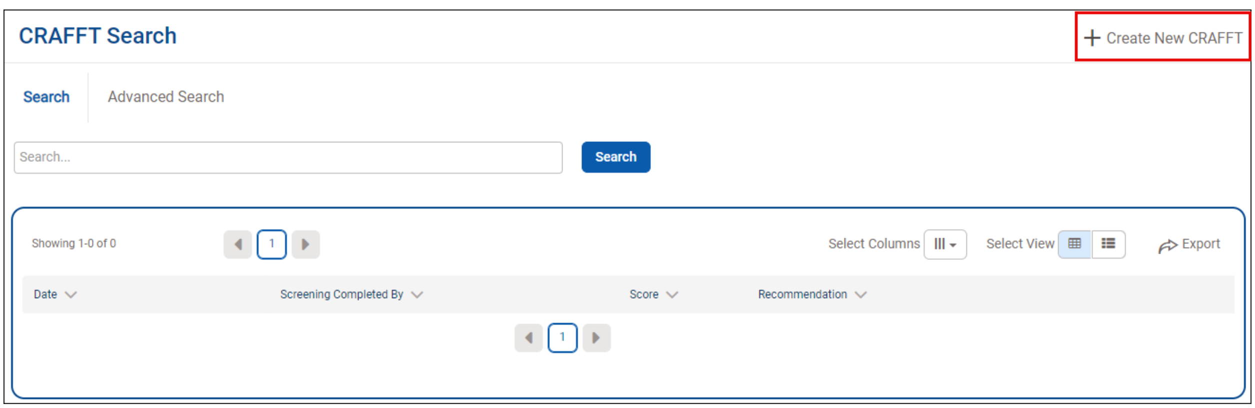


Figure 38: Create CRAFFT

1. Click **+Create New CRAFFT**.
2. The Add CRAFFT window will open.

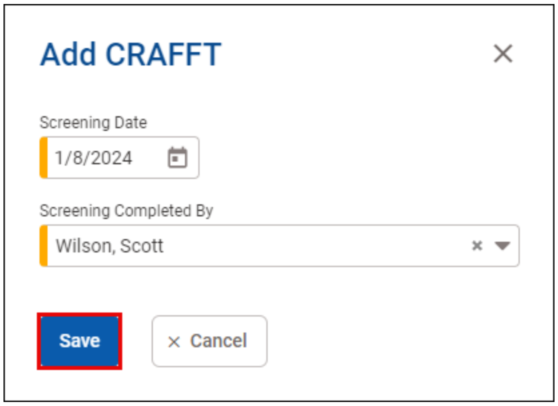


Figure 39: Add CRAFFT

3. Complete the fields and then click **Save**.
    a. The user is notified if the client is over the age of 18, a confirmation will open confirming the creation of the form.

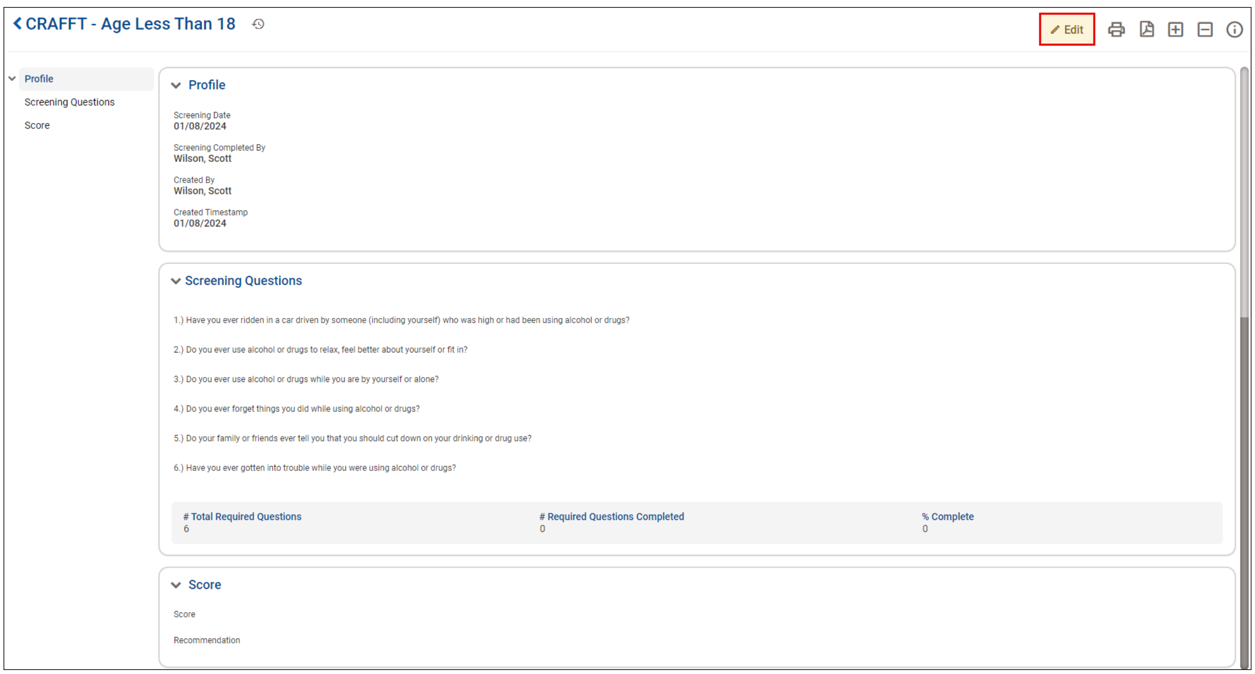


Figure 40: CRAFFT Workspace

4. The CRAFFT Workspace screen displays. To edit the fields, click **Edit**.
5. The Screening Questions section will become editable.
6. Complete all questions.

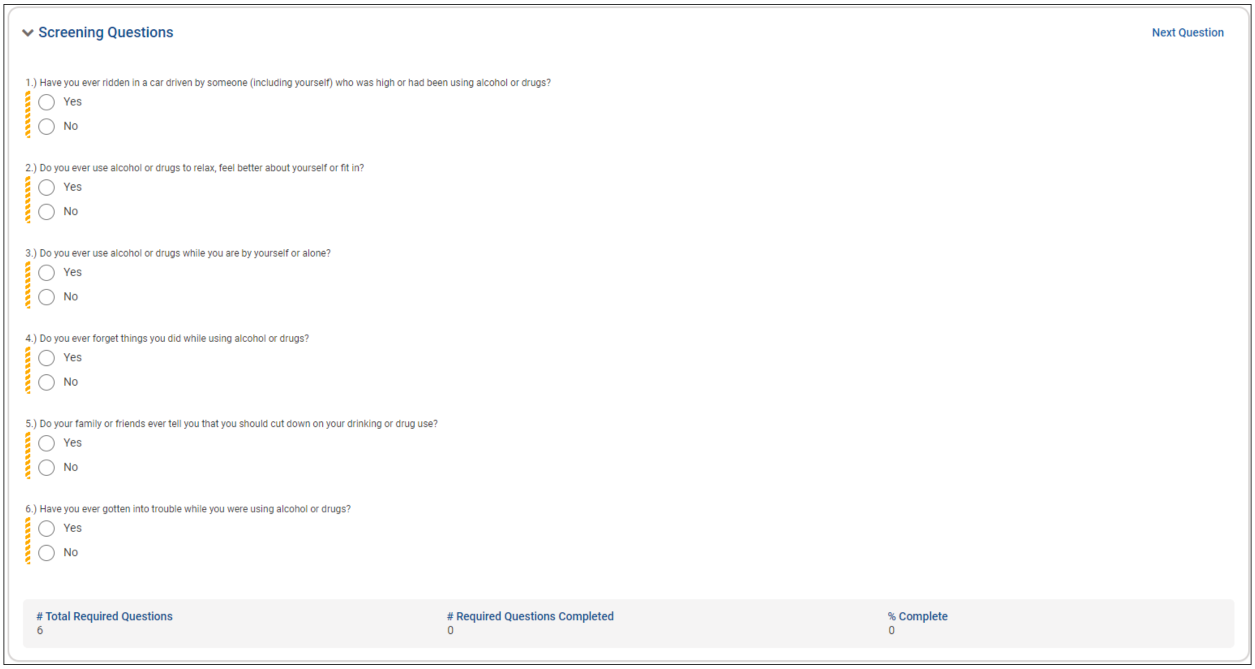


Figure 41: CRAFFT Screening Questions

7. As questions are completed, the Score section will update and provide a recommendation based on answers to the questions.

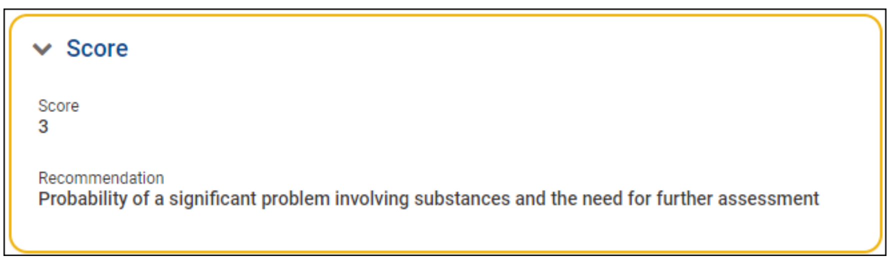


Figure 42: CRAFFT Screening Score

8. Once the form has been completed, click **Done Editing**.

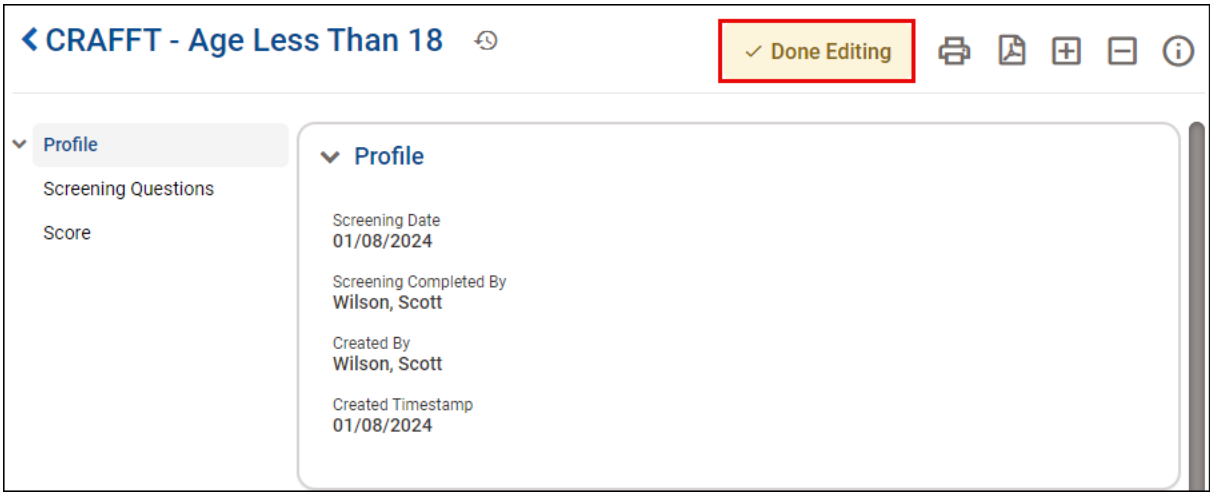


Figure 43: CRAFFT Done Editing

3.4. Admission

After the screening is completed, the user will need to admit the client into a program. This is a mult-step process, which must be completed in the order presented to prevent errors.

complete the ADMH Placement Assessment.

3.4.1. Initial Outcome Measures

The first step in the admission process is to create outcome measures regarding the client's treatment.

1. From within the **Activity List** submenu, click **Outcome Measures**.

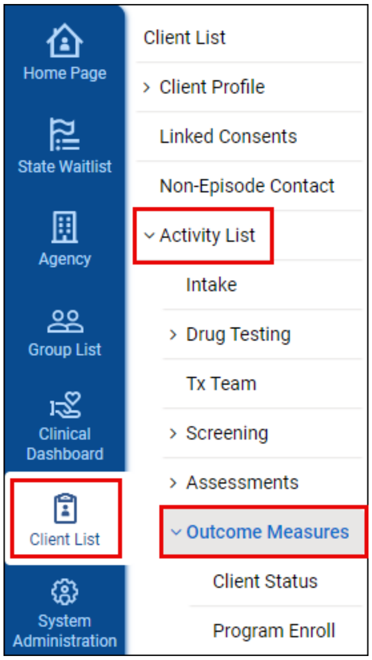


Figure 44: Outcome Measures Navigation

2. The Outcome Measures List screen displays.
    a. Outcome Measures added to the client's record will be listed here.

Figure 45: Add Outcome Measure

3. Click **+Add New** to create a new measure.
4. The Outcome Measures – Client Status screen displays.
5. Some fields will prepopulate based on information provided in the ADMH Placement Assessment.
6. Complete all fields. The fields on Tobacco use are optional.
    a. Table 2: Outcome Measures listed below Figure 65 provides an explanation of each field.

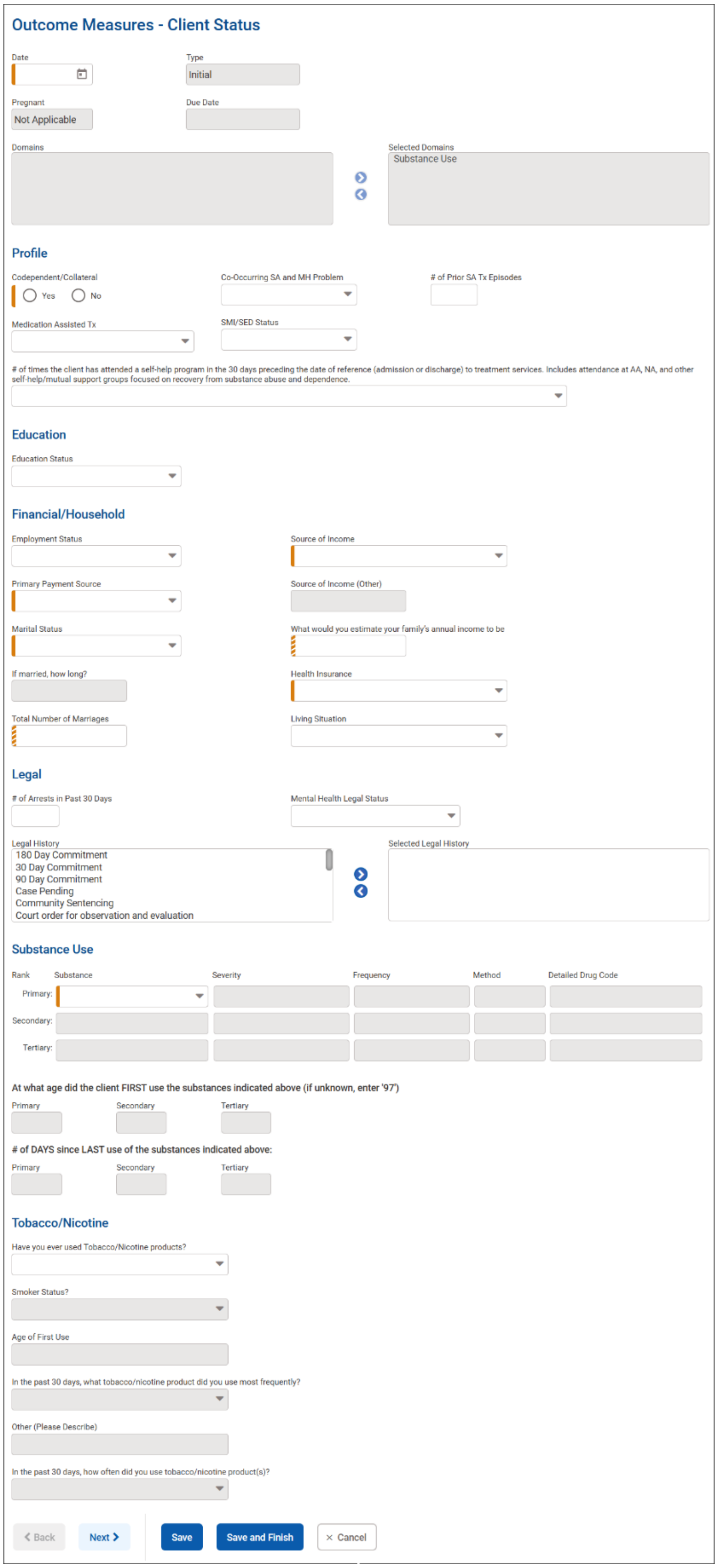


Figure 46: Outcome Measures - Client Status

Table 2: Outcome Measures

Field	Description
Date	This field will auto populate to the current date.
Type	This field auto populates. • Initial – This type is set for the first outcome measure recorded. • Update – Any outcome measure recorded after the first will have this type.
Pregnant	If the client is pregnant, record it here.
Due Date	Enter the client's expected due date.
Domains	The domain(s) assigned to the client record. This will be Substance Use and it will auto populate.
Codependent/Collateral	Set to Yes if the client is seeking treatment for substance use.
Co-Occurring SA and MH Problem	Choose one of the following: • No – The client does not have a mental health problem along with a substance abuse problem. • Yes – The client has a mental health problem along with a substance abuse problem. • Unknown – It is not known if the client has a mental health problem.
# of Prior SA TX Episodes	If the client has received substance abuse treatment services in the past, record the number of time treatment was sought.
Medication Assisted TX	Is the client receiving medication to assist with SA treatment, record it here.
SMI/SED Status	If the client has a serious mental illness, serious emotional disturbance, or both, record it here.
# of times the client has attended a self-help program in the 30 days preceding the date of reference (admission or discharge) to treatment services. Includes attendance at AA, NA, and other self-help/mutual support groups focused on recovery from substance abuse and dependence.	Enter the number of times the client attended a self-help program in the last 30 days leading up to admission or discharge of treatment services.
Education Status	Highest level of education the client has received.
Employment Status	The client's current employment status.
Source of Income	The client's main source of income.
Source of Income (Other)	If Other was selected as the Source of Income, Type in the source.
What would you estimate your family's annual income to be	Enter the client's estimated annual income for their family.
Primary Payment Source	The primary source of payment for services rendered.
Marital Status	Indicated the client's current marital status.
If married, how long?	This only needs to be completed if the client is currently married. Enter how long the client has been married. This is a text field, so years and months can be recorded.
Total Number of Marriages	Indicate how many times the client has been married.

Health Insurance	Indicate if the client has health insurance, and if so, what type.
Living Situation	Indicate where the client currently lives.
# of Arrests in Past 30 Days	Record how many times the client has been arrested in the past 30 days.
Mental Health Legal Status	Not Used
Legal History	Legal history options will display in the left box. Any options that are applicable to the client should be moved to the Selected Legal History box.
Substance Use – Primary/Secondary/Tertiary	• Primary – This is the primary substance use issue for the client. • Secondary – If the client has a secondary substance use problem record it here. Otherwise, leave blank. • Tertiary – If the client has a third substance use problem record it here. Otherwise, leave blank. For each substance identified, complete the severity, frequency, and method fields.
Severity	Indicate how severe the problem is.
Frequency	Indicate how often the client uses the substance.
Method	Indicate how the client receives the drug into their system.
At what age did the client FIRST use the substances indicated above (if unknown, enter '97')	Enter the age when the client first started using the substance. If unknown, enter 97. Secondary and tertiary do not need to be completed unless a client indicates additional substance use beyond the primary.
# of Days since Last use of the substances indicated above	Enter how many days it has been since the client's last use for each substance identified.
Have you ever used Tobacco/Nicotine products?	Record if the client has ever used tobacco or nicotine products.
Smoker Status	Does the client currently smoke or not.
Age of First Use	How old was the client when they first used tobacco or nicotine products.
In the past 30 days, what tobacco/nicotine product did you use most frequently?	Indicate the tobacco/nicotine product the client uses most.
Other (Please Describe)	If Other is selected for the previous field, use this field to explain why other was chosen.
In the past 30 days, how often did you use tobacco/nicotine product(s)?	Indicated how often in the last 30 days the client has used tobacco/nicotine products.

7. Click **Save and Finish**.

3.4.2. Record Diagnosis

While this is not identified as a requirement in WITS, each client must have a principal diagnosis associated with their record to enter encounter services.

1. From the Client List, click **Diagnosis List** under the **Activity List** submenu.

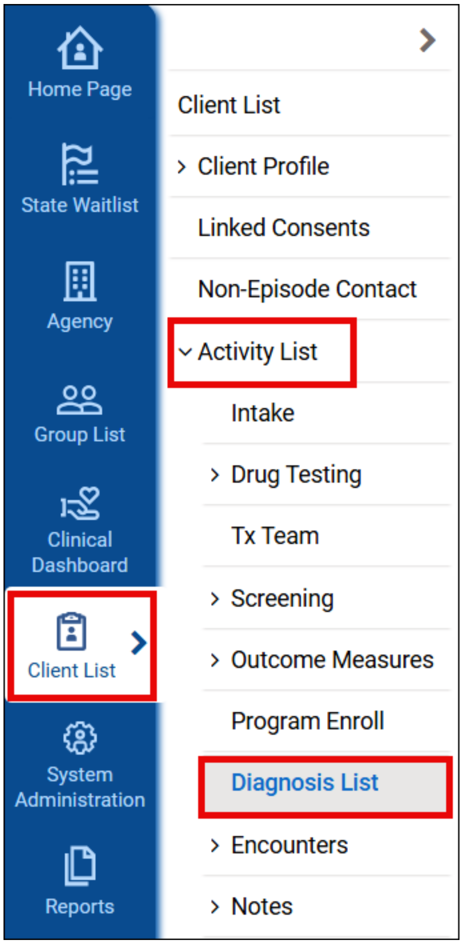


Figure 47: Accessing Diagnosis List

2. On the Diagnosis Search screen, click **+Create New Diagnosis**.

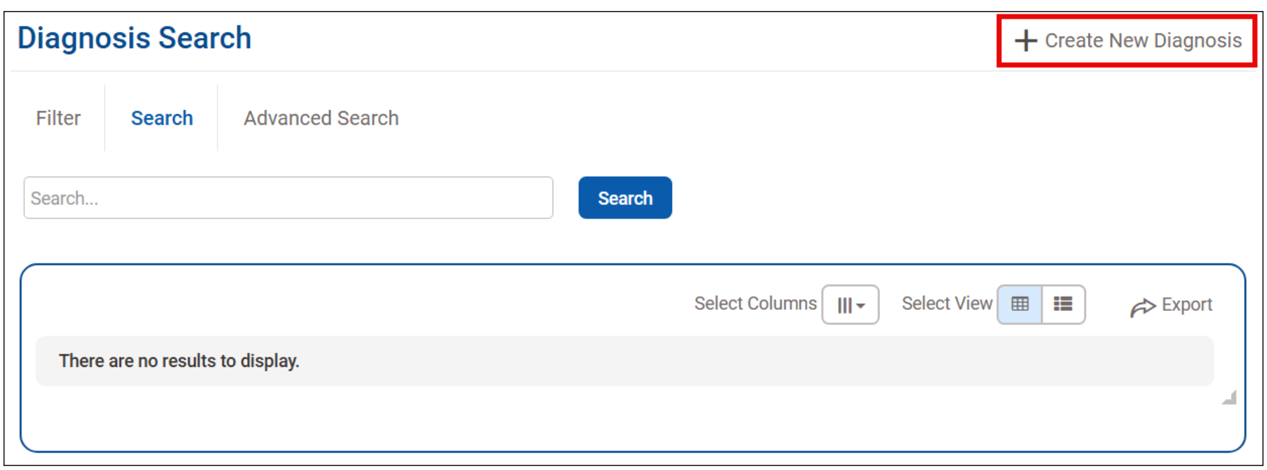


Figure 48: Create Diagnosis

3. The Add Diagnosis screen will display. At a minimum, record the required fields, and indicate the diagnosis status. Use Table Add Diagnosis for information on completing each field.

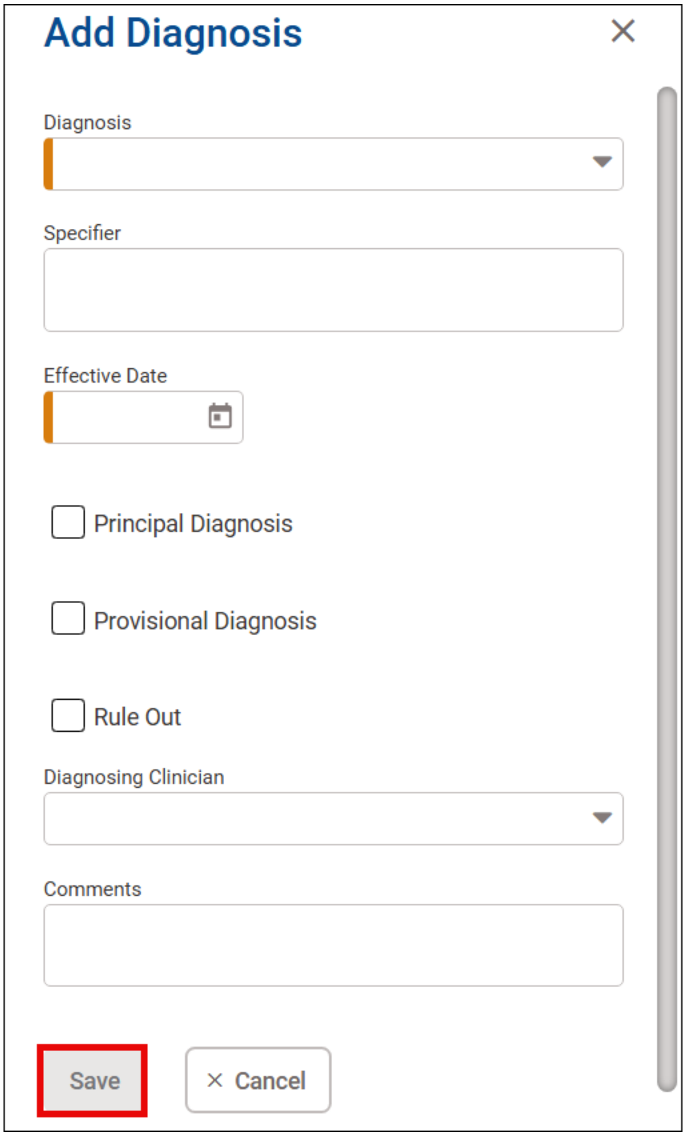


Figure 49: Add Diagnosis

4. Click **Save**.

Table 3: Add Diagnosis

Field	Description
Diagnosis	This dropdown field contains a list of all diagnoses added into WITS. Start typing in the name of the diagnosis to display possible options. You can also enter the International Classification of Diseases code.
Specifier	If there are any specifiers associated with the diagnosis, record them here.

Effective Date	The date the diagnosis was given.
Principal Diagnosis	The client can have multiple diagnoses. Check this box, if the diagnosis is the primary concern.
Provisional Diagnosis	If the diagnosis is provisional, check this box.
Rule Out	If a diagnosis has been ruled out, check this box.
Diagnosing Clinician	The clinician that diagnosed the client.
Comments	Any comments relevant to the diagnosis can be recorded here.

3.4.3. Program Enrollment

To enroll the client in a program:

1. From within the **Activity List** submenu, click **Program Enroll**.

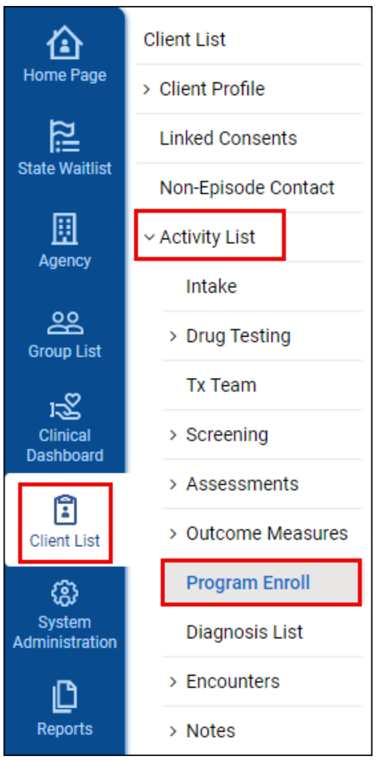


Figure 50: Accessing Program Enrollment

2. The Program Enrollment screen will display.
    a. Any programs the client is currently enrolled in will display under Program Enrollment List.
    b. If needed, the user can search for programs the client is assigned.

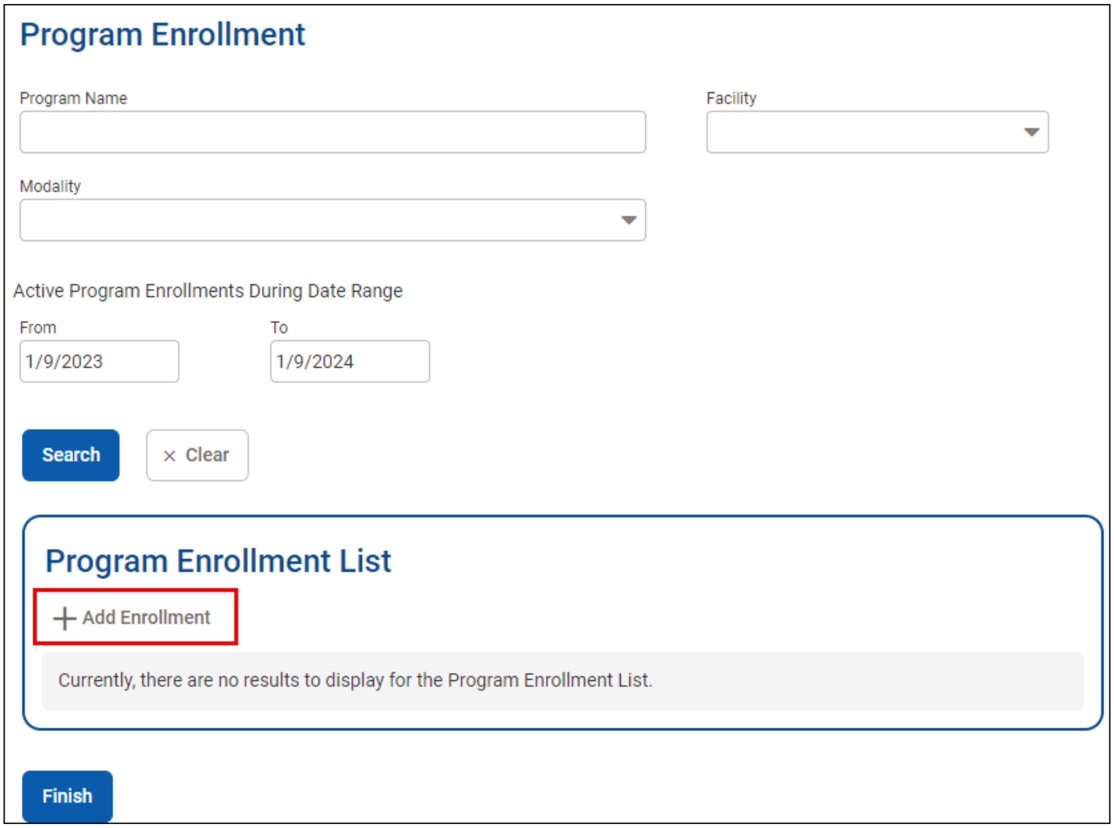
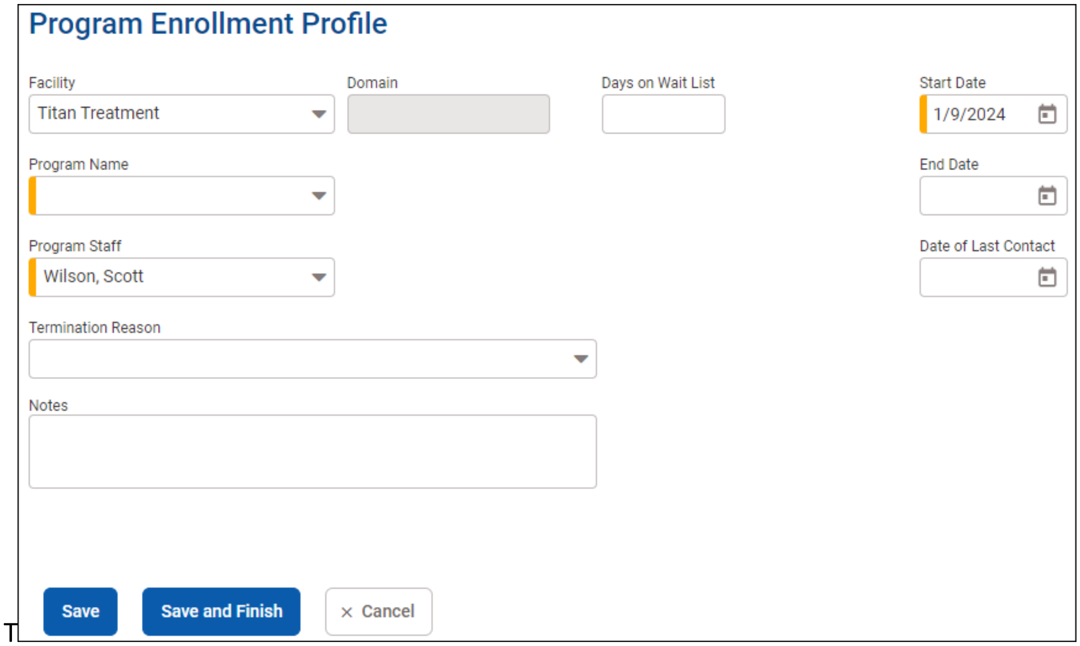


Figure 51: Add Enrollment

3. Under Program Enrollment List, click **+Add Enrollment**.
4. The Program Enrollment Profile displays.
5. Complete all required and relevant fields.
    a. The client should be enrolled in the same level of care that was indicated in the assessment.



T

Figure 52: Program Enrollment Profile

6. Click **Save and Finish**.

3.5. Encounters

When the provider delivers services to the client, those services will be captured as encounters.

NOTE: The client record must be active, and the client enrolled in a program to record an encounter.

1. From the Activity List submenu, click Encounters.

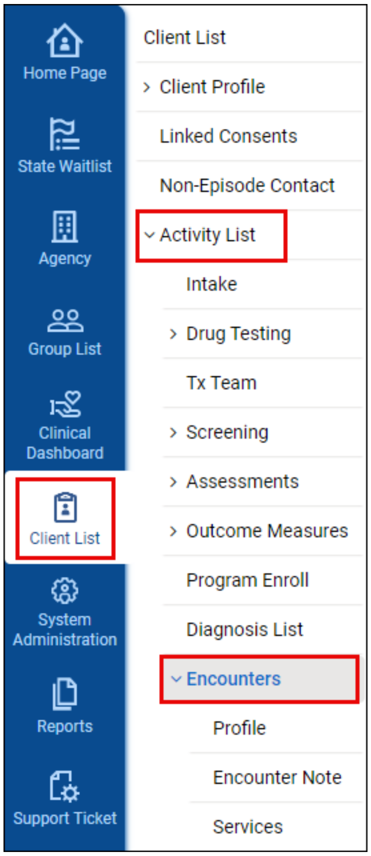


Figure 53: Accessing Encounters

2. The Encounter Search screen will display.
    a. Past encounters will be listed in the Encounter List section.
    b. A search can be performed to filter what encounters display.

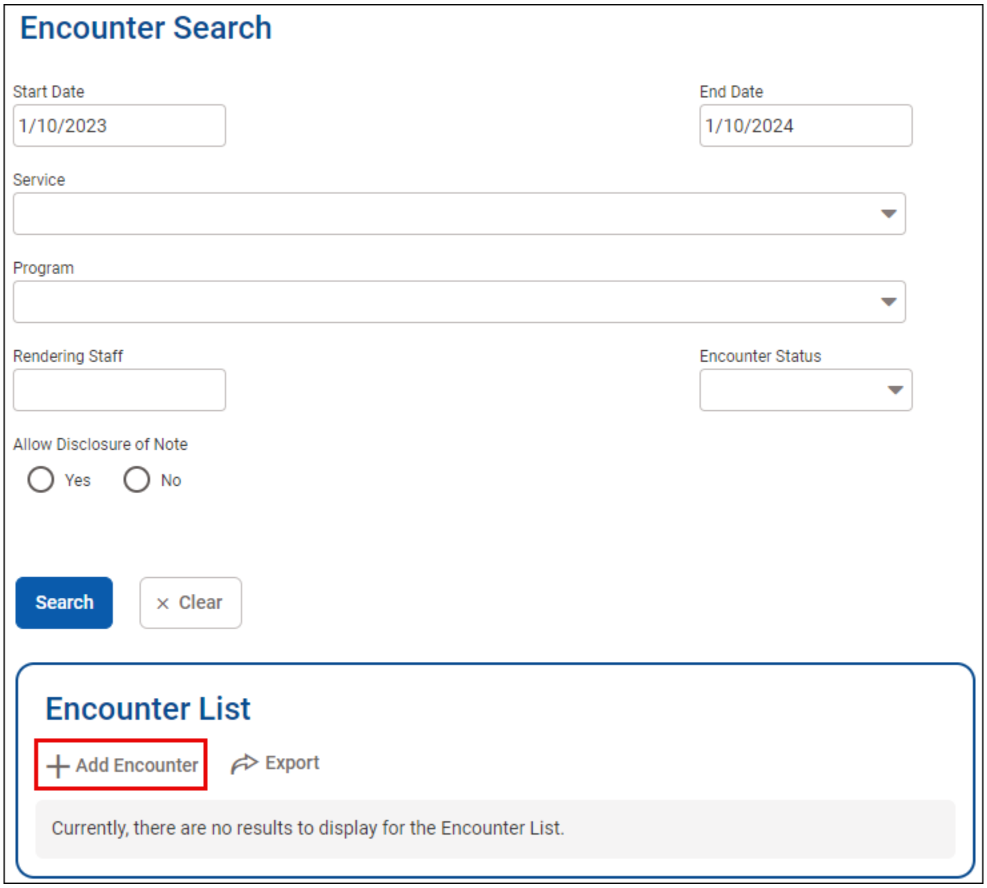


Figure 54: Add Encounter

3. Click **+Add Encounter**.
4. The Encounter screen displays.

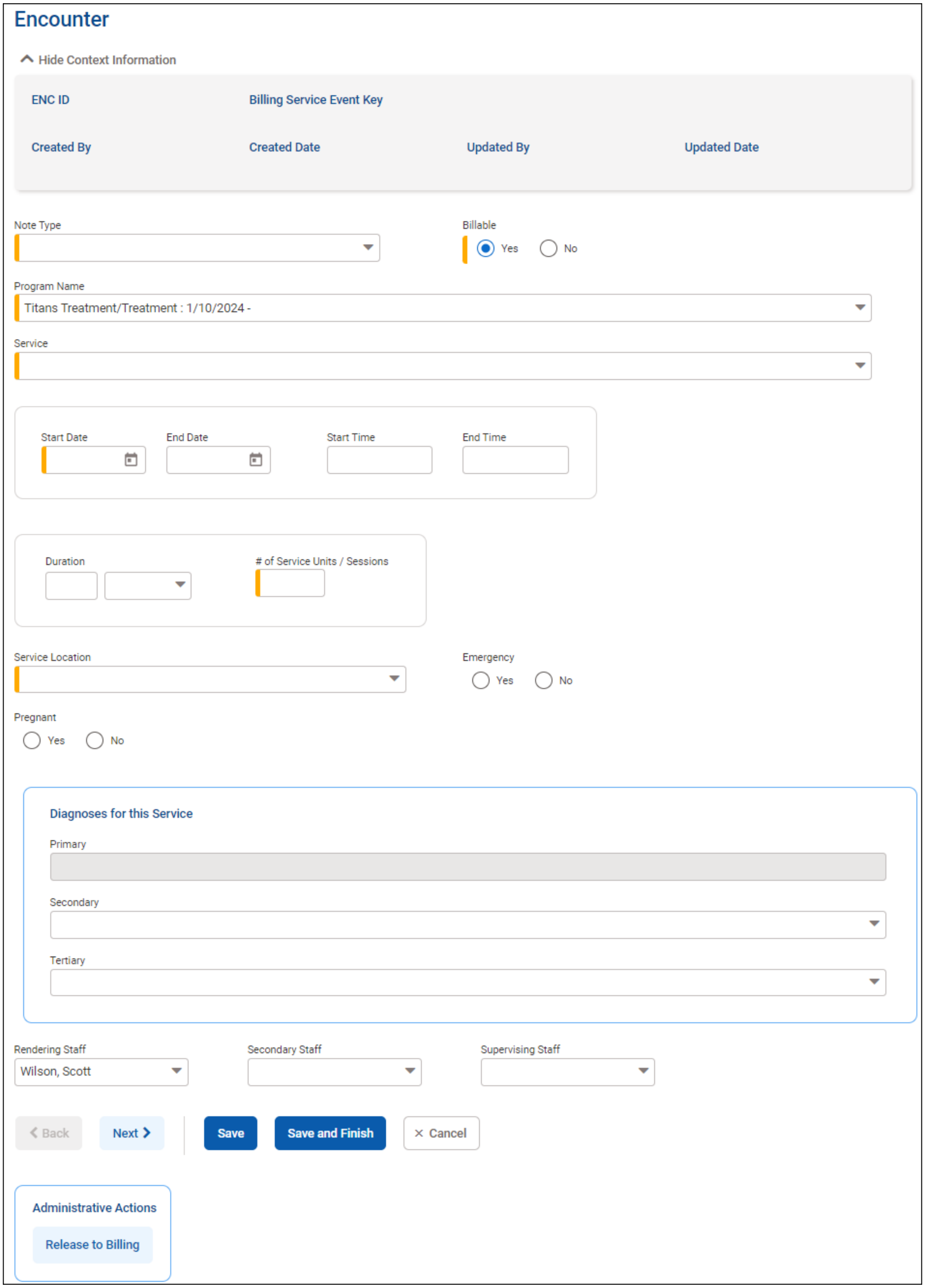


Figure 55: Encounter Screen

5. Complete all required and relevant fields.

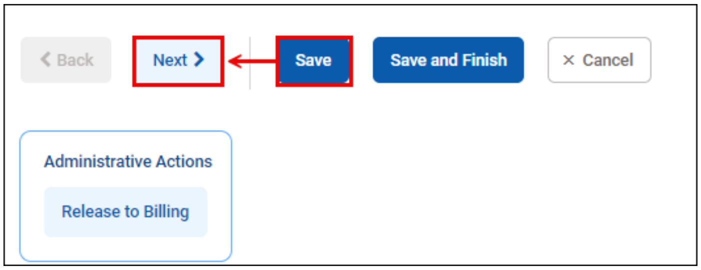


Figure 56: Save/Next Buttons

6. Click **Save** and then click **Next**.
7. The Encounter Notes screen displays.
8. While these fields are not required, they can be used to document the client's progress and link relevant fields of the treatment plan.
    a. **NOTE:** Goals, objectives, and interventions can only be linked to an encounter if a Treatment Plan has been created for the client.

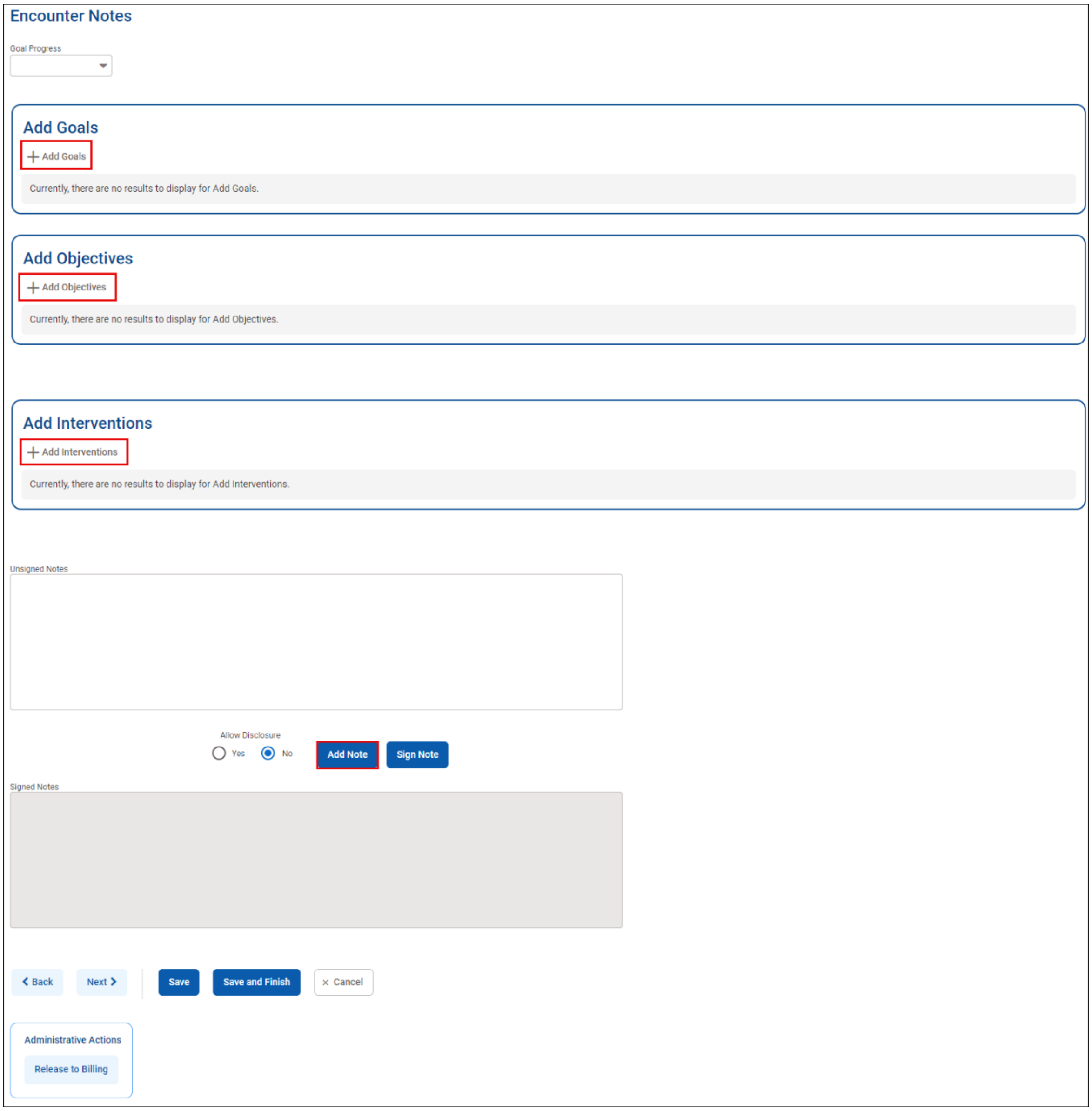


Figure 57: Encounter Notes

9. To link a goal, click **+Add Goals**.
10. The Select Goals screen will display.

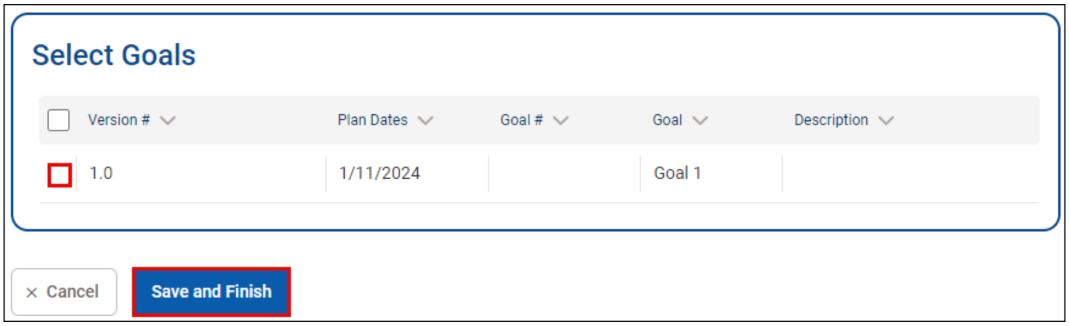


Figure 58: Select Goals

11. Check the box to the left of the goal, and then click **Save and Finish**.
12. Repeat steps 9 – 11 for adding objectives and interventions.
13. Notes can be added using the **Unsigned Notes** text box.
14. Click **Sign Note** to save the notes to the encounter.
    a. Saved notes will display in the **Signed Notes** text box.
15. If there is a template that is used when adding notes, click **Add Note**.
16. The Append Encounter Notes screen will display.
    a. If a template was created for the Append Notes text box, it will display here.
17. Complete the template.

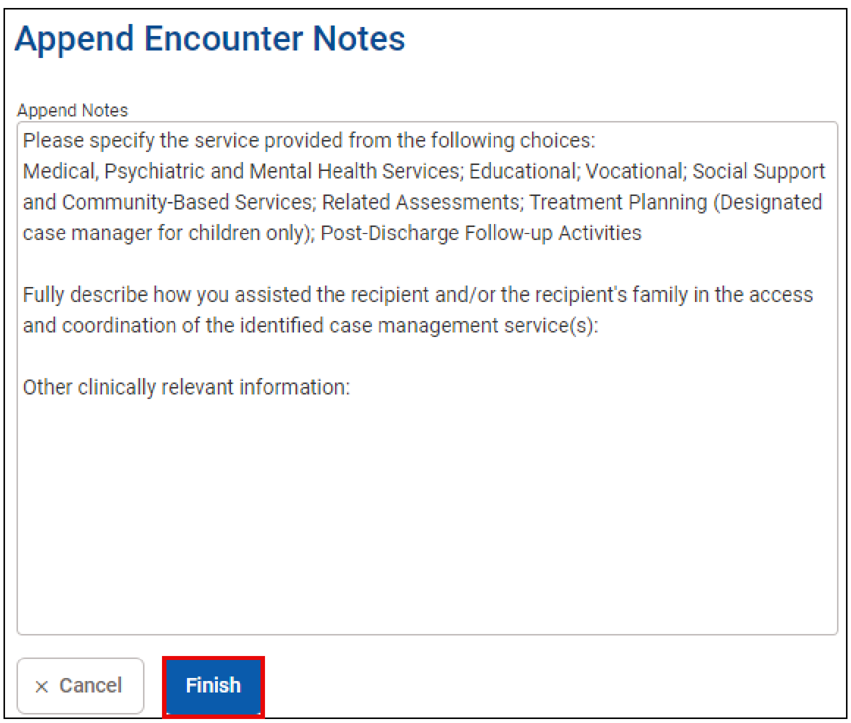


Figure 59: Append Notes

18. Click **Finish**.
19. The notes will display in the Unsigned Notes text box.

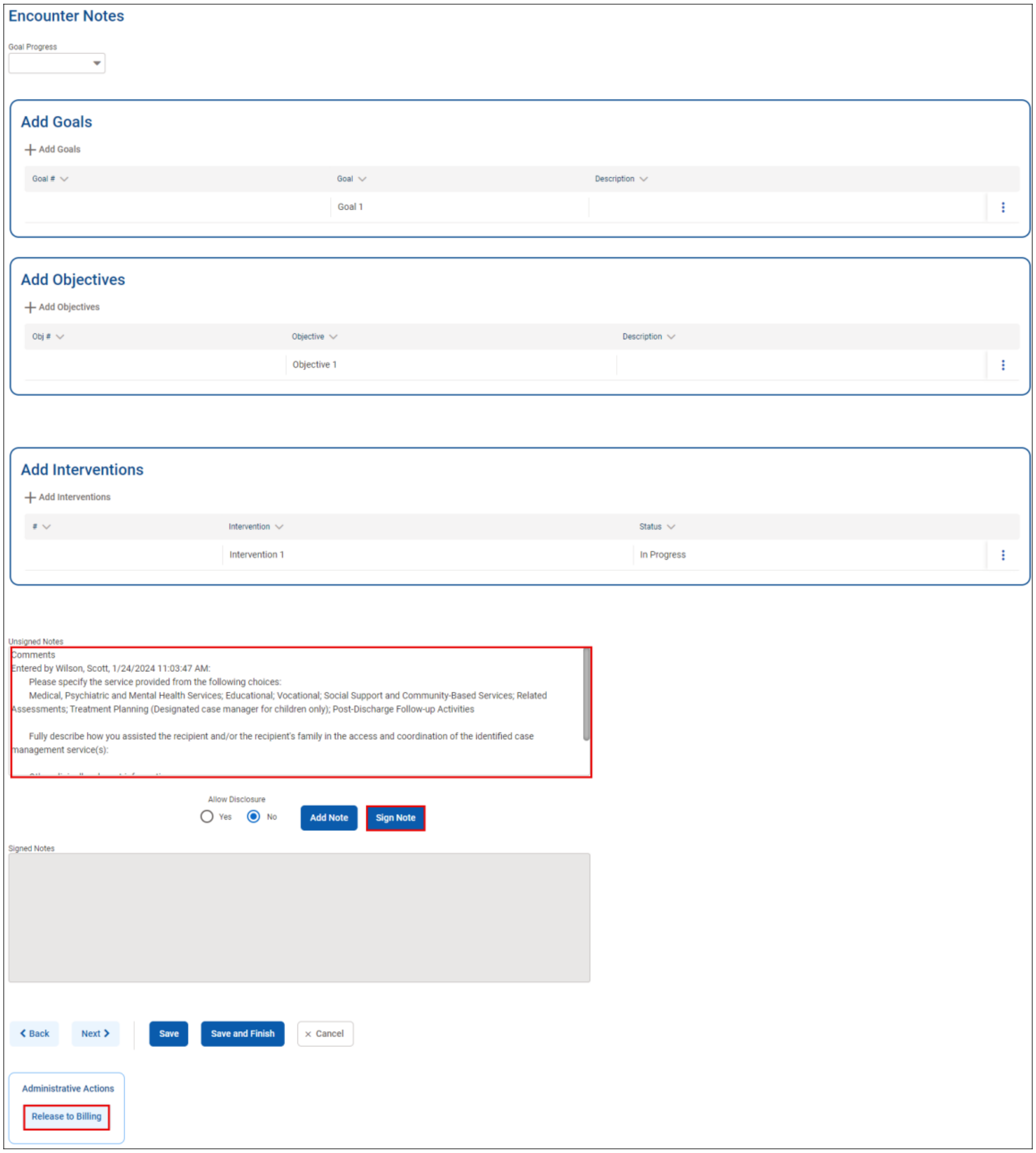


Figure 60: Encounter Screen - Notes Added

20. Click **Sign Note**.
21. Once notes have been signed, the encounter can be released to billing.
22. Click **Release to Billing**.
23. The Release to Billing screen will display.
24. Select the appropriate **Client Group Enrollment** from the dropdown list.

Figure 61: Release to Billing

25. Click **Save and Finish**.

3.6. Level of Care Changes

During the life cycle of a client's treatment, updates may need to be made regarding the client's level of care.

NOTE: To make any of the following changes, the user will need to have the client's record active.

3.6.1. Outcome Measures Updates

As the client progresses through treatment, existing outcome measures may need to be reviewed, and new outcome measures may need to be recorded.

1. From the **Activity List** submenu, click on **Outcome Measures**.

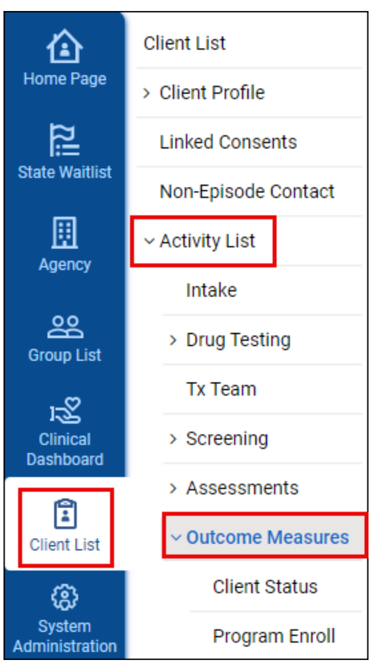


Figure 62: Accessing Outcome Measures

2. The Outcome Measures List screen will display.

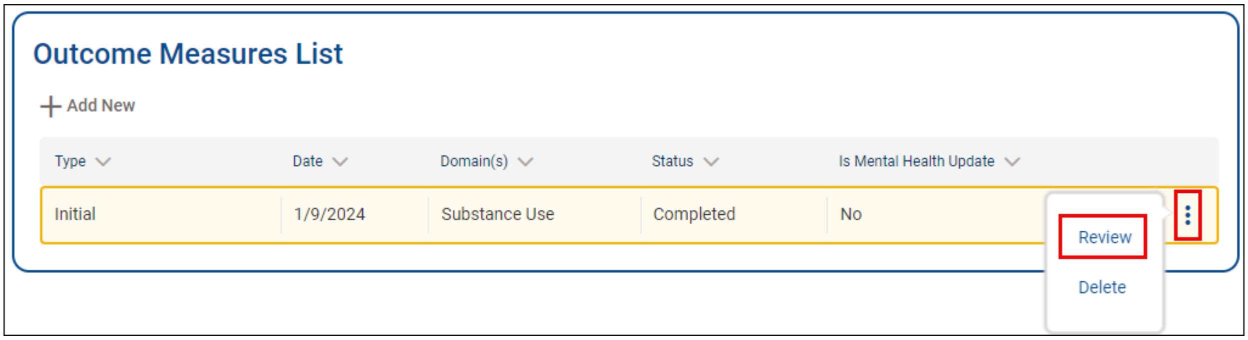


Figure 63: Review Outcome Measure

3. To the right of the Outcome Measure, click the **vertical ellipsis** and then click **Review**.

3.6.1.1. Update Outcome Measure

If a client's program is changing or they are being disenrolled in a program, a new outcome measure will need to be recorded. The existing outcome measure should not be edited.

To add an updated outcome measure for the client, click **+Add New** on the Outcome Measures screen.

Figure 64: Add Update Outcome Measure

The new outcome measure will have the Type: Update.

Completing the update will follow the same process as creating the [Initial Outcome Measure]. However, some completed fields from the initial outcome measure will auto populate and only need to be modified as needed.

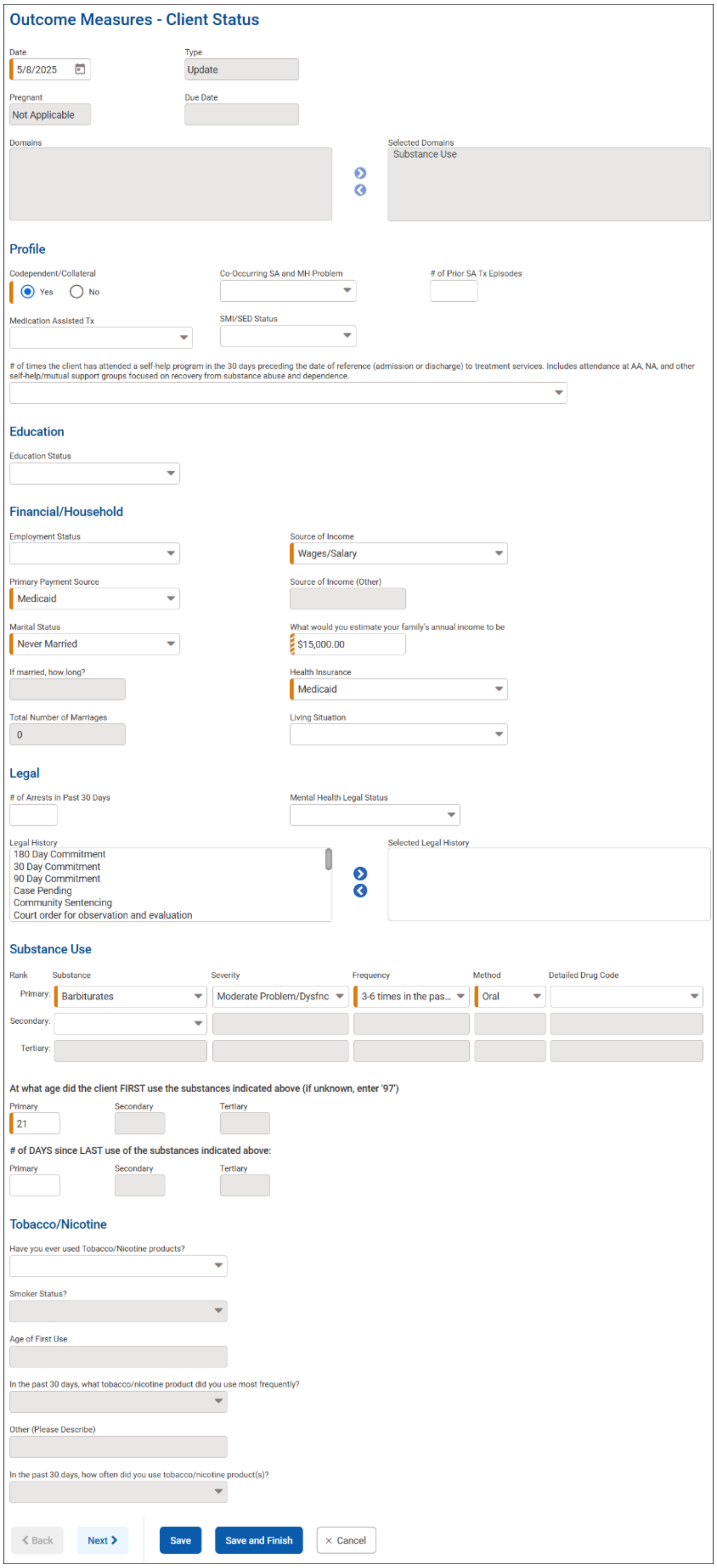


Figure 65: Outcome Measure Update

NOTE: An Outcome Measure recording the client's current status is required before the currently enrolled program can be closed.

3.6.2. Program Changes

As a client's treatment progresses, the treatment program may need to be changed. If the program is no longer needed for whatever reason, the program will need to be closed in the client's record.

1. From the **Activity List** submenu, click on **Program Enroll**.

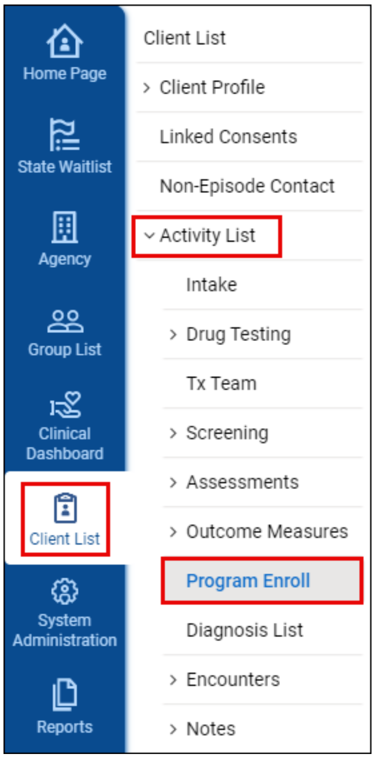


Figure 66: Accessing Program Enrollment - Update

2. Locate the current program for the client.
    a. Use the search function if needed to locate the record.

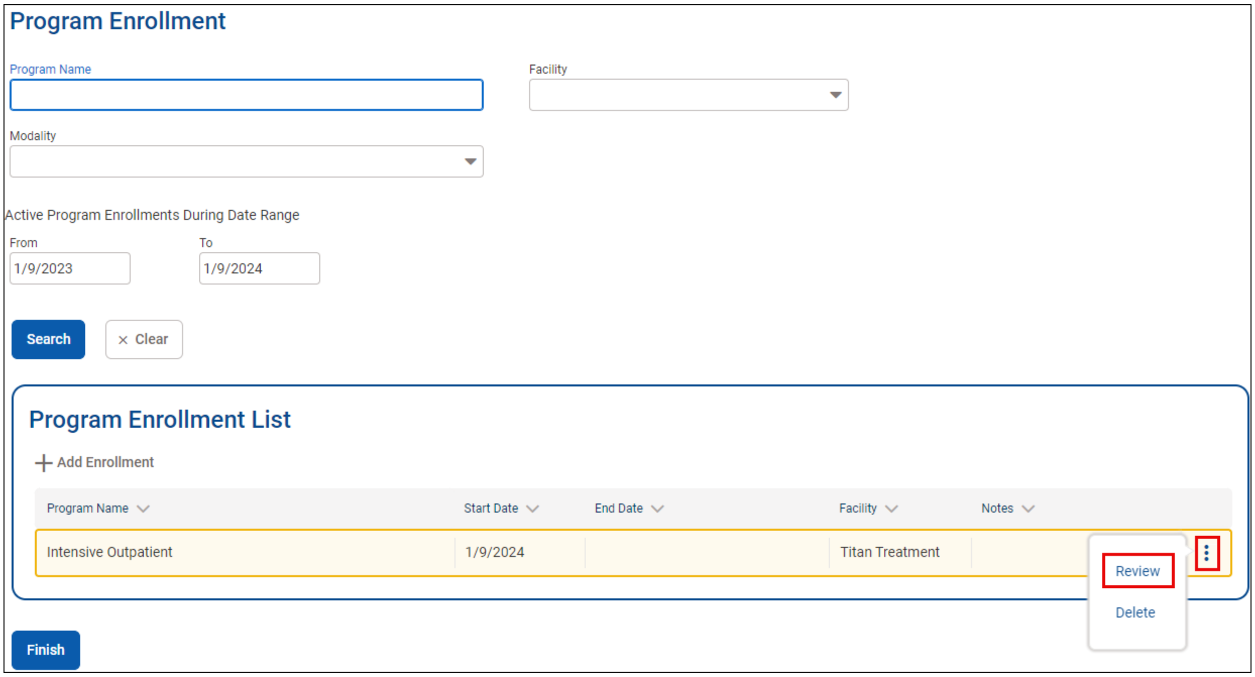


Figure 67: Review Program Enrollment

3. To the right of the enrollment click the **vertical ellipsis** and then click **Review**.
4. While not identified as required fields, the following fields should be completed as appropriate.
   - End Date – When the program was terminated/completed. While not noted as required, this field must be completed.
   - Date of Last Contact – Record this if the client is no longer in contact with the agency. This becomes a required field when the End Date is entered.
   - Termination Reason – This could be anything from successful completion of the program to incarceration. While not noted as required, this field must be completed.
   - Notes – If any relevant information should be captured, provide it here.

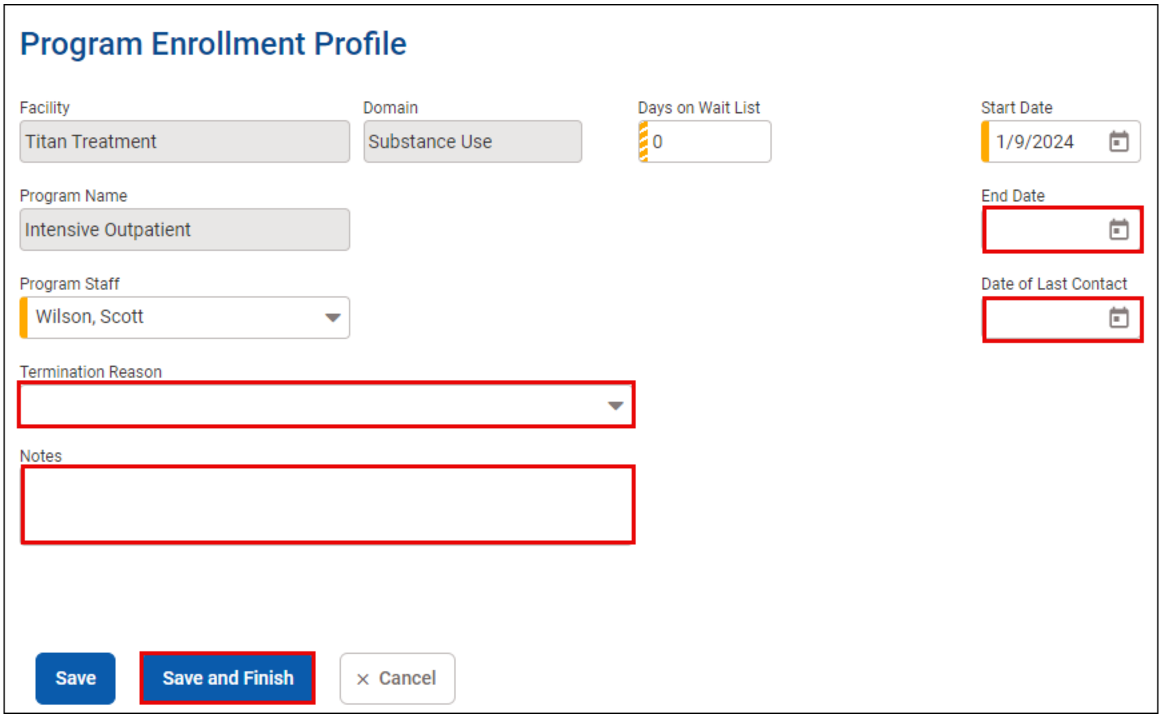


Figure 68: Program Enrollment Profile

5. Click **Save and Finish**.

NOTE: The End Date and Termination Reason must be provided when closing out the program.

If a new program needs to be added for the client, follow the steps from Program Enrollment.

3.6.3. Diagnosis List

The Diagnosis List allows the user to view the client's current and previous diagnoses. The user can also add a new diagnosis or change the status of a current diagnosis to Principal, Provisional or Ruled Out.

NOTE: Accessing this option requires the client record to be active.

1. From the **Activity List** submenu, click **Diagnosis List**.

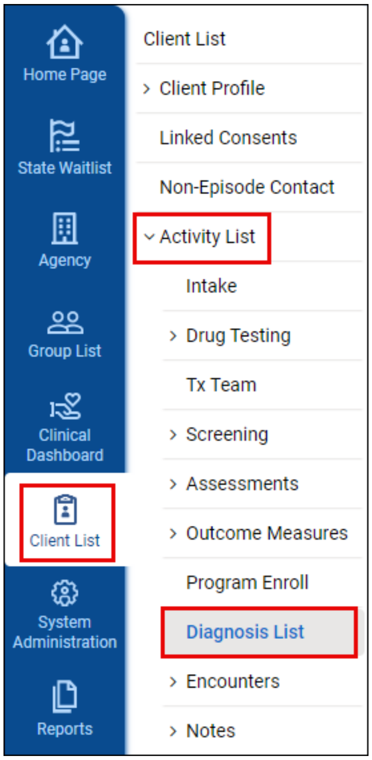


Figure 69: Accessing Diagnosis List

2. The Diagnosis List Search screen will display.
    a. If needed a search can be performed to narrow the results on the page.
3. Click the **vertical ellipsis** to the right of the diagnosis.

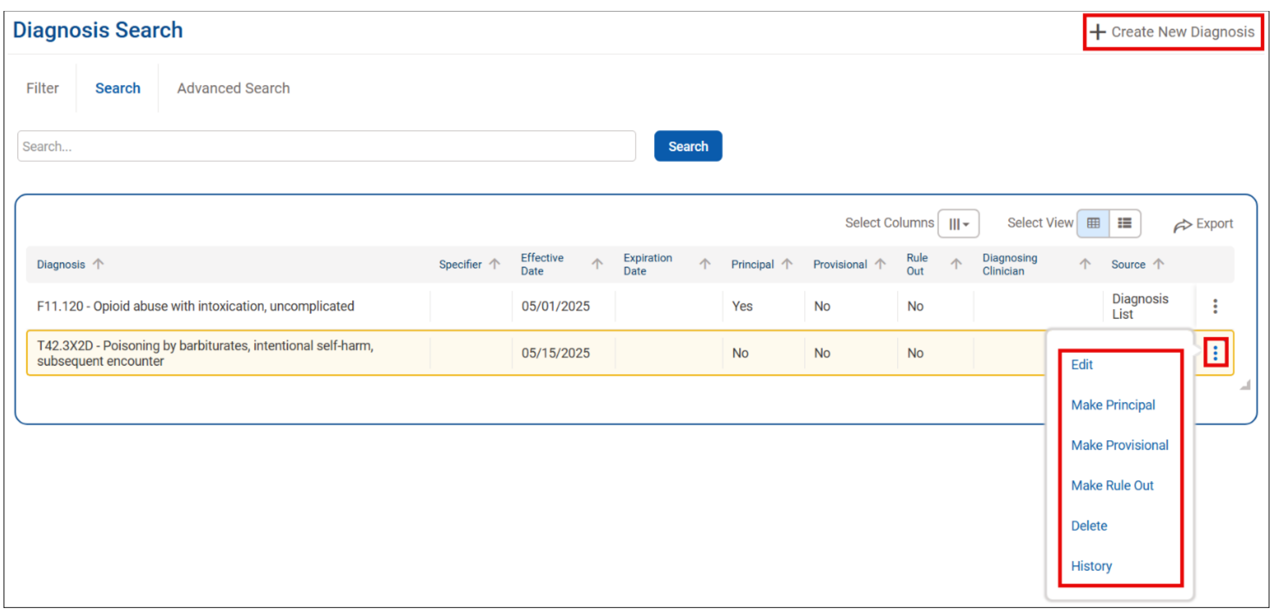
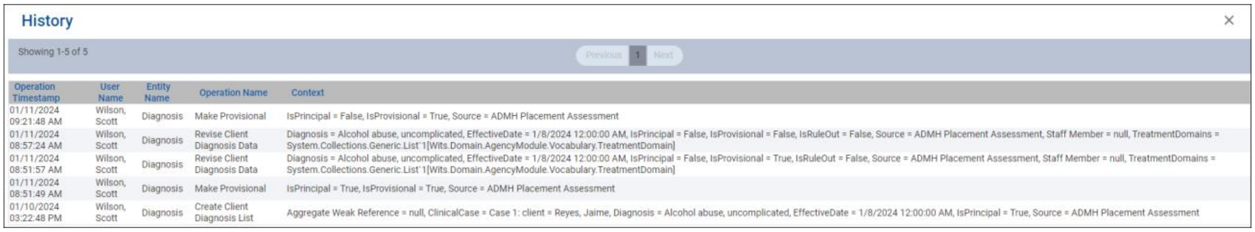


Figure 70: Diagnosis Actions

4. There are several options that may display depending on the current status of the diagnosis.
    a. Make Principal – This action marks the selected diagnosis as principal.
    b. Make Provisional – This action marks the selected diagnosis as provisional.
    c. Make Rule Out – This action marks the selected diagnosis as ruled out.
    d. Delete – This action will delete the diagnosis from the list.
    e. History – This action shows the change history on the diagnosis.


History

Showing 1-5 of 5

Previous 1 Next

Operation Timestamp	User Name	Entity Name	Operation Name	Context
01/11/2024 09:21:48 AM	Wilson, Scott	Diagnosis	Make Provisional	IsPrincipal = False, IsProvisional = True, Source = ADMH Placement Assessment
01/11/2024 08:57:24 AM	Wilson, Scott	Diagnosis	Revise Client Diagnosis Data	Diagnosis = Alcohol abuse, uncomplicated, EffectiveDate = 1/8/2024 12:00:00 AM, IsPrincipal = False, IsProvisional = False, IsRuleOut = False, Source = ADMH Placement Assessment, Staff Member = null, TreatmentDomains = System.Collections.Generic.List`1[Wits.Domain.AgencyModule.Vocabulary.TreatmentDomain]
01/11/2024 08:51:57 AM	Wilson, Scott	Diagnosis	Revise Client Diagnosis Data	Diagnosis = Alcohol abuse, uncomplicated, EffectiveDate = 1/8/2024 12:00:00 AM, IsPrincipal = False, IsProvisional = True, IsRuleOut = False, Source = ADMH Placement Assessment, Staff Member = null, TreatmentDomains = System.Collections.Generic.List`1[Wits.Domain.AgencyModule.Vocabulary.TreatmentDomain]
01/11/2024 08:51:49 AM	Wilson, Scott	Diagnosis	Make Provisional	IsPrincipal = True, IsProvisional = True, Source = ADMH Placement Assessment
01/10/2024 03:22:48 PM	Wilson, Scott	Diagnosis	Create Client Diagnosis List	Aggregate Weak Reference = null, ClinicalCase = Case 1: client = Reyes, Jaime, Diagnosis = Alcohol abuse, uncomplicated, EffectiveDate = 1/8/2024 12:00:00 AM, IsPrincipal = True, Source = ADMH Placement Assessment

Figure 71: Diagnosis History

5. Click **Edit** to open the Diagnosis window. The following changes can be made this way.
    a. Expiration Date – This can be set if the diagnosis is no longer relevant.
    b. Principal Diagnosis – This check box will mark the diagnosis as principal. It can also be unchecked if the diagnosis was marked in error.
    c. Provisional Diagnosis - This check box will mark the diagnosis as provisional. It can also be unchecked if the diagnosis was marked in error.
    d. Rule Out - This check box will rule out the diagnosis. It can also be unchecked if the diagnosis was ruled out in error.

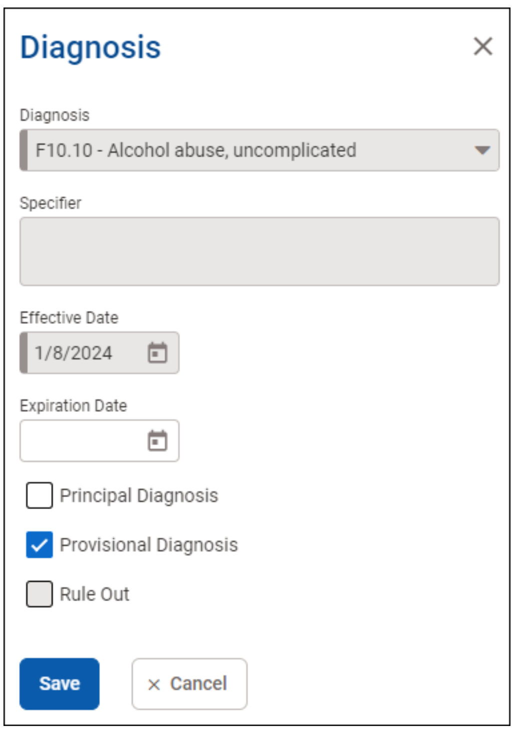


Figure 72: Diagnosis Window

6. Click **Save** to finalize changes.

To add a new diagnosis, click +Create New Diagnosis and follow the instructions under Record Diagnosis to capture the new information.

3.7. Discharge

Before a client can be discharged:

- An Outcome Measurement will need to be recorded to capture the client's current status if the last Outcome Measure is more than 45 days old. See Outcome Measure Updates.
- Any open programs will need to be closed out. See Program Changes.

NOTE: The client record must be active.

1. From the left navigation menu, click **Client List**.
2. In the submenu, click **Activity List** to expand its options.

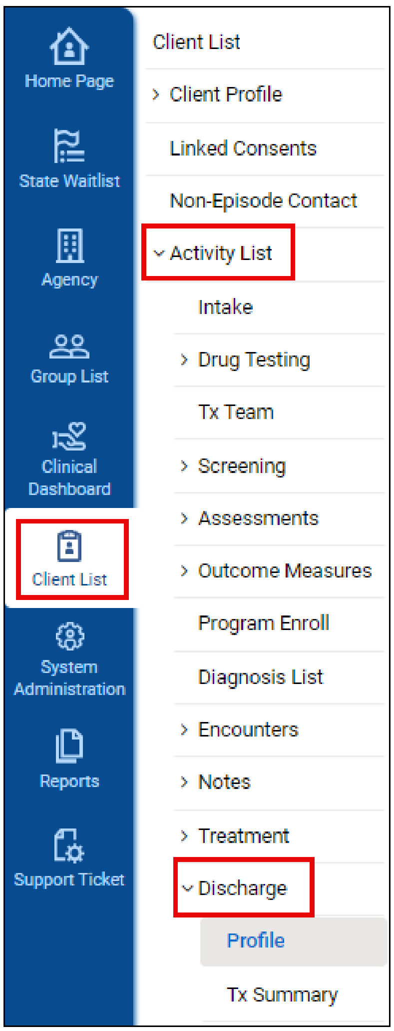


Figure 73: Accessing Discharge

3. Click **Discharge**.
4. The Discharge Profile screen will display.
5. Complete the required and relevant fields.

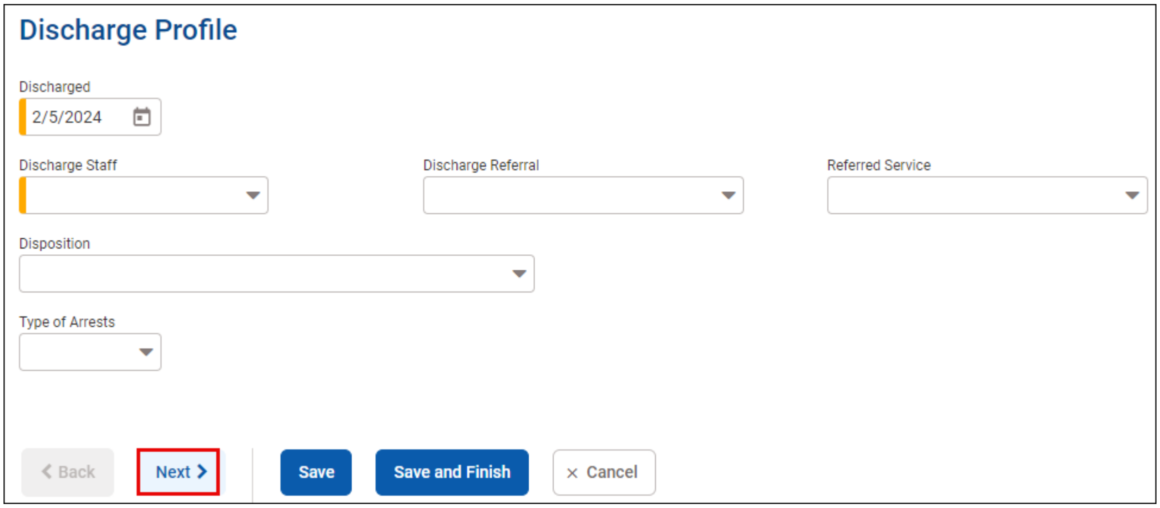


Figure 74: Discharge Profile

6. Click **Next**.
7. The Discharge screen will display providing a Treatment Summary.
    a. There are some optional fields that can be completed based on established processes.

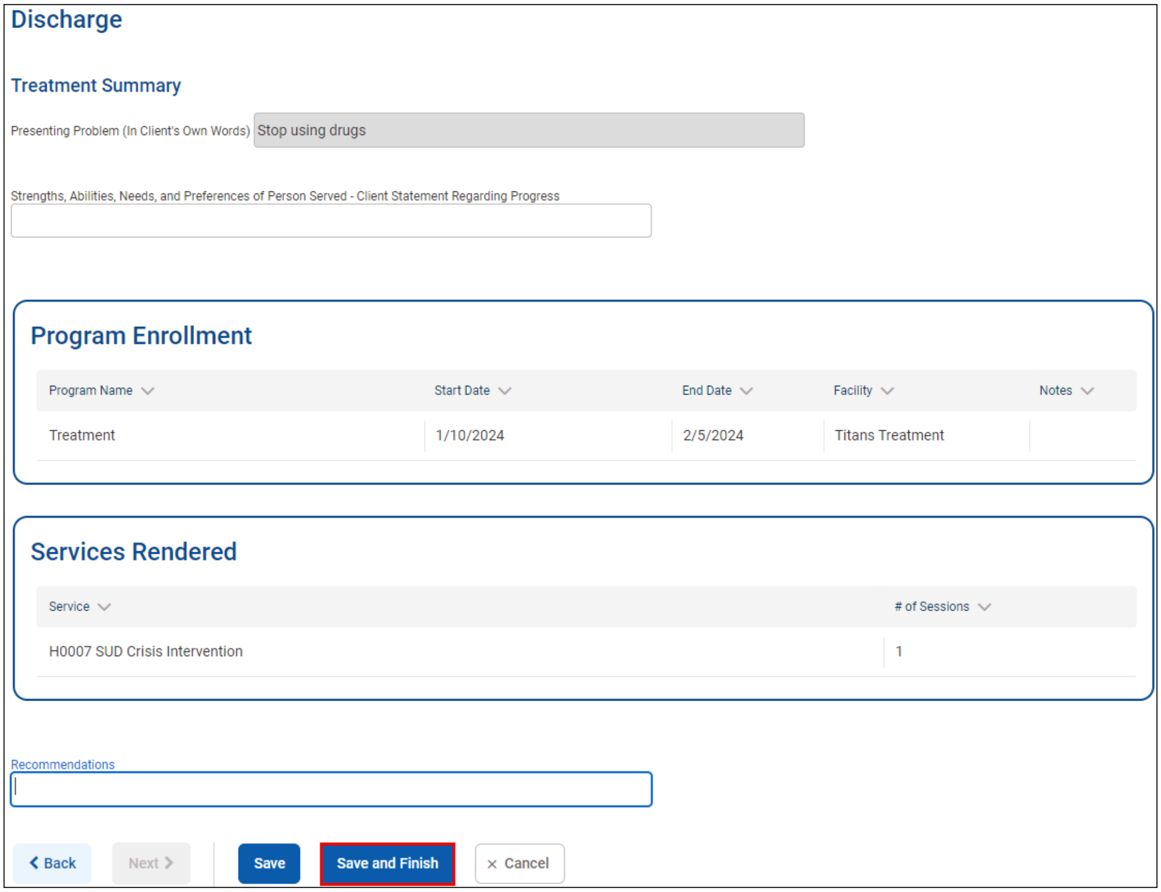


Figure 75: Discharge Screen

8. Click **Save and Finish**.

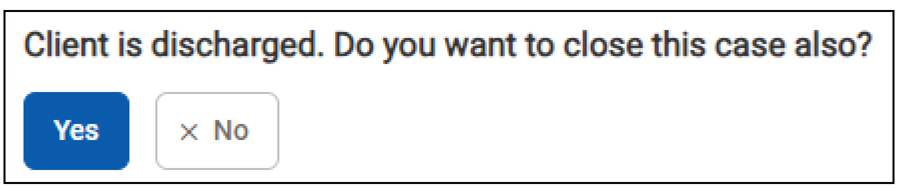


Figure 76: Close Case

9. The user will be asked if they want to close the case.
    a. Click **Yes** if the client will receive no additional services from the provider.
    b. Click **No** if the client will continue to receive services from the provider.
10. Selecting **Yes** will close the Intake record for the client.
    a. The Date Closed field of the Client Intake is updated to show the record has been closed.

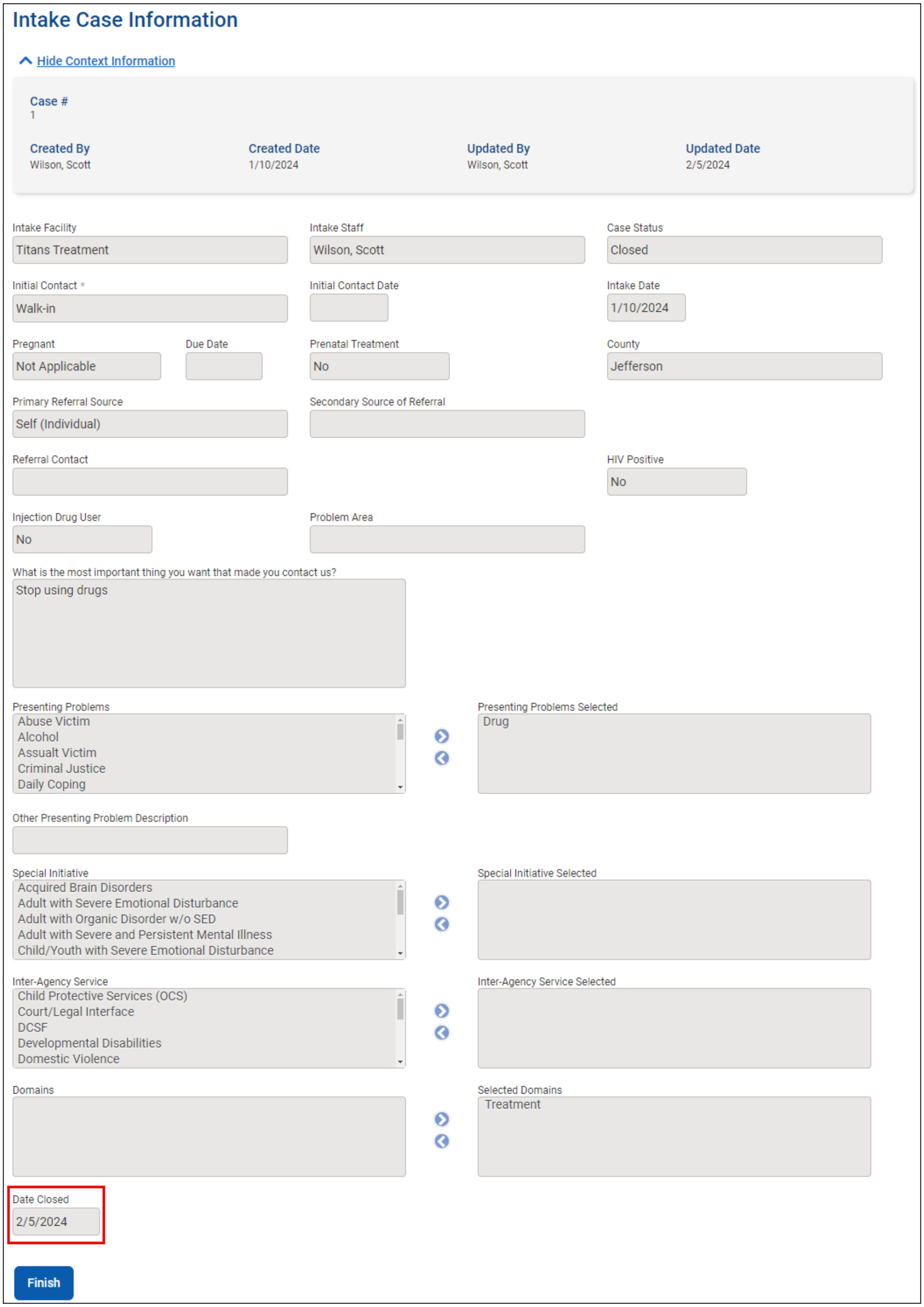


Figure 77: Client Intake - Closed

4. TREATMENT WORKFLOW RELATED FUNCTIONS

While completing the treatment workflow, it may be required of the user to perform other steps or functions. Those functions include:

- Adding a treatment team or member to a client’s record.
- Referring a client to a different location or provider.
- Adding a client to a waitlist.
- Creating a treatment plan for the client.

4.1. Treatment Team

For some functions related to treatment to work properly, a treatment team member or group will need to be added to a client’s record.

NOTE: The client record must be active to complete the following steps.

1. Click the **Activity List** submenu to expand its options.
2. Click **Tx Team**.

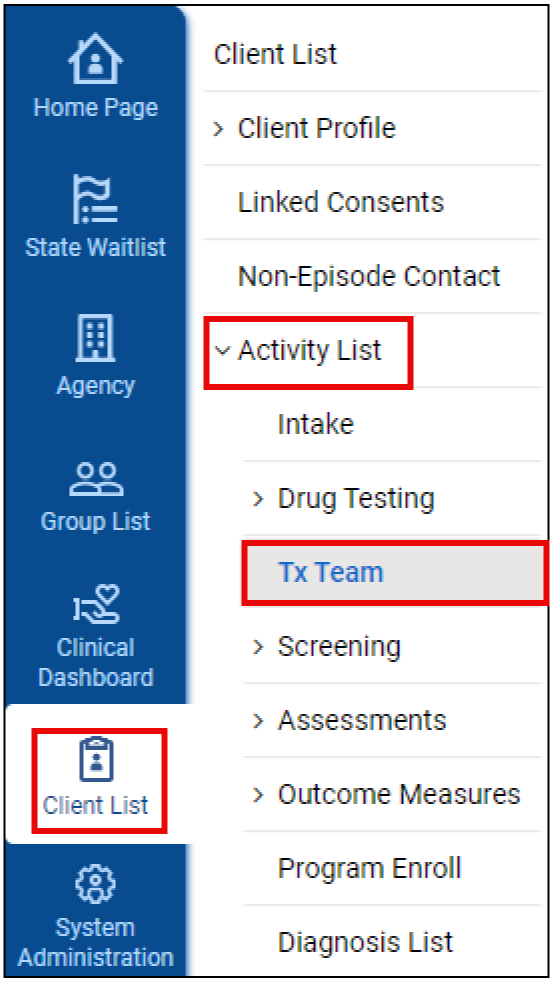


Figure 78: Accessing Treatment Team

3. The Treatment Team screen will display.

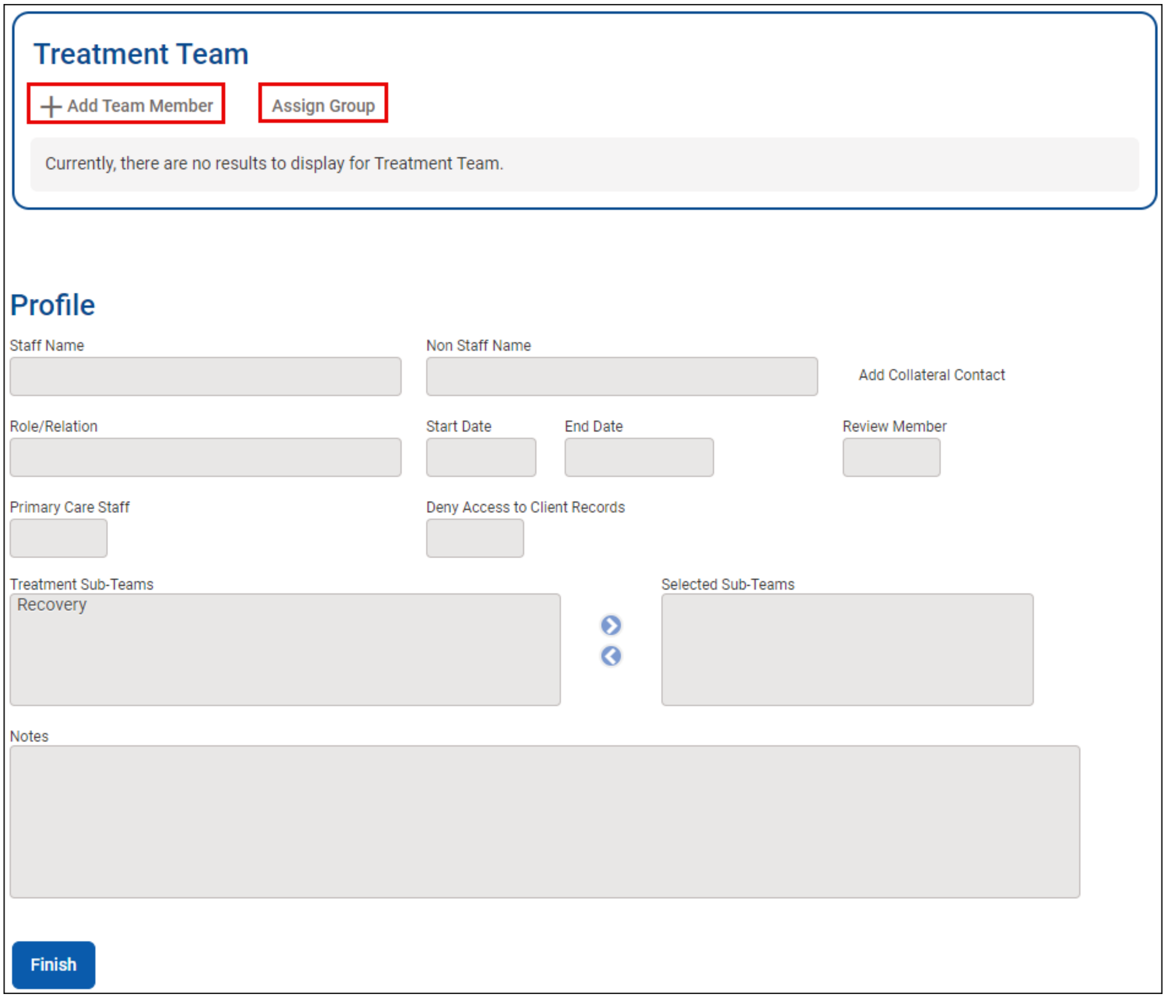


Figure 79: Treatment Team

At this point, the user can either assign a team member or a group to the client's record.

4.1.1. Add Team Member

To add a team member:

1. Click **+Add Team Member**.
2. The Profile section will become active.
3. Complete all required and relevant fields.
    a. While not listed as required fields, **Staff Name** or **Non Staff Name** must be chosen from their respective dropdown lists.
    b. Collateral contacts display in the Non Staff Name dropdown. If a collateral contact needs to be added, click **Add Collateral Contact**.

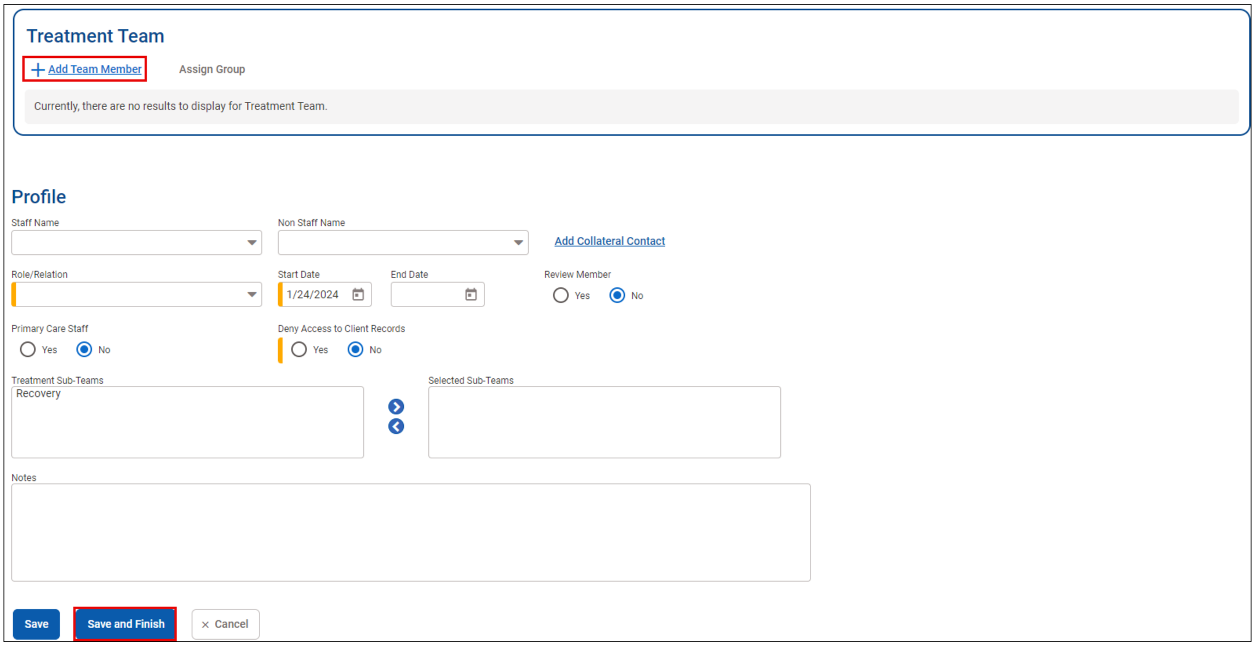


Figure 80: Add Treatment Team Member

4. Click **Save and Finish**.

4.1.2. Assign Treatment Team Group

To assign a group:

1. Click **Assign Group**.
2. Available Groups will be listed on the left and can be added to the Selected Groups.

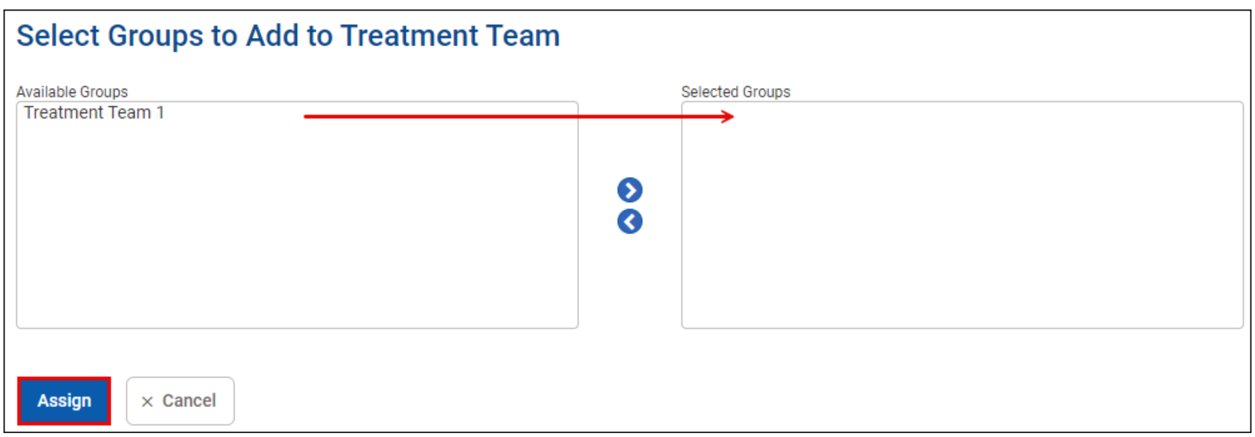


Figure 81: Assign Treatment Team Group

3. Click **Assign** to save changes.
4. Click **Finish** to leave the Treatment Team screen.

4.2. Referral

If a client needs to be referred to another provider, a linked consent will need to be generated before the referral can be entered.

NOTE: The client's record will need to be active for the user.

1. From the **Activity List** submenu, click **Consent**.

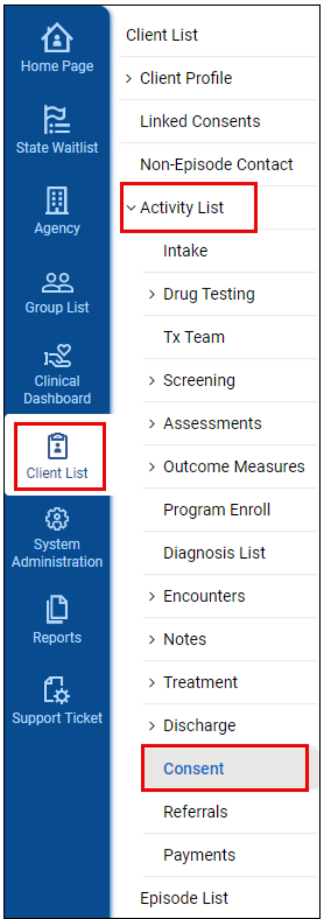


Figure 82: Accessing Consent

2. The screen Client Consent List will display.
    a. Existing consents will display in the Linked Consent List section.

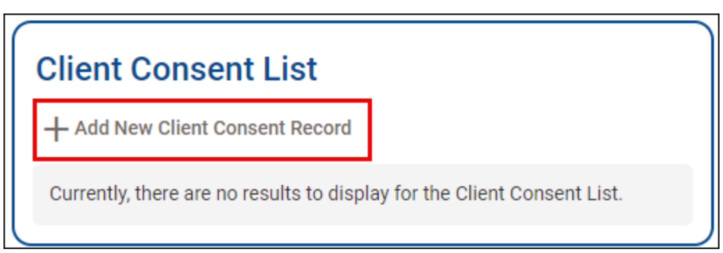


Figure 83: Add Client Consent

3. Click **+Add New Client Consent Record**.
4. The question "Is this related to a waitlist record?" will be asked.

Figure 84: Related to Waitlist Record?

5. Click **Yes** or **No** as appropriate.
6. The Client Disclosure Agreement screen displays.

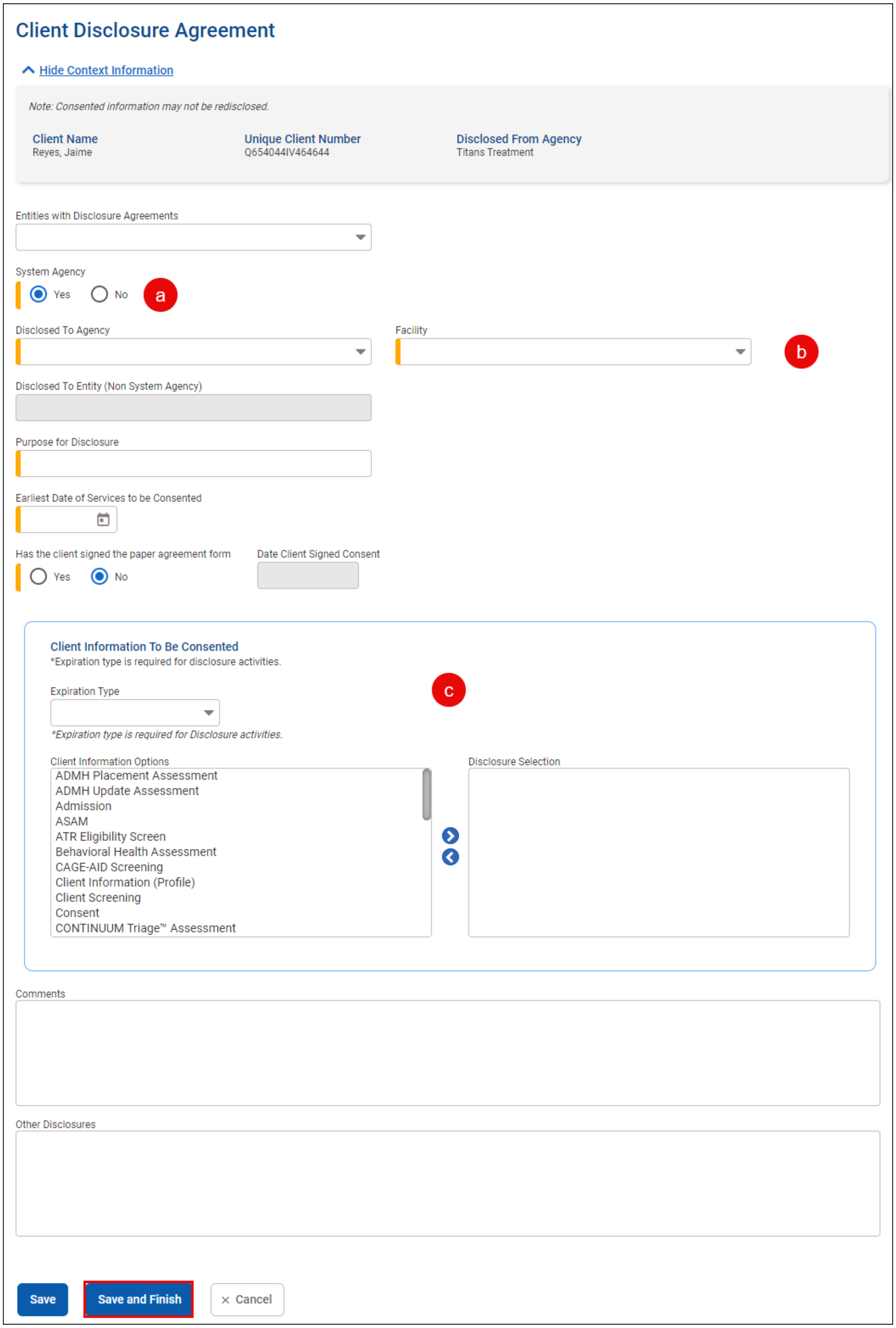


Figure 85: Client Disclosure Agreement

7. Complete all required and relevant fields. Most of the fields are self-explanatory. However, a couple of fields are described as follows:
    a. System Agency
        i. Set to **Yes** if referring the client to a different provider.
        ii. Set to **No** if referring the client to an external entity, such as a physician, hospital, etc.
    b. Agency and Facility – Agency must be selected first.
    c. Information to be Consented – The client's information to be shared with the consenting agency is selected here, as well as setting an expiration date if any.
8. Once the Expiration Type for Client Information to Be Consented is set, a **+Days** field will display.
    a. This field determines how long after the expiration trigger information with the agency will be shared.

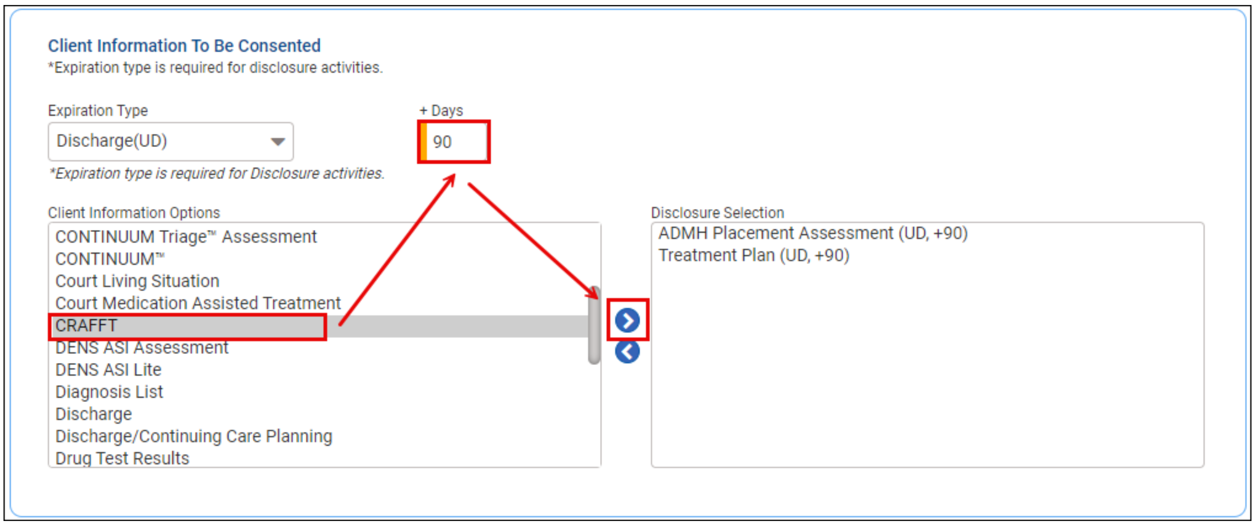


Figure 86: Shared Information Expiration Date

9. For each **Client Information Option** shared the **+Days** field to the right of **Expiration Type** must be reentered.
10. Click **Save and Finish**.

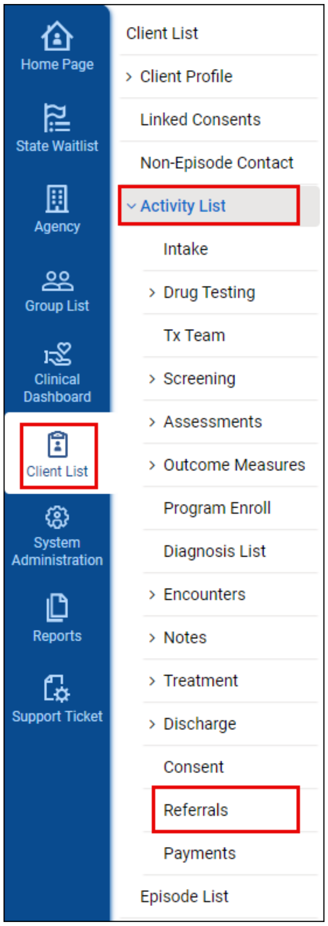


Figure 87: Accessing Referrals

11. From the **Activity List** submenu, click **Referrals**.
12. The Client Referral List screen will display.
    a. Any current/previous referrals will be listed here.

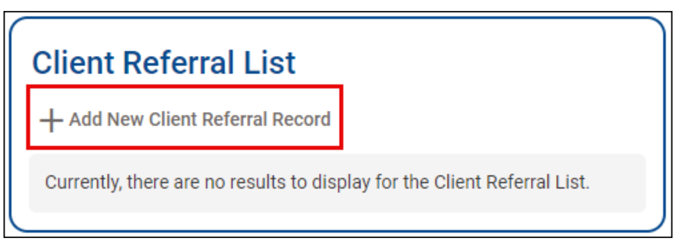
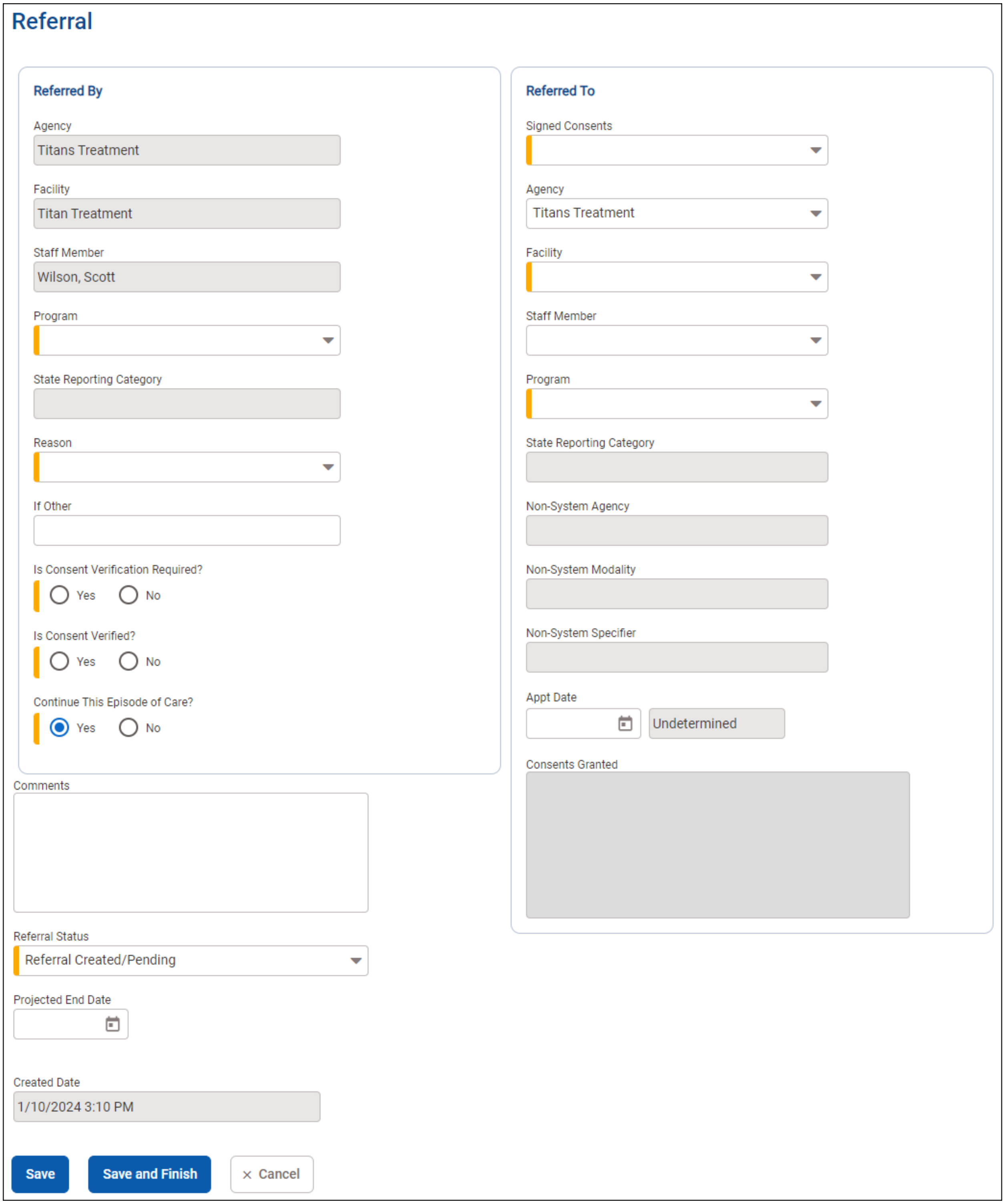


Figure 88: Add Referral Record

13. Click **+Add New Client Referral Record**.
14. The Referral screen displays.
15. Complete all required and relevant fields.



Referral

Referred By

Agency: Titans Treatment

Facility: Titan Treatment

Staff Member: Wilson, Scott

Program

State Reporting Category

Reason

If Other

Is Consent Verification Required? Yes No

Is Consent Verified? Yes No

Continue This Episode of Care? Yes No

Referred To

Signed Consents

Agency: Titans Treatment

Facility

Staff Member

Program

State Reporting Category

Non-System Agency

Non-System Modality

Non-System Specifier

Appt Date: Undetermined

Consents Granted

Comments

Referral Status: Referral Created/Pending

Projected End Date

Created Date: 1/10/2024 3:10 PM

Save | Save and Finish | × Cancel

Figure 89: Referral Form

16. Click **Save and Finish**.
17. The referral will be listed under the Client Referral List in a pending status.

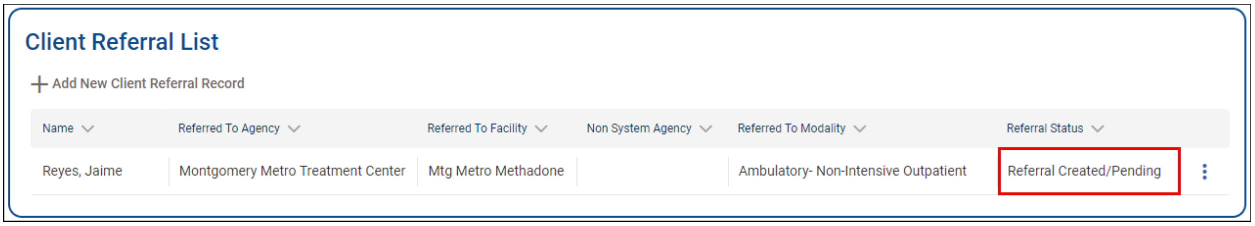


Figure 90: Referral Status

The referral will remain in this status until the referred to agency makes a decision about the referral.

4.3. State Waitlist

The State Waitlist module is used to manage client referrals and waitlist activities.

Click on **State Waitlist** from the left navigation menu to access this module.

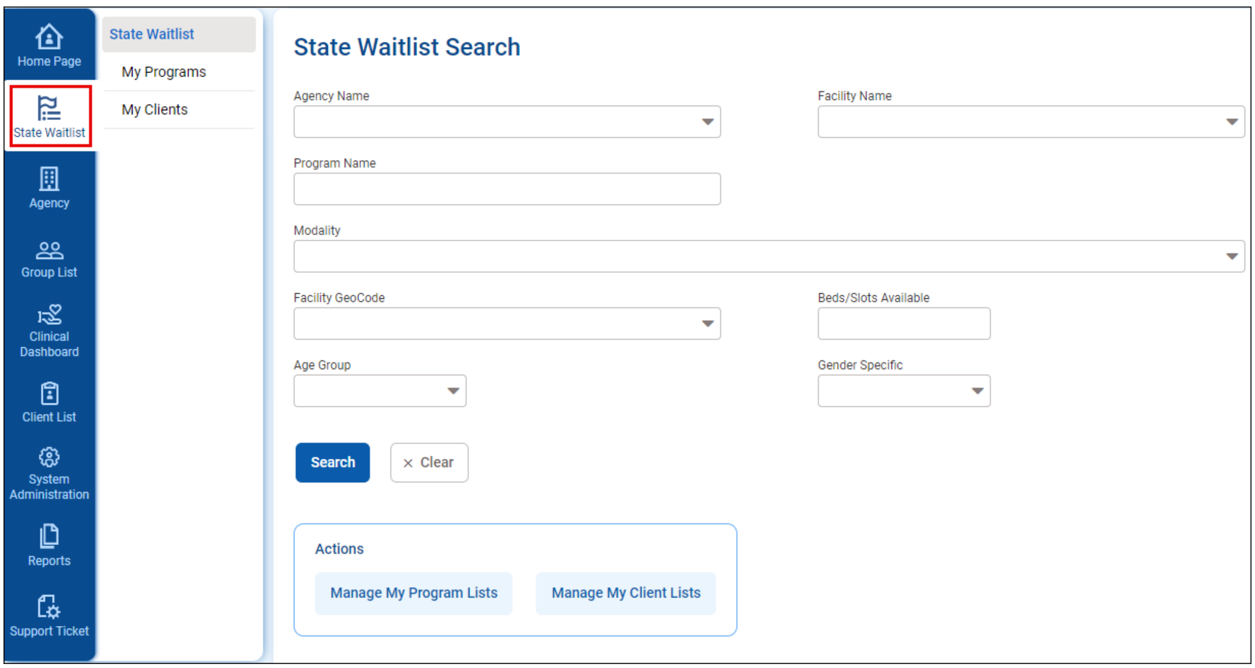


Figure 91: Accessing State Waitlist

Below the Actions section, the State Waitlist section displays any agency that has a client on a waitlist (referrals included).

Search may be used to narrow the list of agencies listed.

Results will display in the section State Waitlist List.

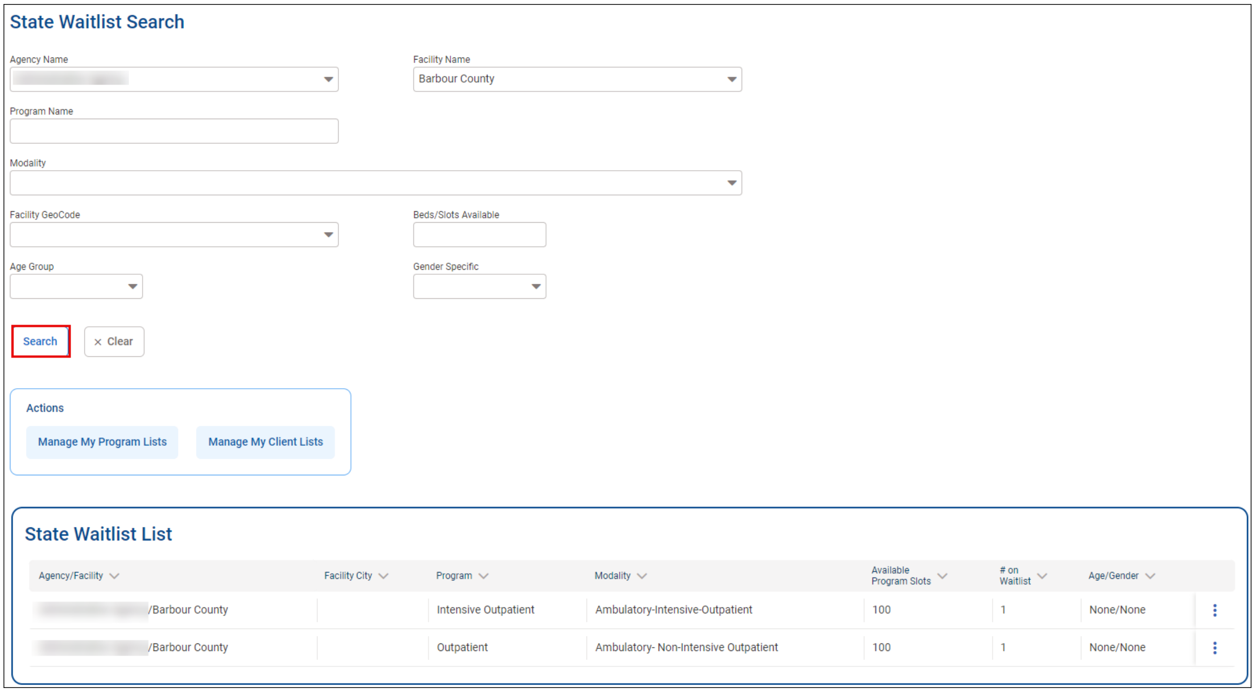


Figure 92: State Waitlist Search Results

Two actions, reviewing the list and facility details, can be taken on the search results by clicking the **vertical ellipsis** and then selecting one of two options.

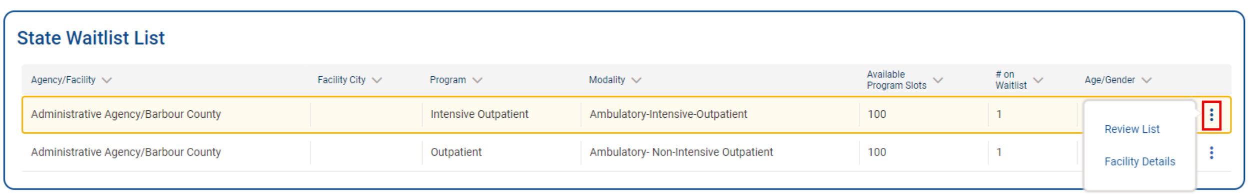


Figure 93: Waitlist Actions

4.3.1. Review List

Clicking **Review List** will display the Client Waitlist screen.

Results can be narrowed by using **Search**.

Clients are listed in the Client Waitlist List section. To take an action on a client, click the vertical ellipsis and choose one of three options.

- **Accept** – The client is to be accepted into the agency's program.
    - The originating agency will receive an email of the client's acceptance.
    - If the client was not referred through the Referral functionality in WITS, the email will also state that a referral and consent need to be completed for the client.
- **Reject** – Do not accept a client into the agency's program.
    - Rejected clients cannot be referred to the same facility at a later date.

- **Delete** – Delete the client from the waitlist.

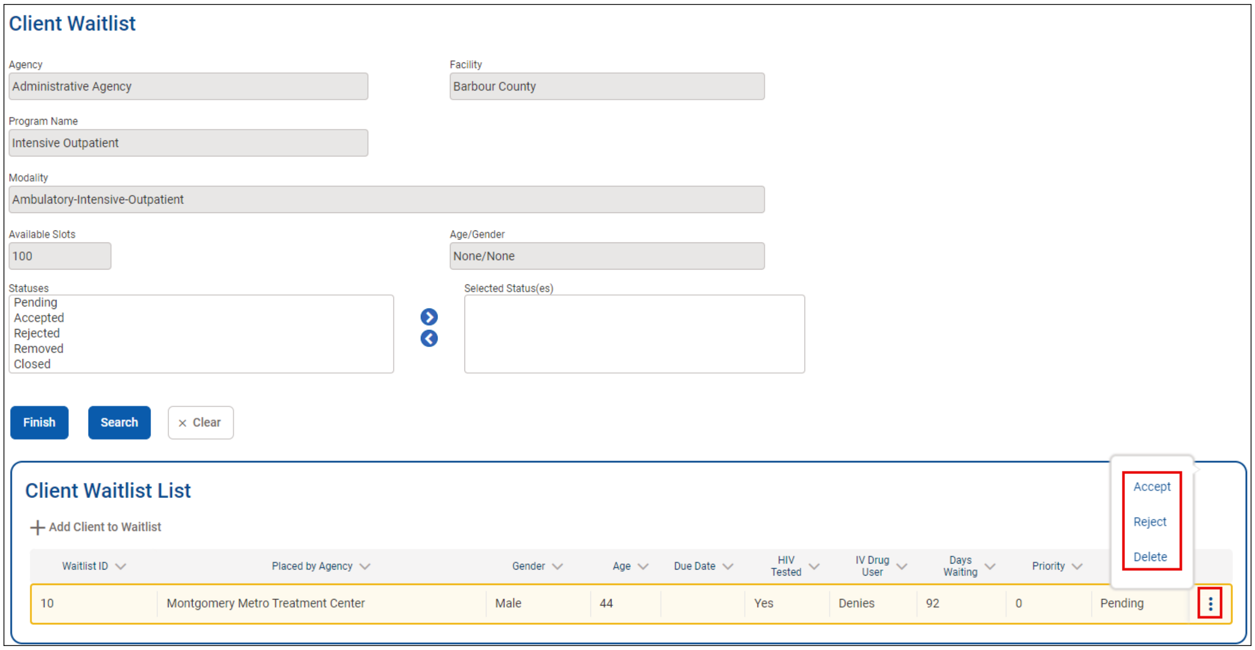


Figure 94: Client Waitlist

Regardless of the option selected, the user will need to click **Yes** to confirm their choice.

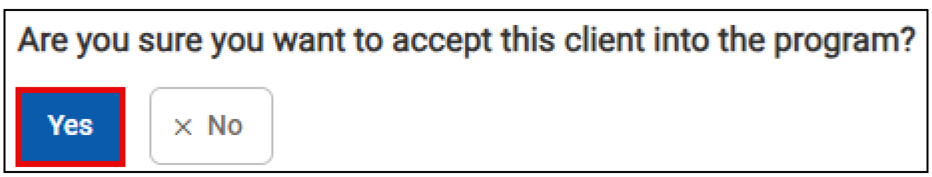


Figure 95: Confirm Selection

If accepted, the client will now be listed in the accepting agency/facility's client list.

4.3.2. Facility Details

Clicking **Facility Details** will open a separate window providing general information and special services provided by the facility.

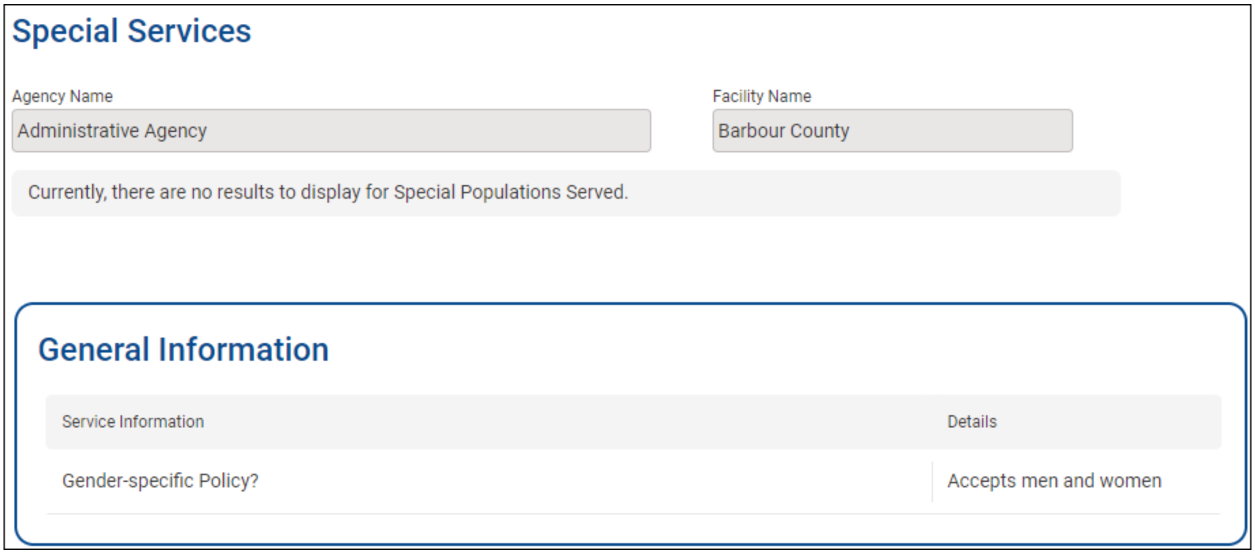


Figure 96: Facility Details

4.3.3. My Programs

My Programs can be accessed by clicking **My Programs** from the submenu or by clicking **Manage My Program Lists** from the State Waitlist Search screen.

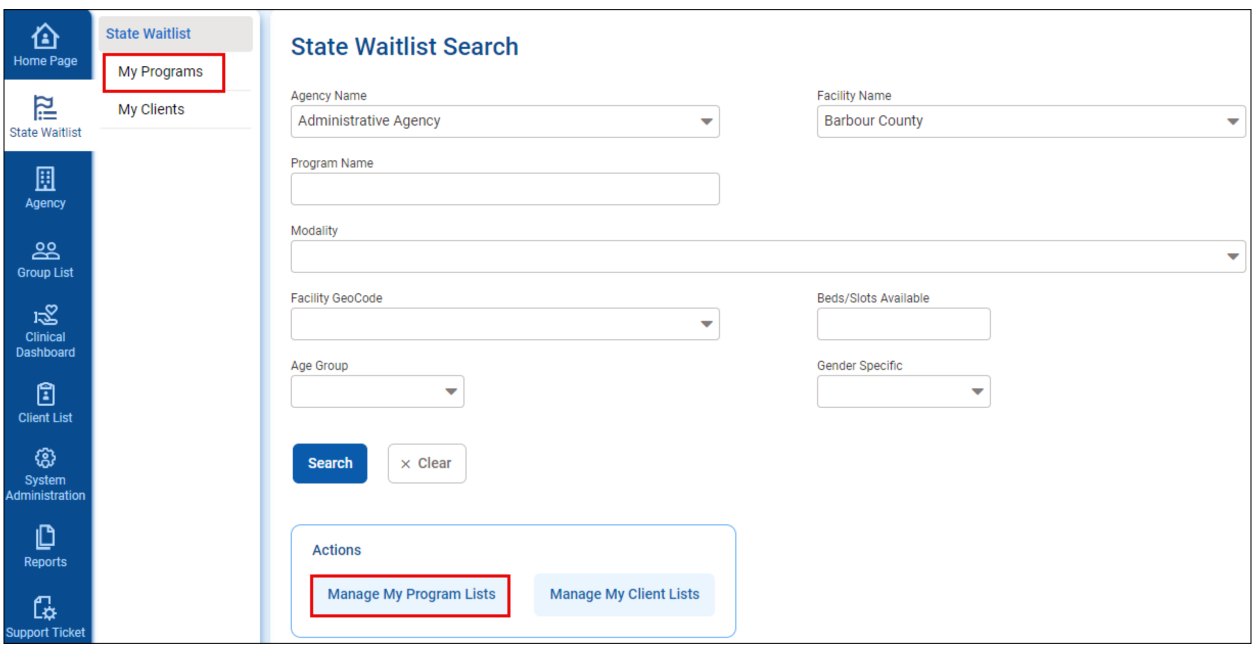


Figure 97: Accessing My Programs

The Program Waitlist Search screen will display. This screen allows the agency to manage their waitlist based on the programs they offer.

Search can be used to narrow the listed results.

From this screen, clients on a waitlist by program can be accepted or rejected.

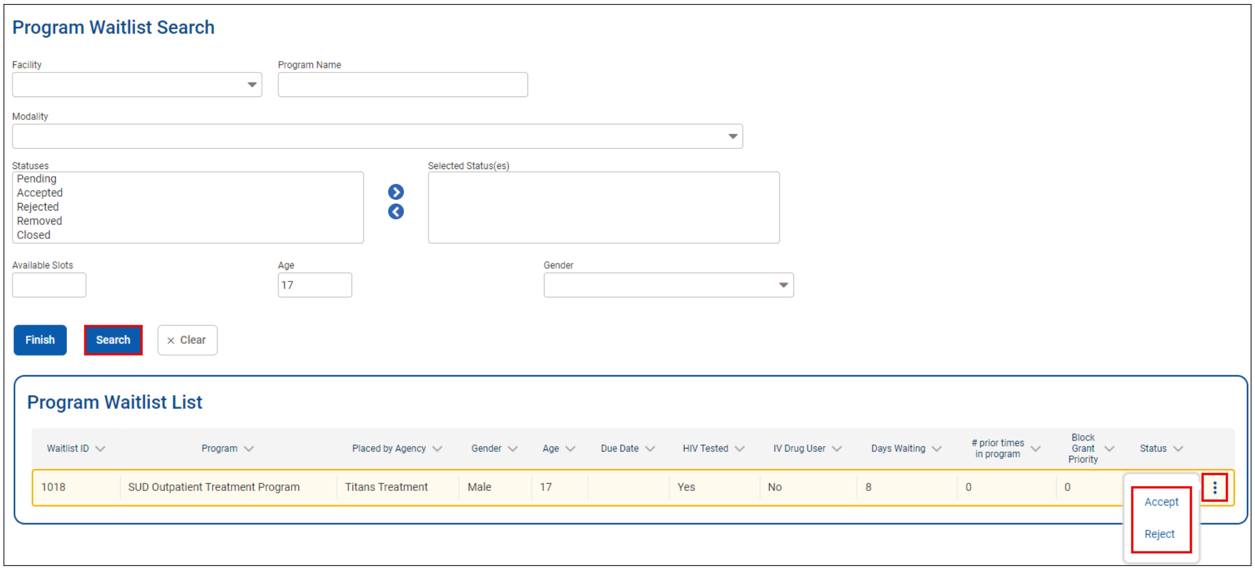


Figure 98: Program Waitlist

4.3.4. My Clients

My Clients can be accessed by clicking **My Clients** from the submenu or by clicking **Manage My Client Lists** from the State Waitlist Search screen.

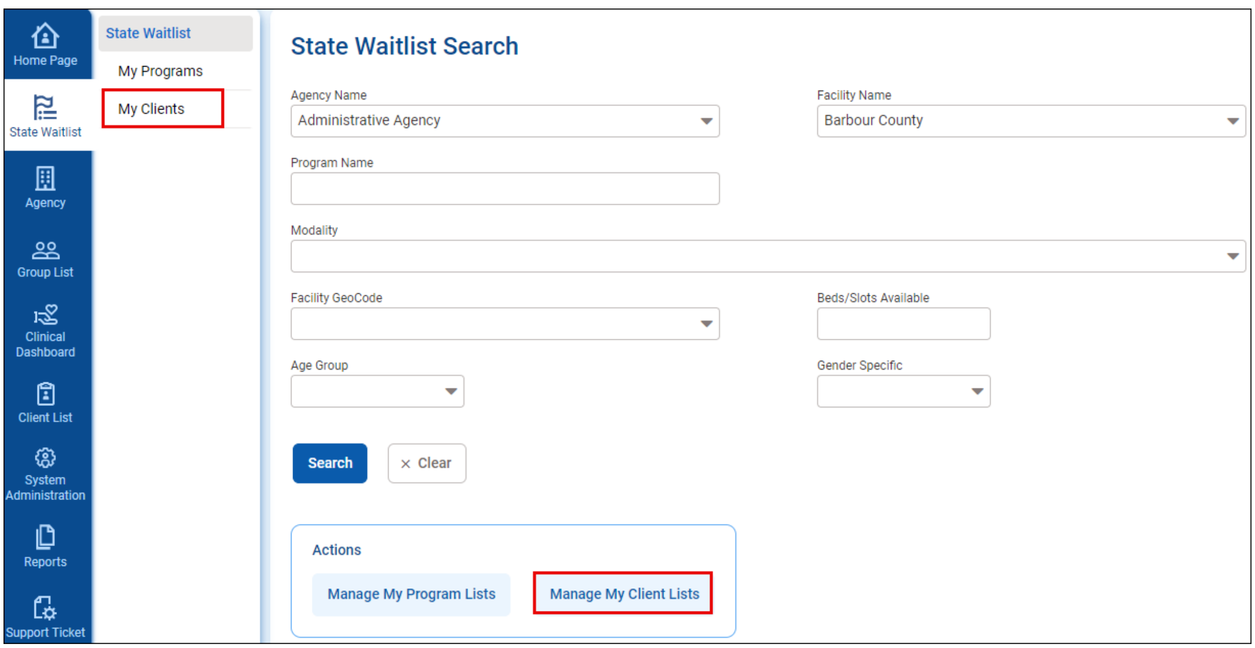


Figure 99: Accessing My Clients

The Client Waitlist Search screen will display. This screen allows the agency to manage their waitlist by clients.

Search can be used to narrow the listed results.

From this screen, the client's waitlist profile can be reviewed, or the client can be removed from the waitlist.

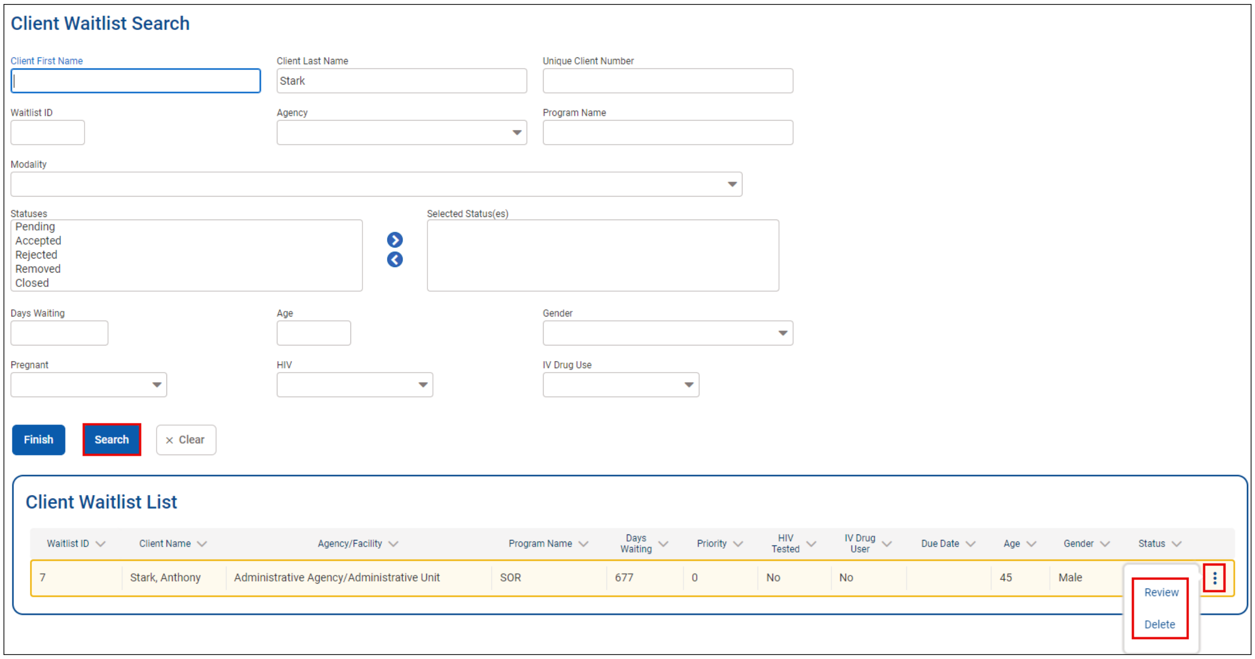


Figure 100: Client Waitlist

4.3.5. Add Client to Waitlist

To add a client to a facility's program waitlist:

1. Click **State Waitlist** from the left navigation menu.
2. **Search** for the agency-facility and/or program in question.
3. To the right of the desired result, click the **vertical ellipsis** and then click **Review List**.

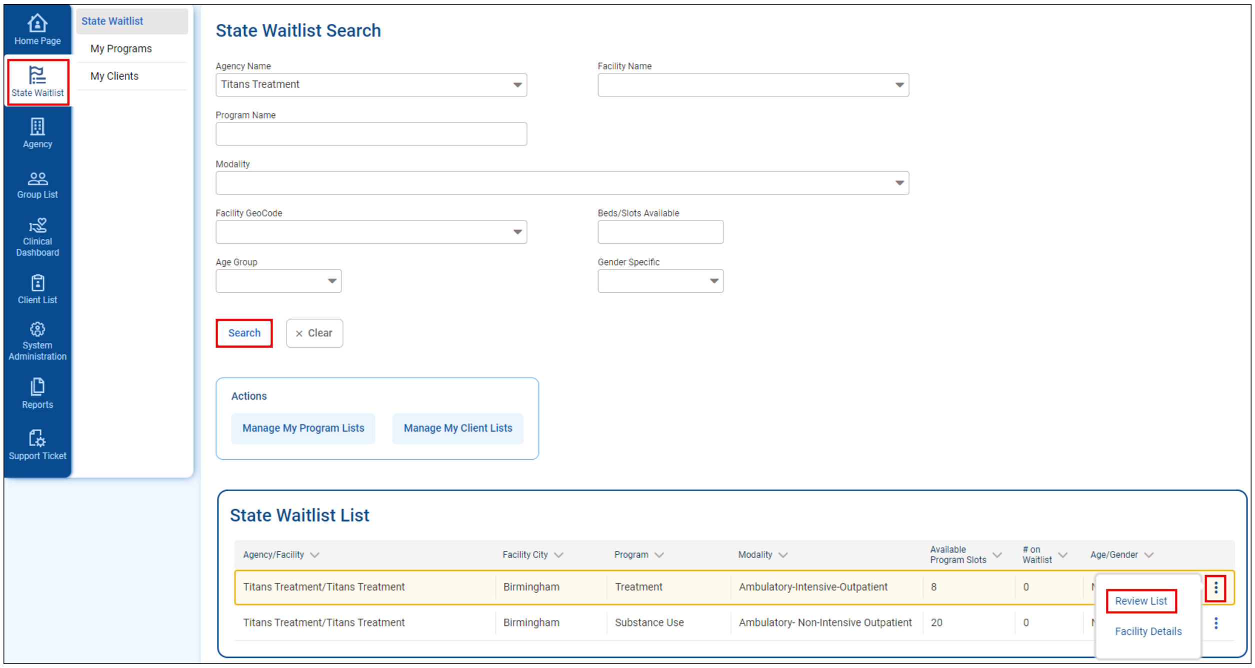


Figure 101: Adding Client to Waitlist

4. The Client Waitlist screen will display.

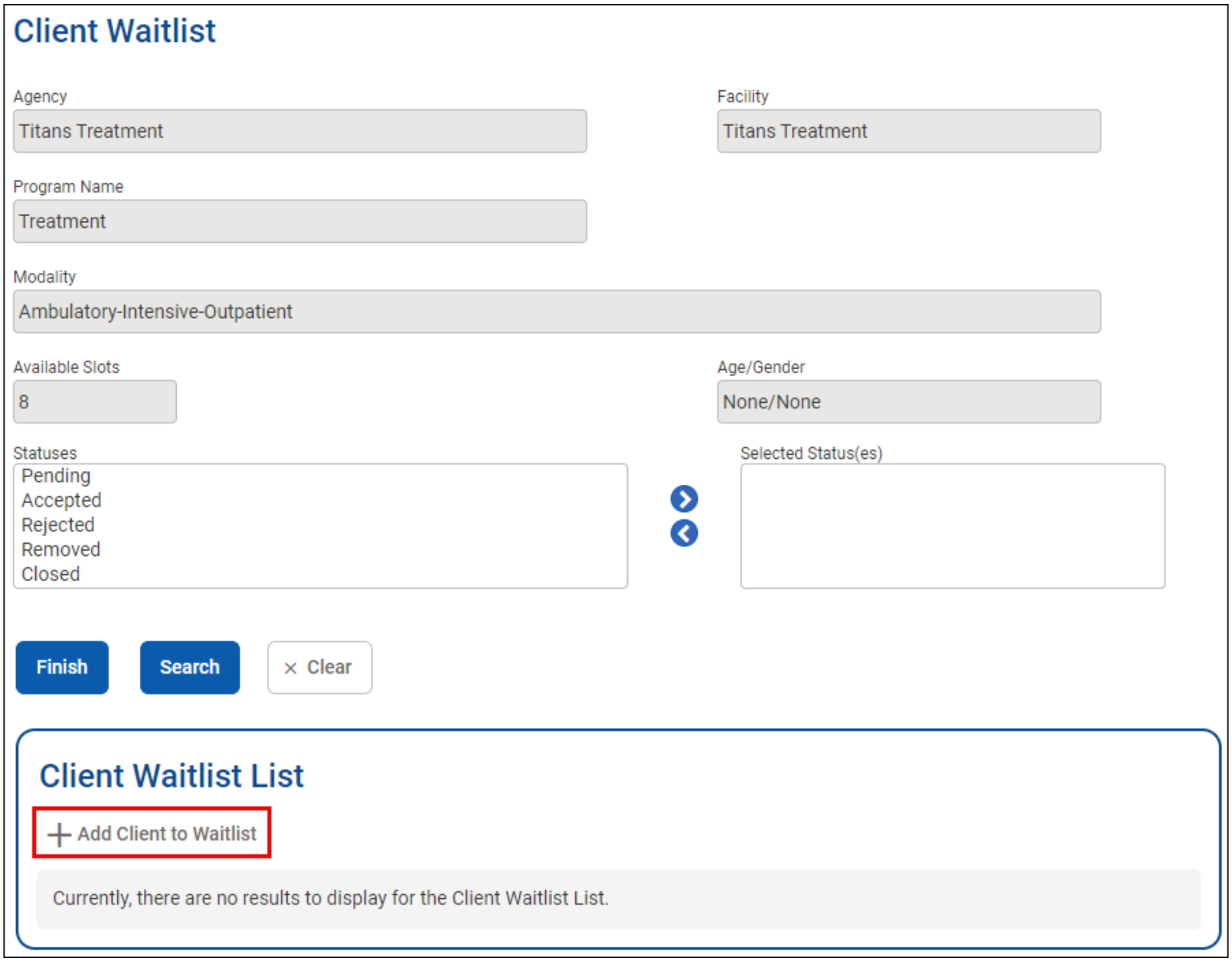


Figure 102: Client Waitlist - Add

5. Click **+Add Client to Waitlist**.
6. Several fields will auto populate and are read only.
7. Complete the required and relevant fields.

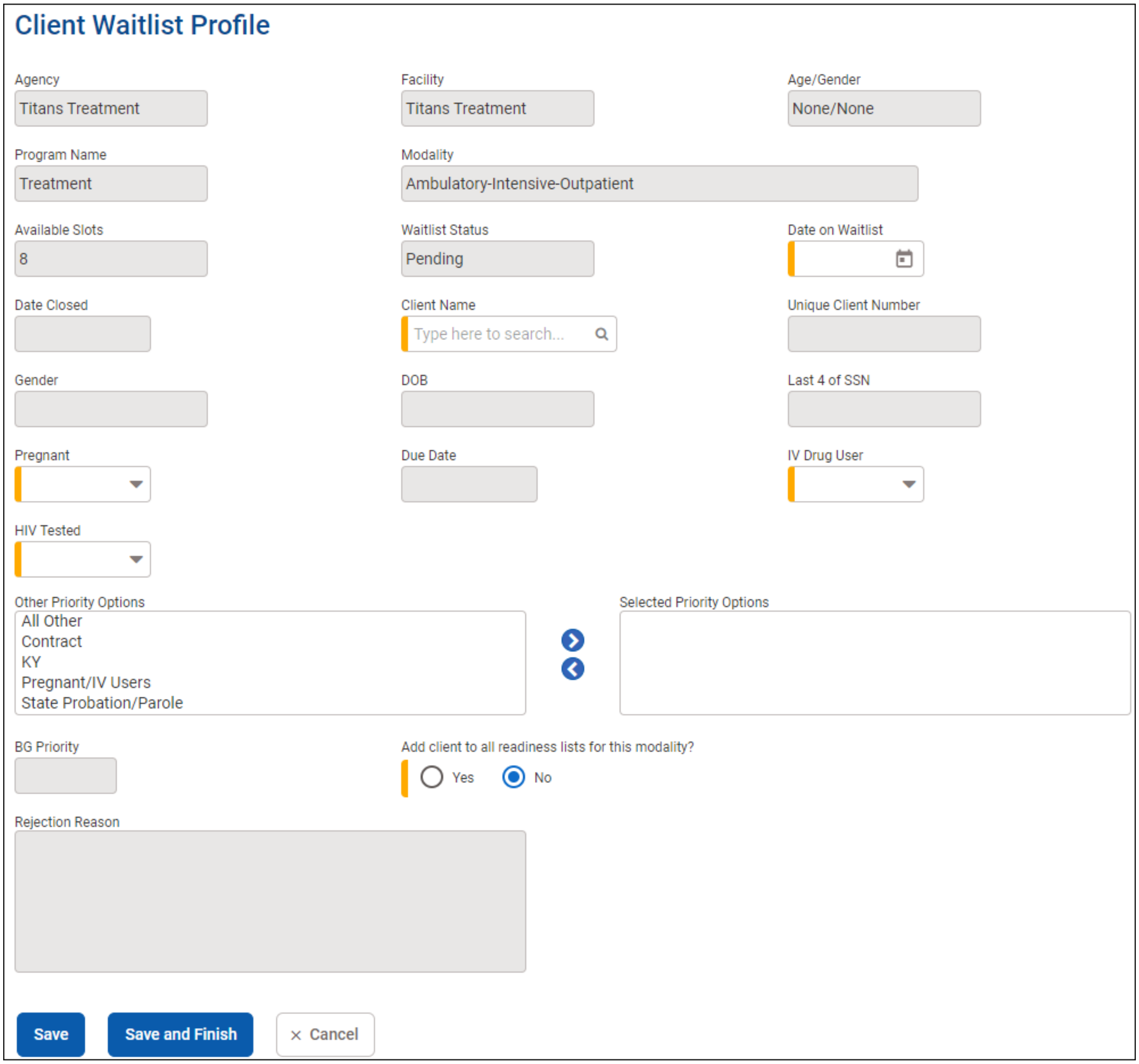


Figure 103: Client Waitlist Profile

8. Click **Save and Finish**.

4.4. Treatment Plan

A treatment plan can be created for the client.

NOTE: This function requires the user to have the client record active.

To create a treatment plan:

1. From the **Activity List** submenu, click **Treatment** and then **Treatment Plan**.

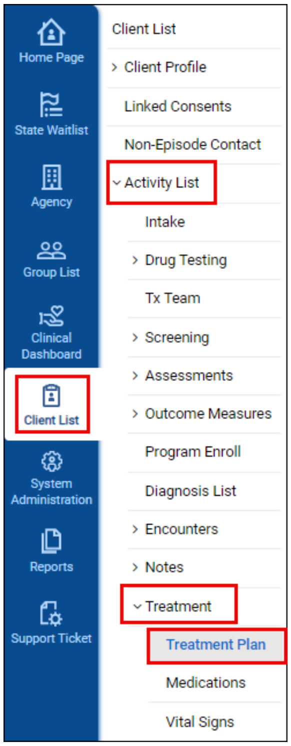


Figure 104: Accessing Treatment Plan

2. Click **Treatment Plan** under the Treatment submenu.
3. The Treatment Plan screen will display.
    a. Previous plans for the client will be listed here.

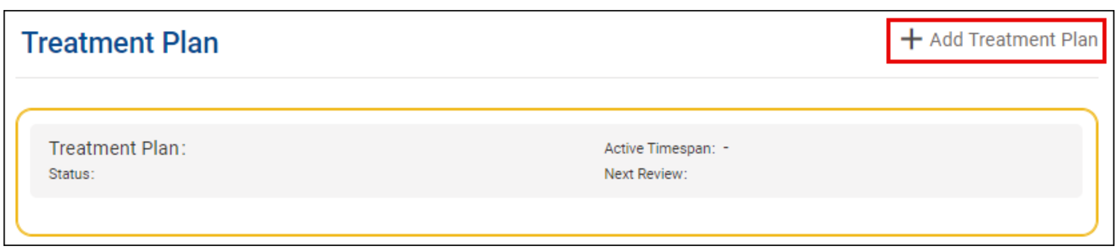


Figure 105: Add Treatment Plan

4. Click **+Add Treatment Plan**.
5. The Add Treatment Plan window will open.
6. Complete all required and relevant fields.
    a. Copy values from Active Plan if available – If there was already a treatment plan active, this box will transfer data from that plan into the new one being created.

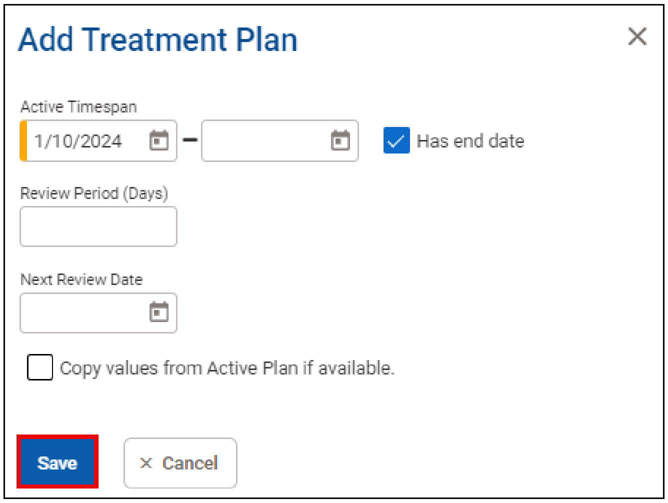


Figure 106: Add Treatment Plan Window

7. Click **Save**.
8. The Treatment Plan Workspace displays.
    a. The left side displays the different sections of the plan. Clicking on one will navigate to the selected plan workspace section.
    b. The middle section is the workspace.
    c. Completion Requirements are listed on the right.
    d. As this workspace is completed, additional requirements will display.

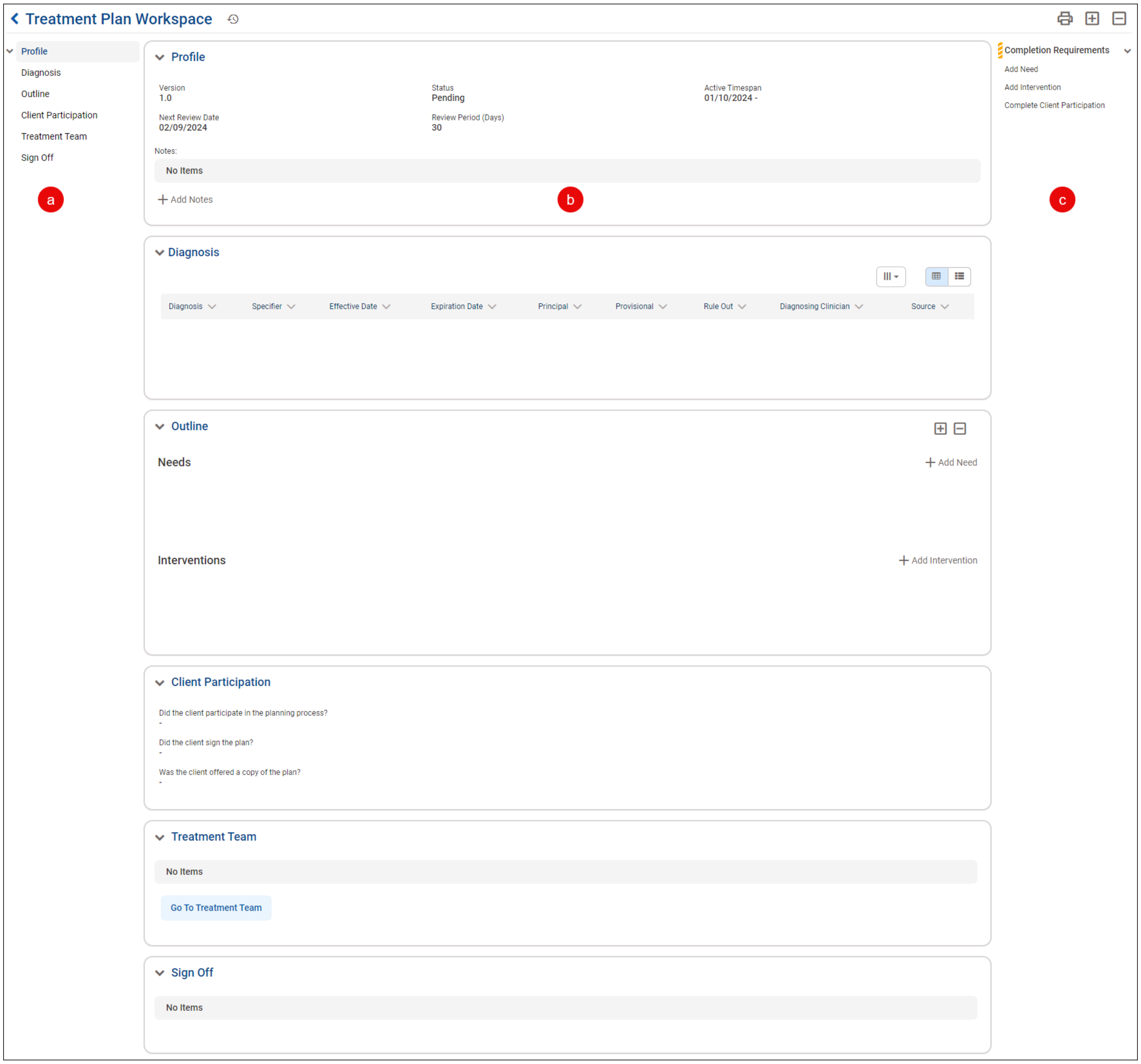


Figure 107: Treatment Plan Workspace

9. Complete all sections as required.

Below is an explanation of each section.

4.4.1. Profile

Most of the profile information will be prepopulated when the plan is initially created. However, there is an option to add notes if needed.

1. Click **+Add Notes**.

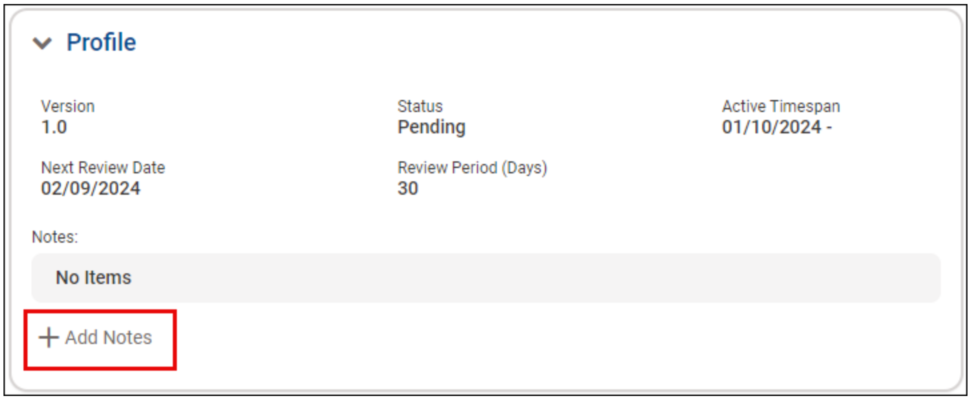


Figure 108: Treatment Plan Profile

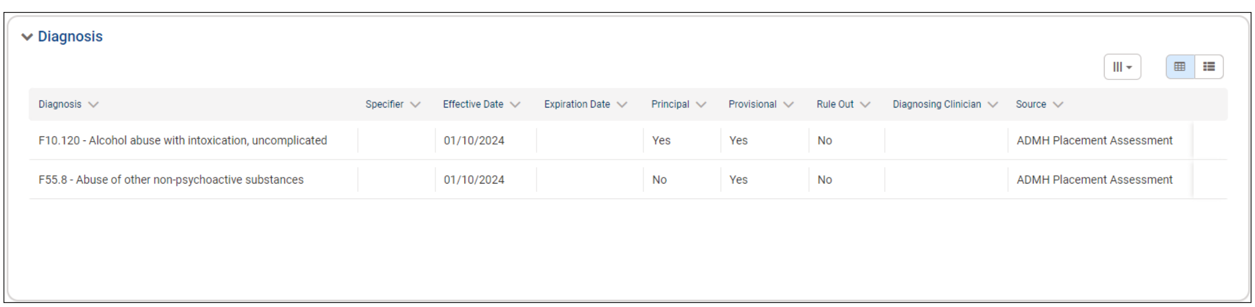
2. The Notes window will open.
3. Set the note's **Type**.
4. Enter comments in the **Note** text box.

Figure 109: Notes Window

5. Click **Save**.

4.4.2. Diagnosis

This section lists the client's diagnosis.


Diagnosis

Diagnosis	Specifier	Effective Date	Expiration Date	Principal	Provisional	Rule Out	Diagnosing Clinician	Source
F10.120 - Alcohol abuse with intoxication, uncomplicated		01/10/2024		Yes	Yes	No		ADMH Placement Assessment
F55.8 - Abuse of other non-psychoactive substances		01/10/2024		No	Yes	No		ADMH Placement Assessment

Figure 110: Treatment Plan - Diagnosis

4.4.3. Outline

This section allows the user to capture needs, goals, and interventions.

Figure 111: Needs and Interventions

1. Click **+Add Need** to open the Add Need window.

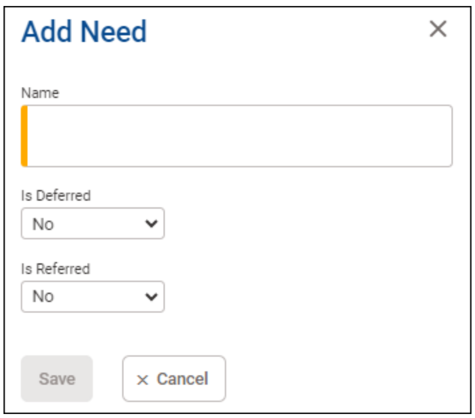


Figure 112: Add Need

2. Complete fields as necessary or required and click **Save** when finished.
3. The Outline will update and display Notes and Goals for each created Need.
   a. A goal will need to be added to each need.

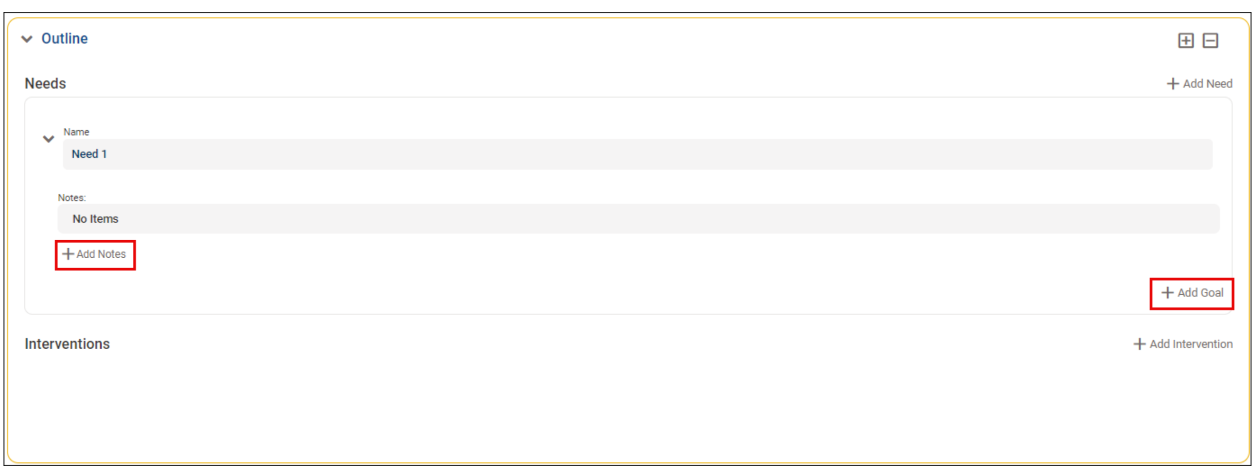


Figure 113: Outline with Added Need

4. Click **+Add Note** to create a note the same as in the Profile section.

5. Click **+Add Goal** to open the Add Goal window.

Figure 114: Add Goal

6. Complete fields as necessary or required and click **Save** when finished.
7. The Outline will update and display Notes and Objective for each created Goal.
    a. At least one objective will need to be added to each goal.

Figure 115: Outline with Goal Added

8. Click **+Add Objective** to open the Add Objective window.

Figure 116: Add Objective

9. Complete fields as necessary or required and click **Save** when finished.
10. The Outline will update and display Notes for the added Objective and the Associate Intervention button.
    a. For each need created, an intervention will need to be associated.

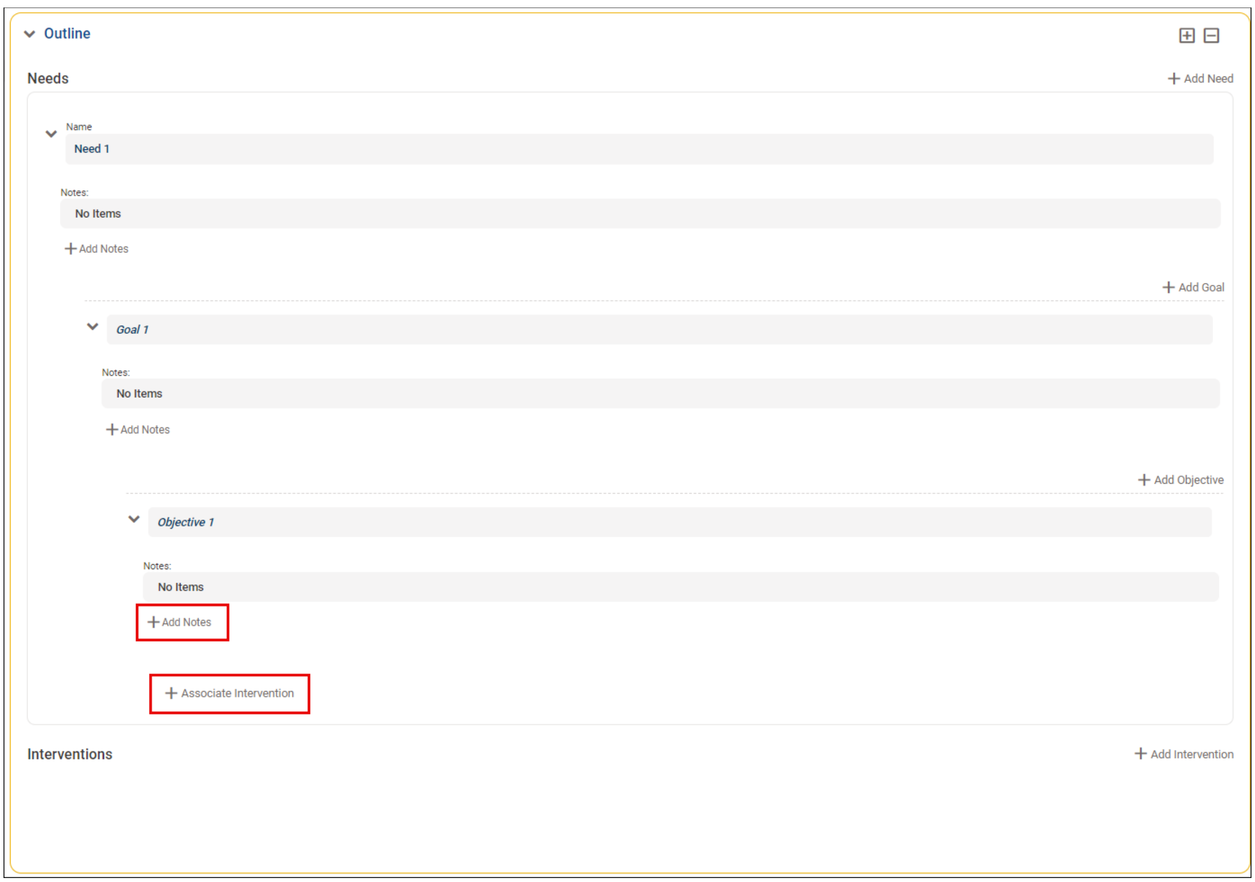


Figure 117: Outline with Objective Added

11. Click **+Add Intervention** to open the Add Intervention window.

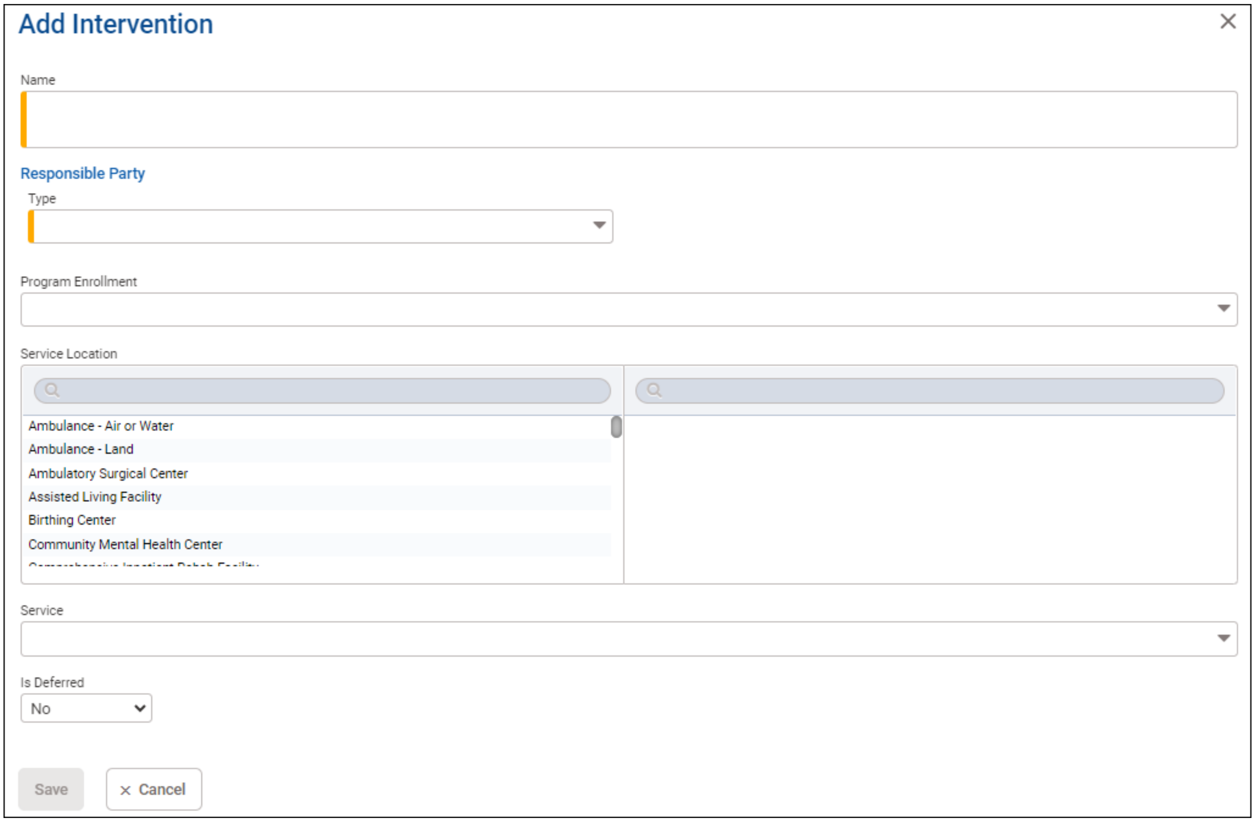


Figure 118: Add Intervention

12. Complete fields as necessary or required and click **Save** when finished.
13. The Interventions section of the Outline will update.
    a. If needed, click +Add Responsible Party to add more to this field.
    b. Notes can also be added to the Intervention as necessary.

Figure 119: Outline with Intervention Added

14. Click **+Associate Intervention** in the Need section to be linked.
15. The Associate Intervention window will open.

Figure 120: Associate Intervention

16. Select the Intervention to be associated, and then click **Save**.
17. If needed, more than one Intervention can be associated to a Need.
18. The Outline will update to show the associations between the Need and the Intervention.

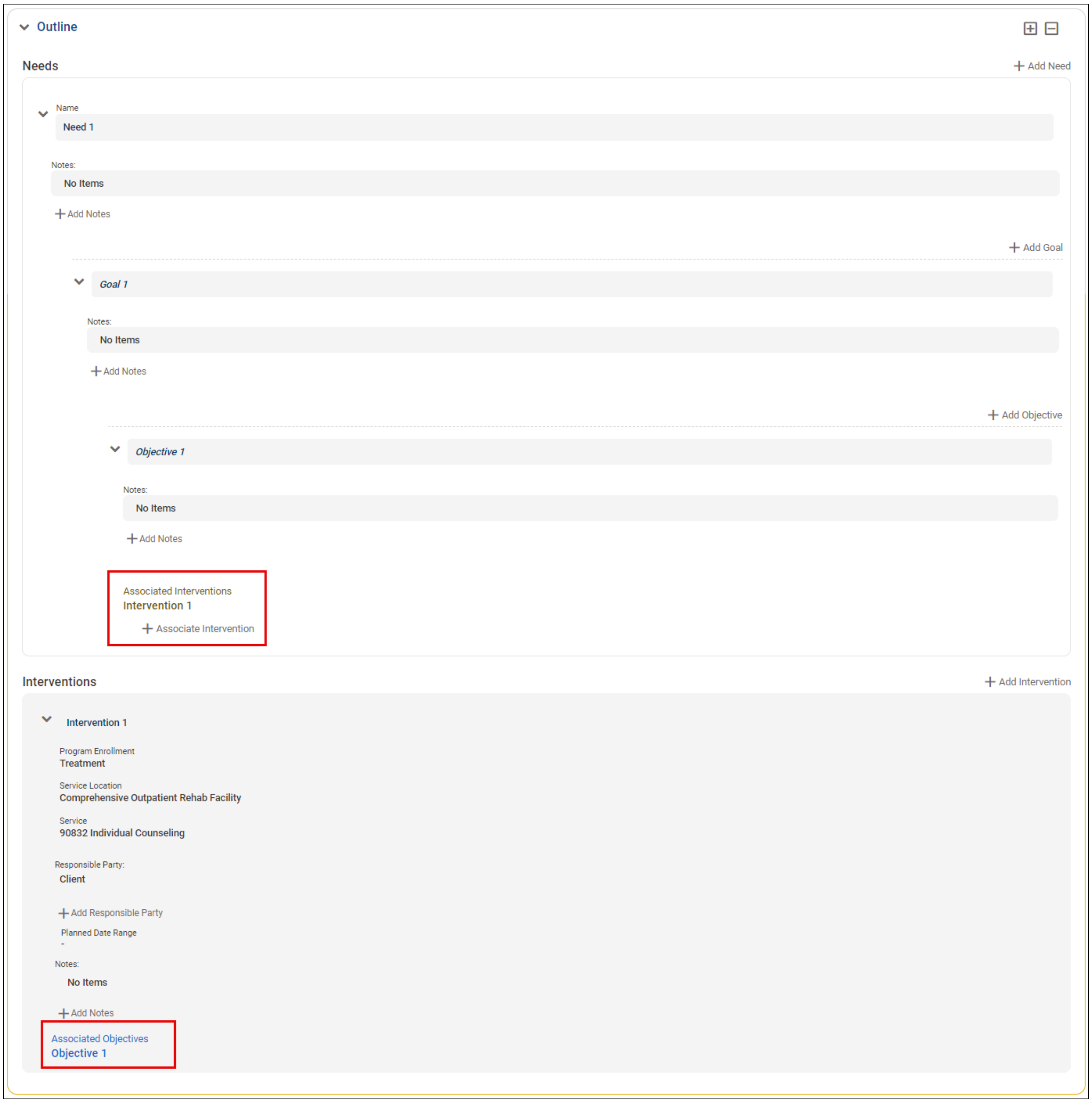


Figure 121: Outline with Associations

4.4.4. Client Participation

This section captures information regarding the client's participation in creating the treatment plan.

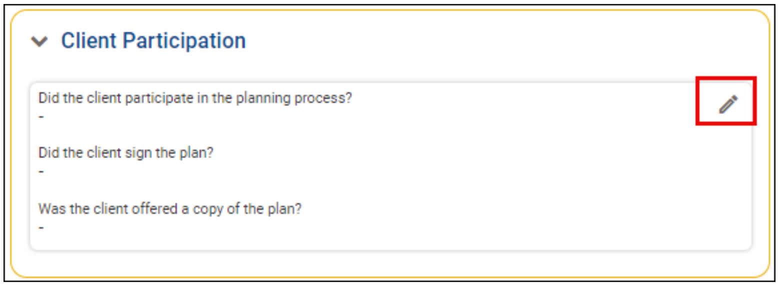


Figure 122: Client Participation

Hover over the questions to make the pencil icon appear. Click the **pencil** icon to open a window with the questions and answer dropdowns. Complete these fields and click **Save** when finished.

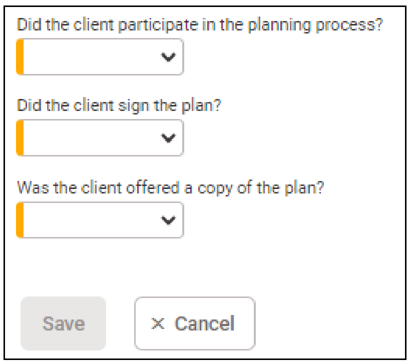


Figure 123: Client Participation Questions

4.4.5. Treatment Team

While not listed as a completion requirement, a treatment team or member must be assigned to the client's treatment plan.

1. Click **Go To Treatment Team**.

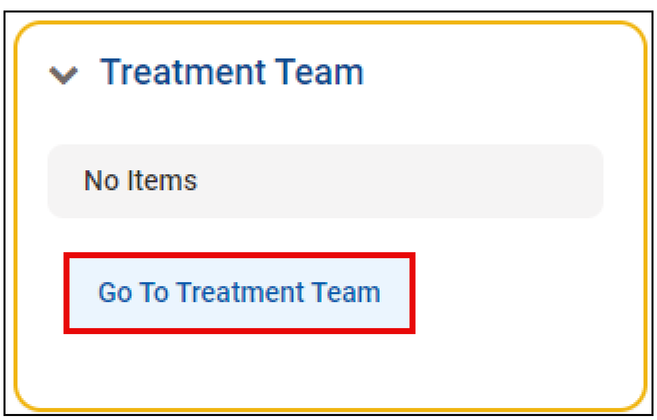


Figure 124: Go To Treatment Team Button

2. The Treatment Team screen will display.

3. To add a treatment team member, click **+Add Team Member**.

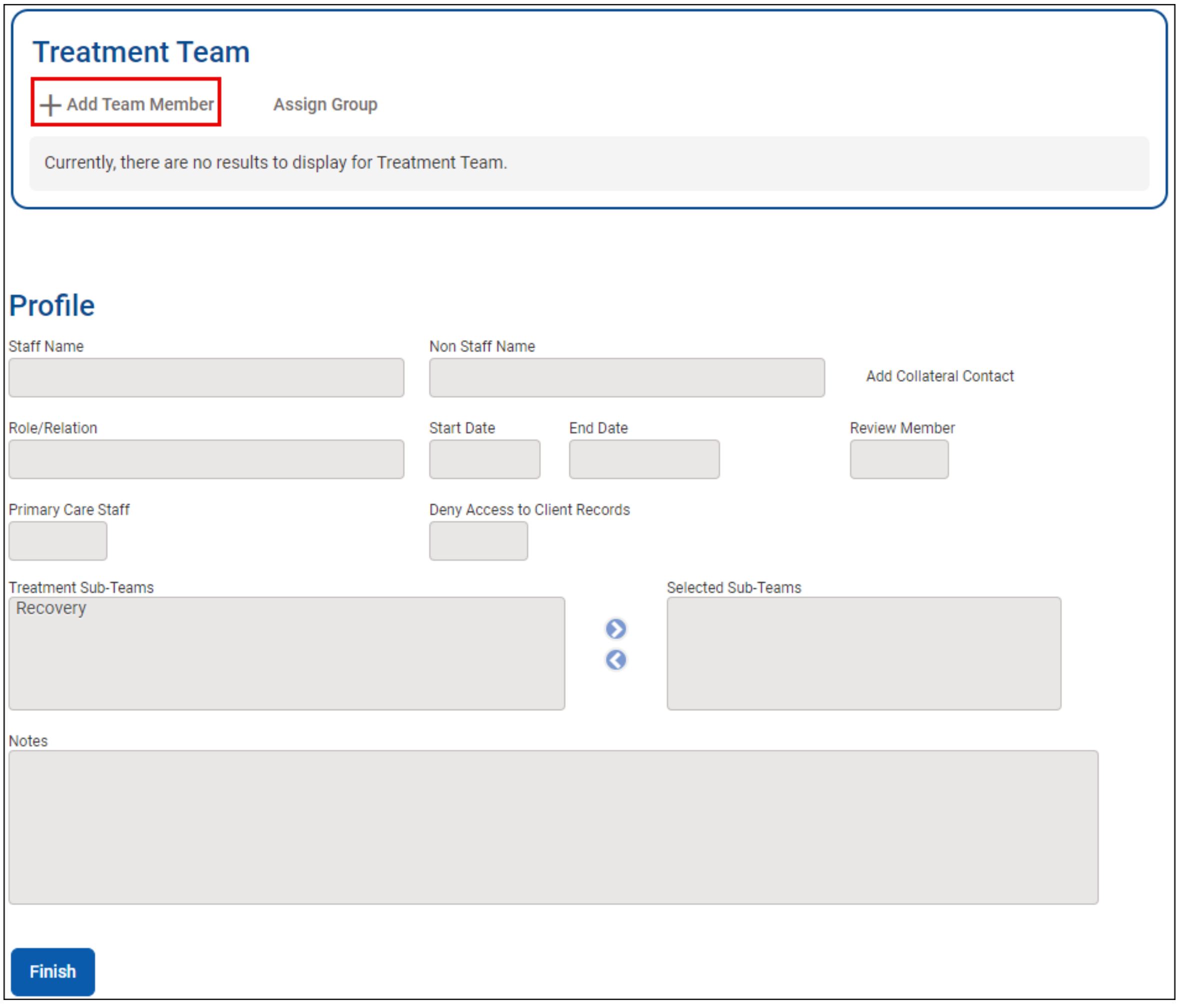
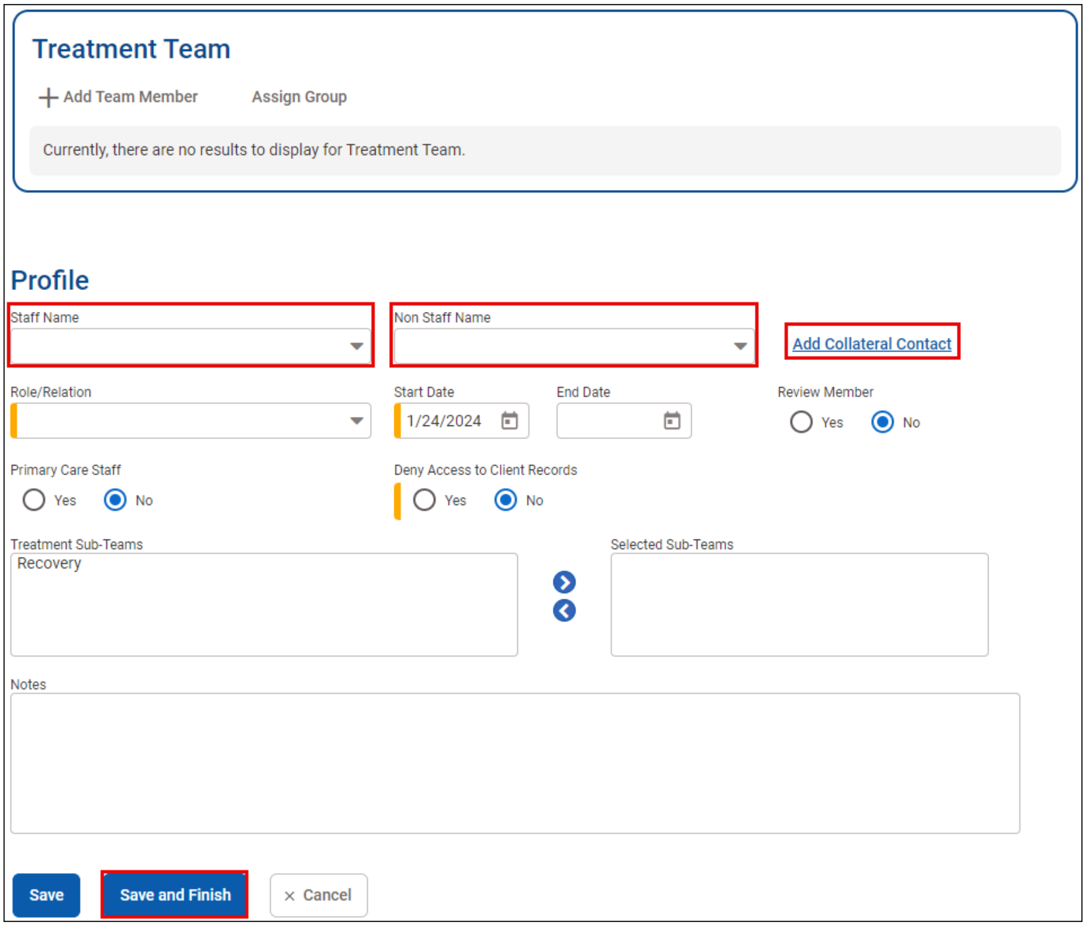
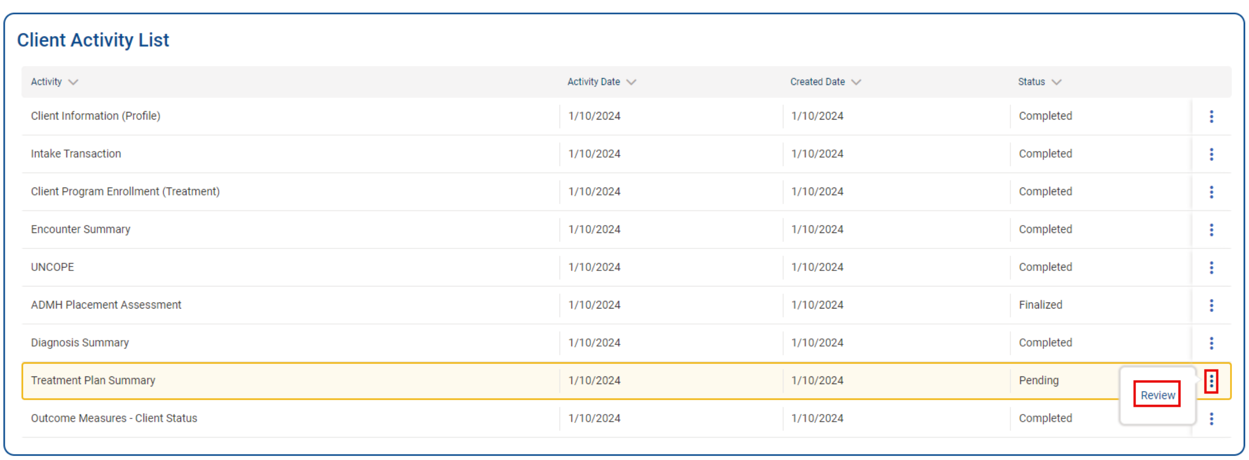


Figure 125: Treatment Team - Add Team Member

4. The Profile section will become active.
5. Complete all required and relevant fields.
    a. While not listed as required fields, **Staff Name** or **Non Staff Name** must be chosen from their respective dropdown lists.
    b. Collateral contacts display in the Non Staff Name dropdown. If a collateral contact needs to be added, click **Add Collateral Contact**.



6. Click **Save and Finish**.
7. The user is returned to the Client Activity List screen.
8. To return to the treatment plan, click the **vertical ellipsis** to the right of Treatment Plan Summary, and then click **Review**.



Client Activity List

Activity	Activity Date	Created Date	Status
Client Information (Profile)	1/10/2024	1/10/2024	Completed
Intake Transaction	1/10/2024	1/10/2024	Completed
Client Program Enrollment (Treatment)	1/10/2024	1/10/2024	Completed
Encounter Summary	1/10/2024	1/10/2024	Completed
UNCOPE	1/10/2024	1/10/2024	Completed
ADMH Placement Assessment	1/10/2024	1/10/2024	Finalized
Diagnosis Summary	1/10/2024	1/10/2024	Completed
Treatment Plan Summary	1/10/2024	1/10/2024	Pending
Outcome Measures - Client Status	1/10/2024	1/10/2024	Completed

Figure 126: Client Activity List - Treatment Plan

9. Click **View** on the Treatment Plan screen to enter the treatment plan.

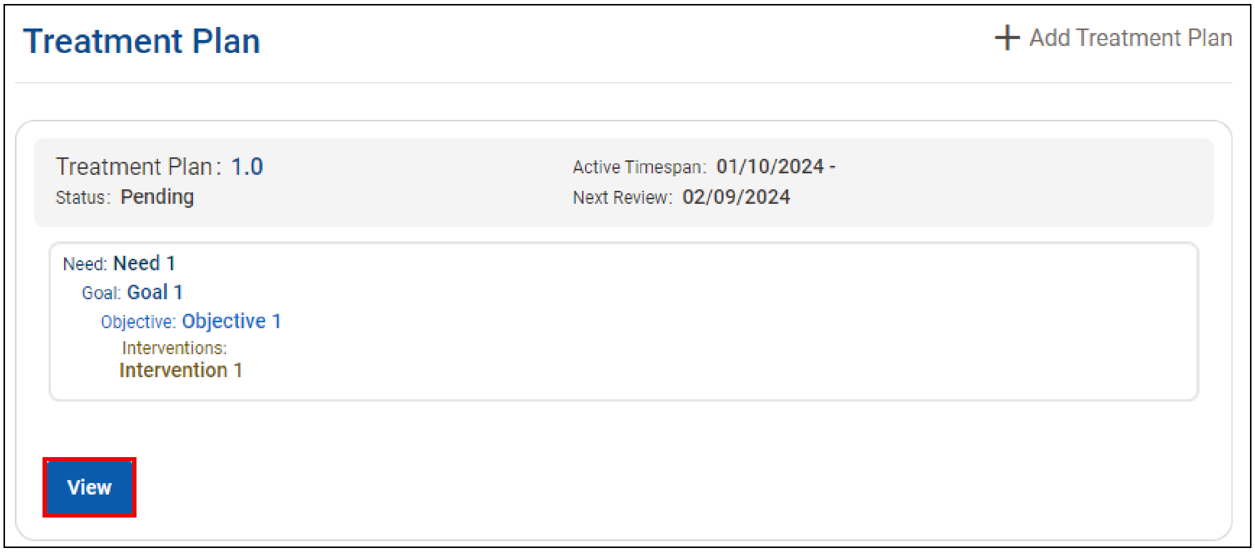


Figure 127: Treatment Plan - View

4.4.6. Sign Off

NOTE: Only individuals assigned to the client's treatment team can sign off on the treatment plan.

Click **Sign and Finalize**.

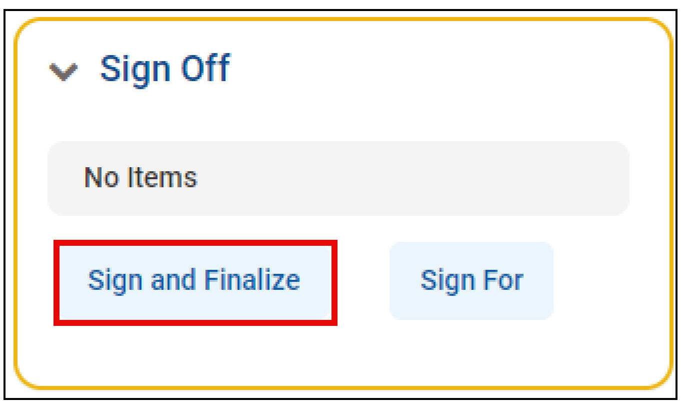


Figure 128: Sign Off

The section will update showing the captured treatment team member's signature. It will also have the status Finalized.

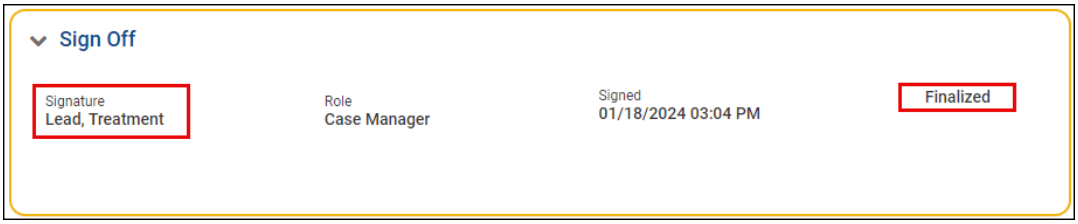


Figure 129: Sign Off Finalized

5. OTHER TREATMENT FUNCTIONS

5.1. Drug Testing

The Drug Testing screen can be used to record results. It does not report the data to systems outside of WITS.

NOTE: To use this functionality, the client record must be active.

1. Click the **Activity List** to expand its options.

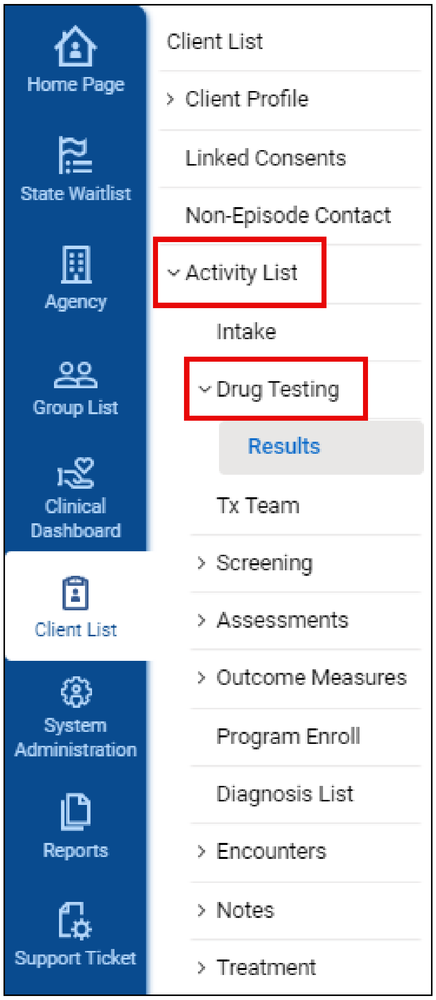


Figure 130: Accessing Drug Testing Results

2. Click **Drug Testing** to display the Drug Test Result Search screen.
    a. Previous results will display in the Drug Test Result List.
    b. A search can be performed to narrow results.

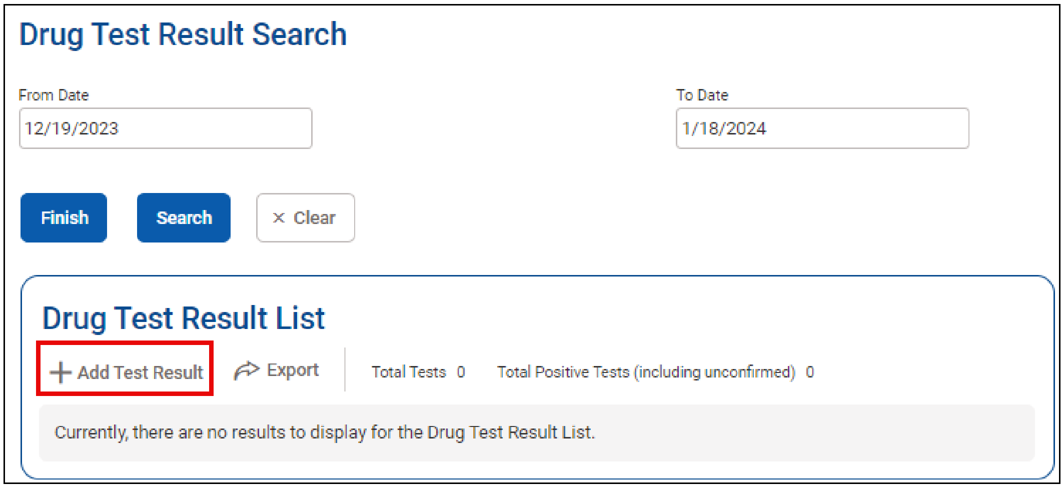


Figure 131: Drug Test Results Search

3. Click **+Add Test Result**.
4. Set the **Client Outcome** field.
    a. Several fields are read-only until the field Client Outcome is set to a variation of specimen collected.

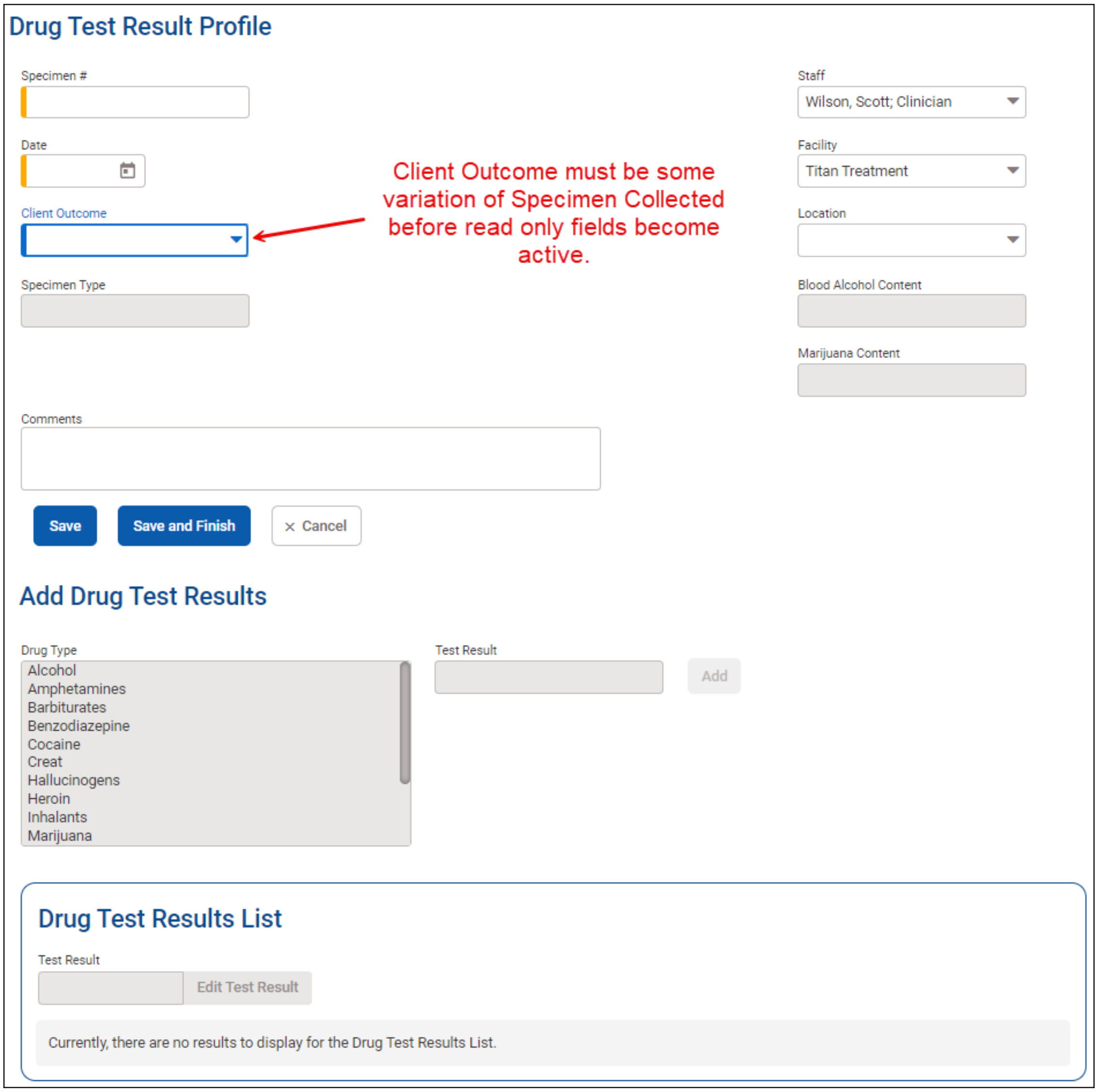


Figure 132: Drug Test Result Profile

5. All fields are now active.
6. Complete all required and relevant fields.
7. Under Add Drug Test Results, multiple results can be recorded.
    a. Each **Drug Type** will need to be selected along with the **Test Result**.
    b. Click **Add** to capture the data.
    c. Drug Test Results List will update with the recorded data.

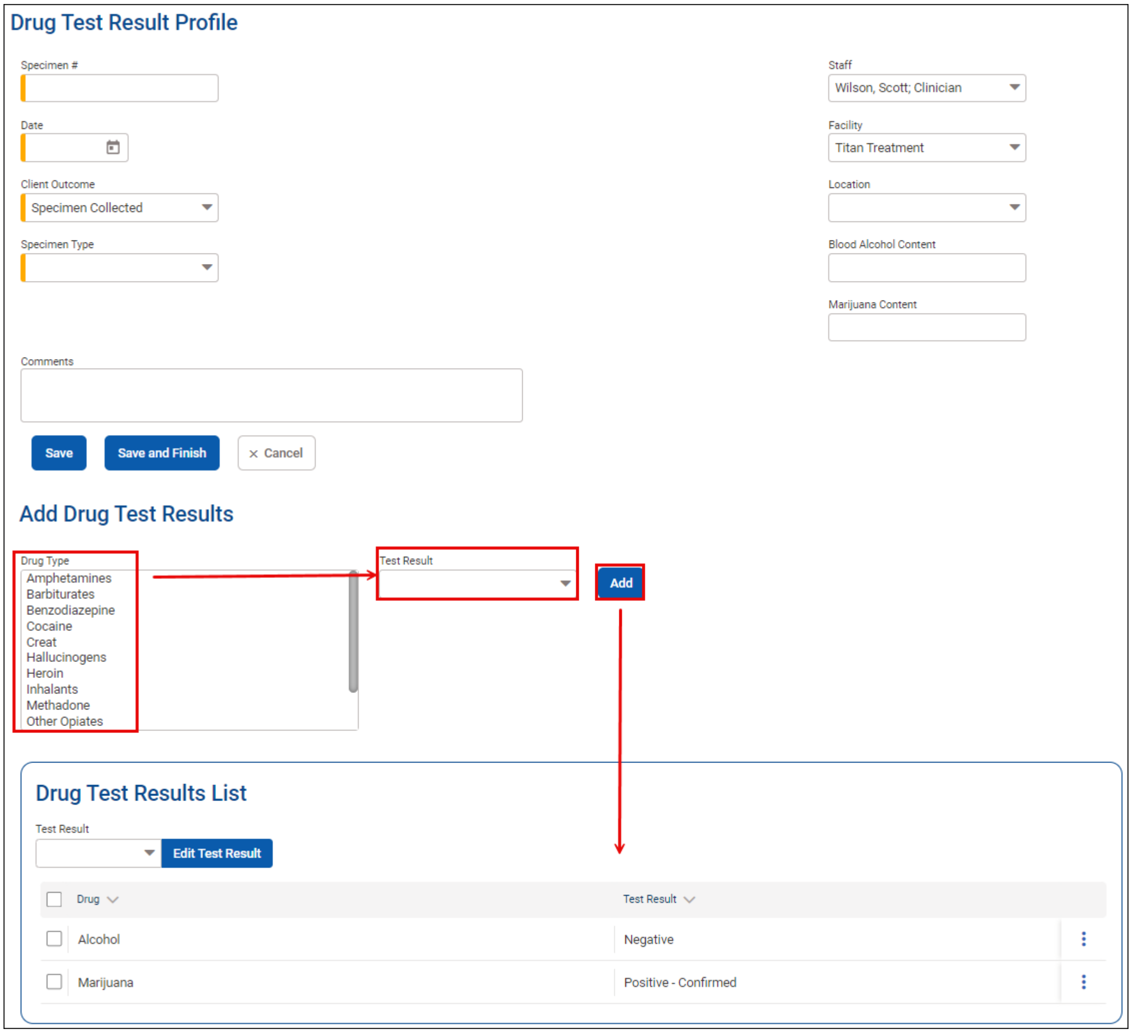


Figure 133: Add Drug Test Results

8. Click **Save and Finish** once all information has been recorded.

5.2. Medications

Any medications prescribed to the client are recorded here. This is just for documentation purposes and is not transmitted from or to sources outside of WITS.

NOTE: The client record must be active.

1. Click on the **Activity List** submenu to expand its options.
2. Click **Treatment** to expand its options.
3. Click **Medications**.

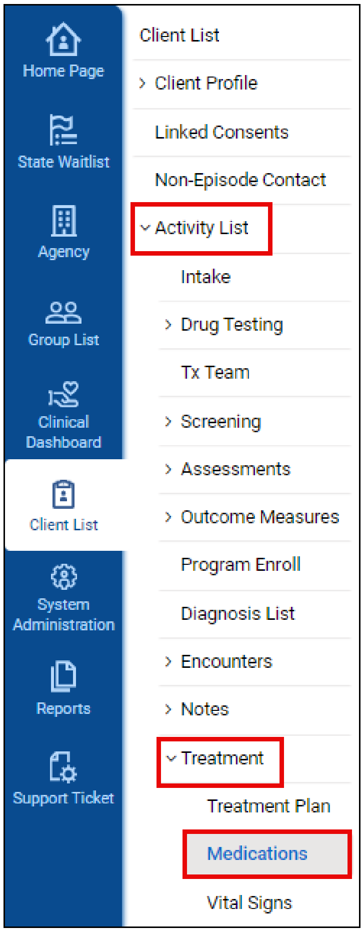


Figure 134: Accessing Medications

4. The Medications screen will display.
    a. Current Medications will be listed here.
    b. A search can be performed to narrow the results listed.

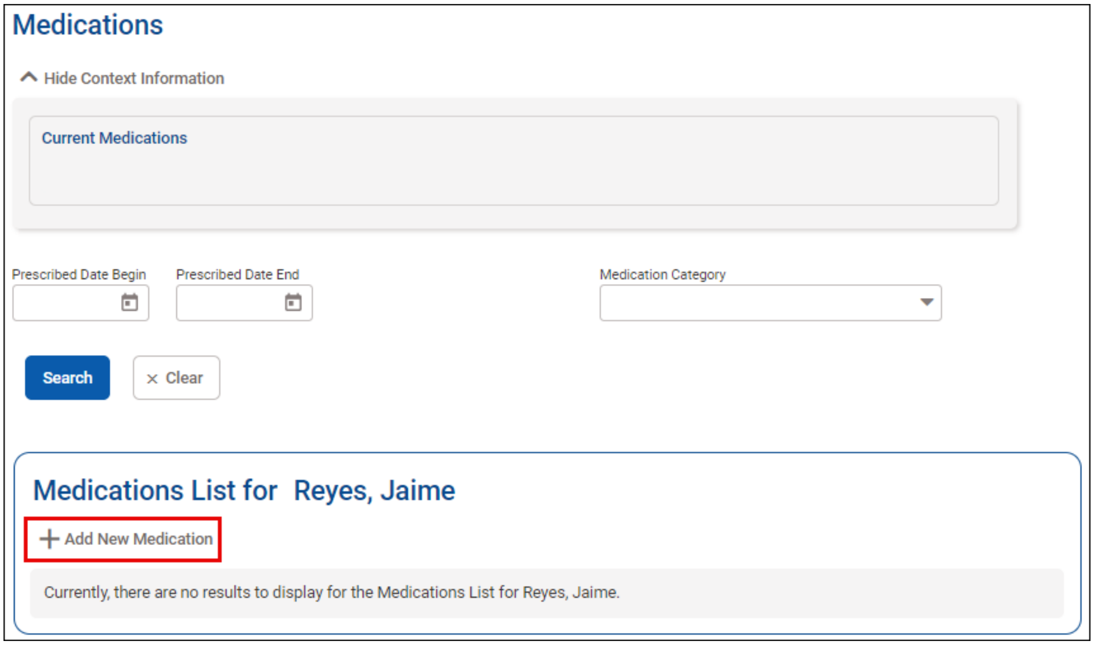


Figure 135: Medications Screen

5. Click **+Add New Medication**.
6. The section below the Medication List will become active.
7. Complete all required and relevant fields.

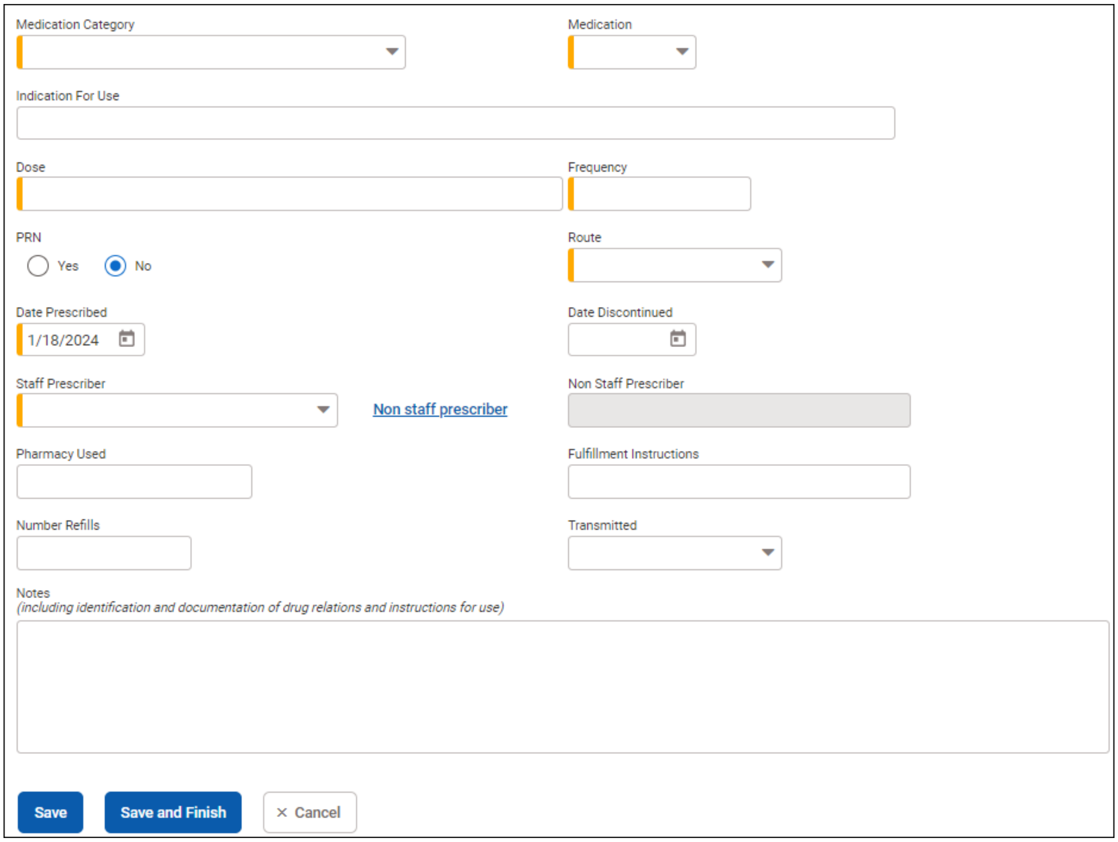


Figure 136: Add New Medication

8. Click **Save and Finish**.

5.3. Vital Signs

Vital signs are recorded for the client here. This is just for documentation purposes and is not transmitted from or to sources outside of WITS.

NOTE: The client record must be active.

1. Click on the **Activity List** submenu to expand its options.
2. Click **Treatment** to expand its options.
3. Click **Vital Signs**.

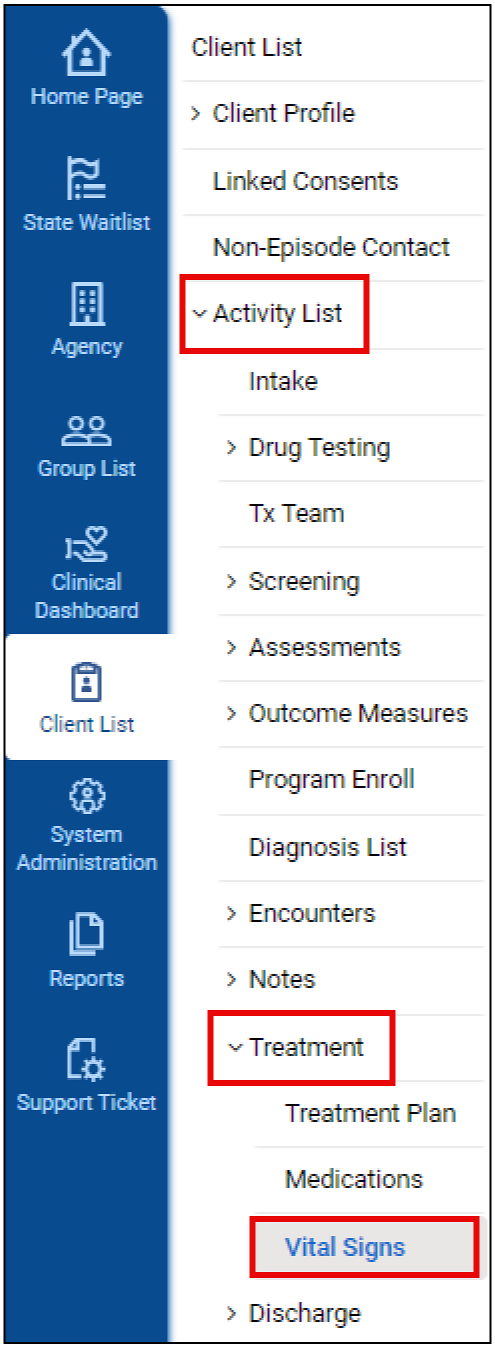


Figure 137: Accessing Vital Signs

4. The Vital Signs Profile screen will display.
    a. Previous recordings will be listed.
    b. This information can be exported to an Excel file.

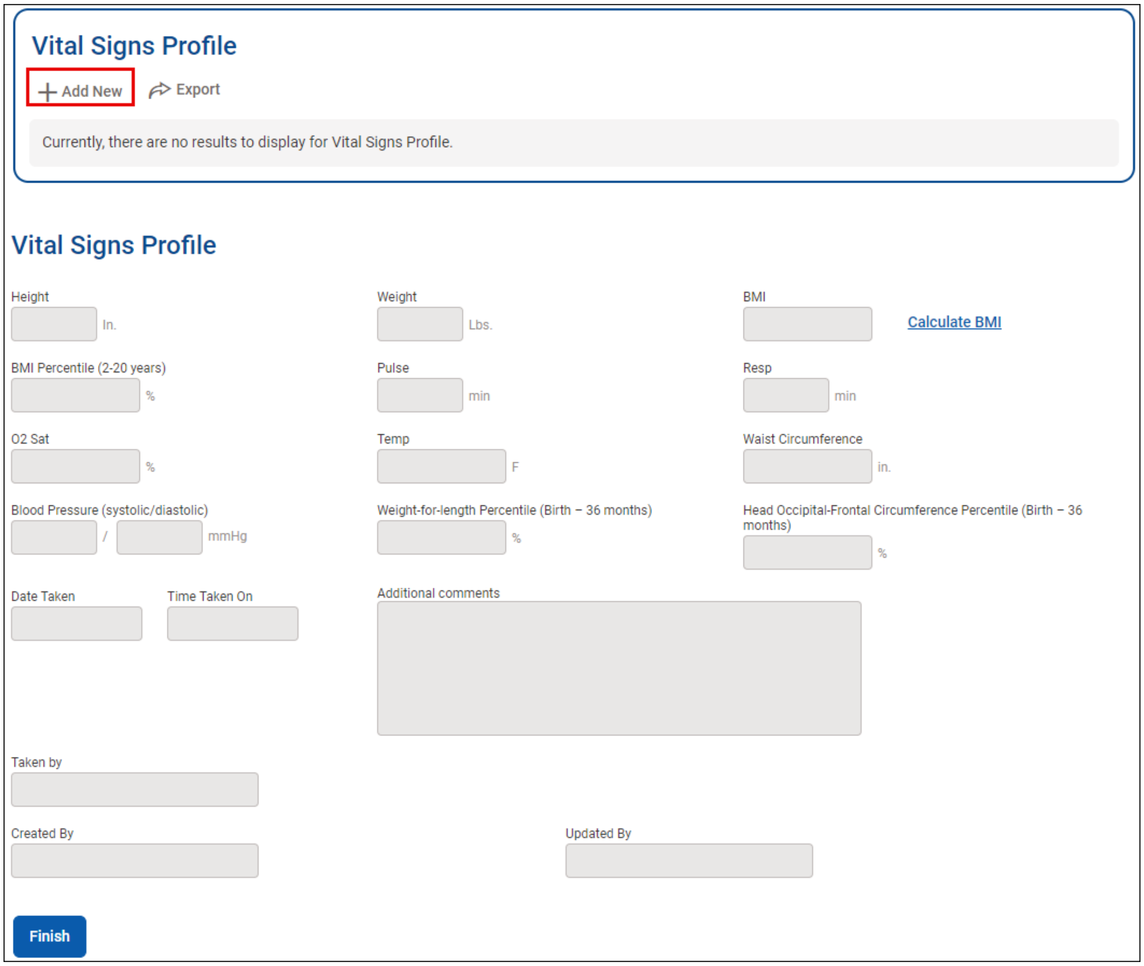


Figure 138: Vital Signs Profile

5. To record a new set of vitals, click **+Add New**.
6. The screen fields will become editable.
7. Complete all required and relevant fields.

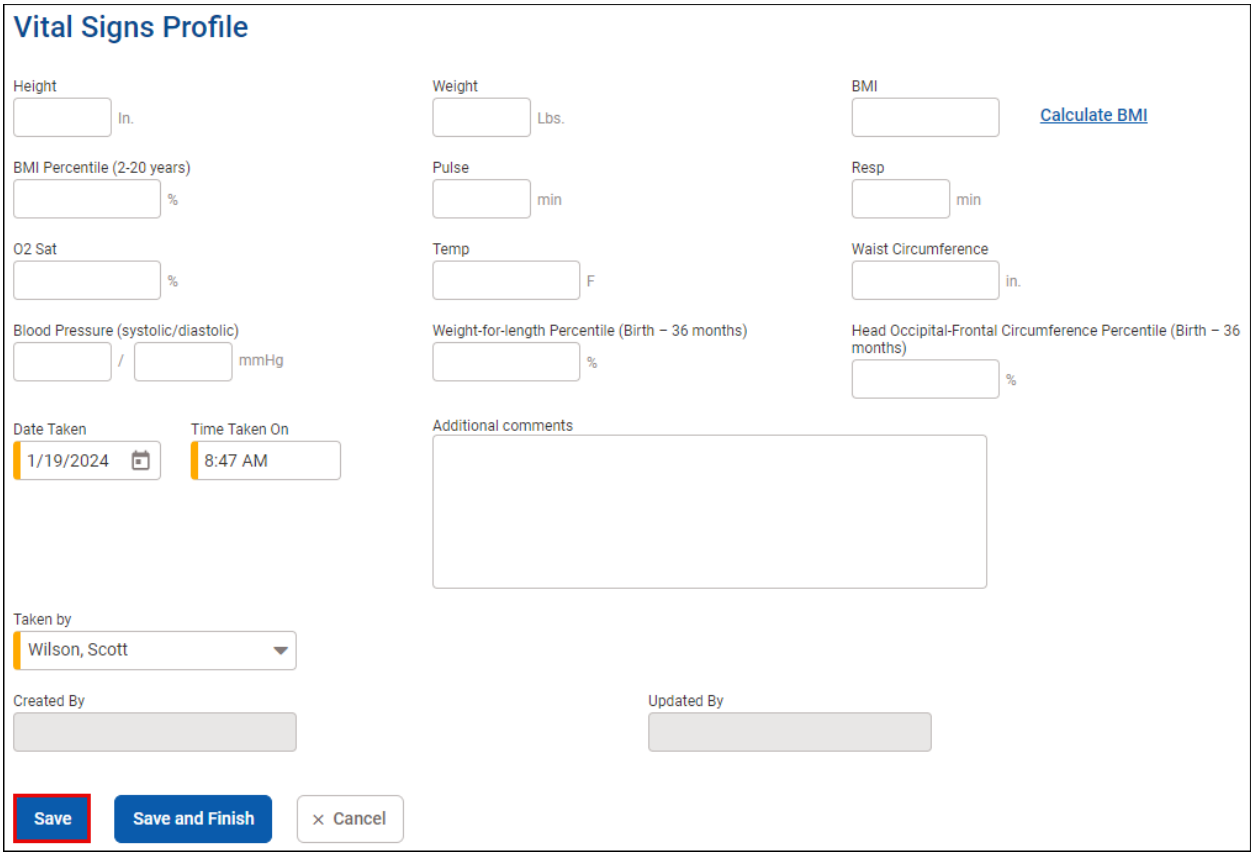


Figure 139: Add Vital Signs

8. Click **Save** to finish creating the record.

5.4. Notes

While most interactions with a client will be logged as encounters, the user also has the option to add a miscellaneous note to the client record. These are a good way to document any non-billable activity that is important.

NOTE: To add a note to a client's record, the client must be active for the user.

1. From the **Activity List** submenu, click **Notes**.

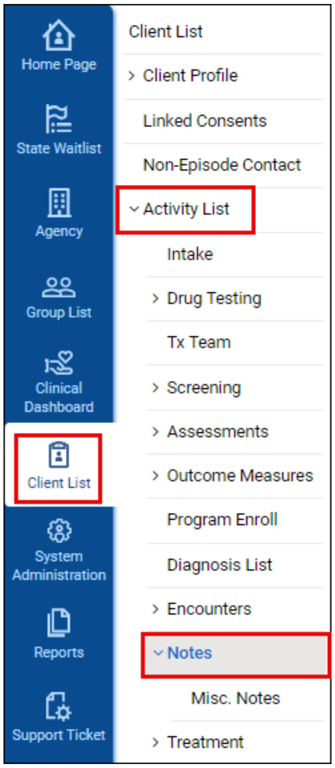


Figure 140: Accessing Notes

2. The Notes Search screen will display.
   a. Searches performed will display results in the Note List section.
   b. Miscellaneous and encounter notes will display here.

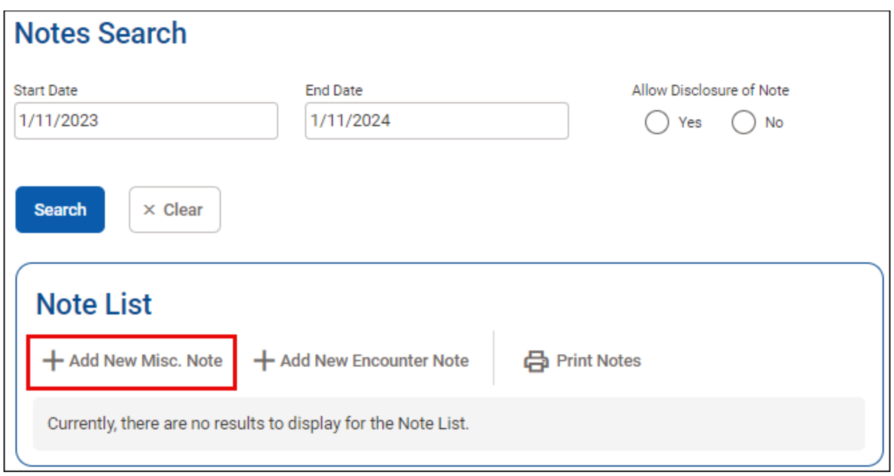


Figure 141: Add Misc Note

3. Click **+Add New Misc. Note**.
4. The Miscellaneous Notes screen displays.
5. Complete all required and relevant fields.

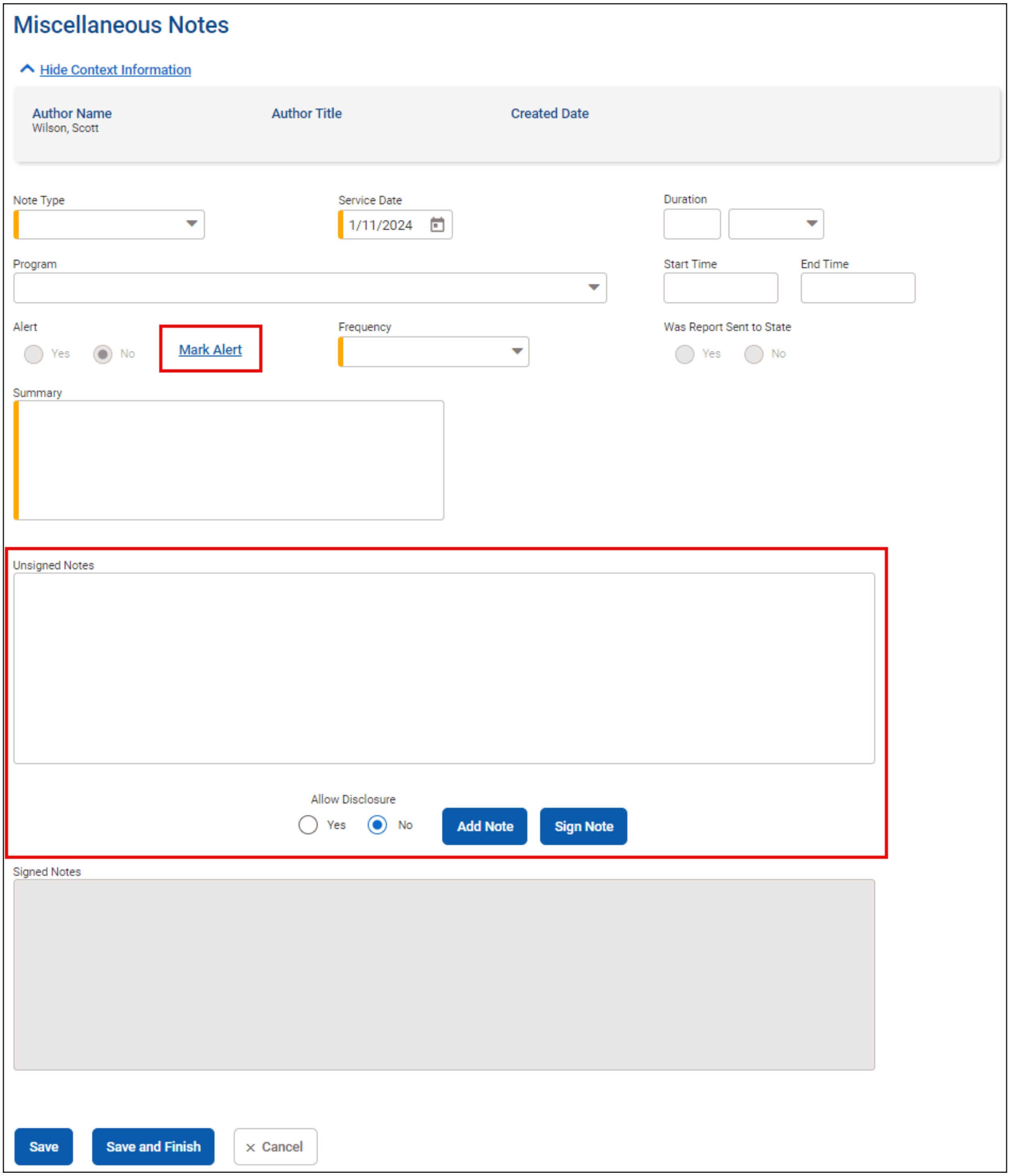


Figure 142: Miscellaneous Notes

6. Click **Save and Finish**.

There are some fields that require further explanation.

- **Mark Alert/Remove Alert** – When selected, this will flag the client record and highlight it in red. Anyone that accesses Notes or looks at the client's record in the Client List will see a bell icon and the red highlight.

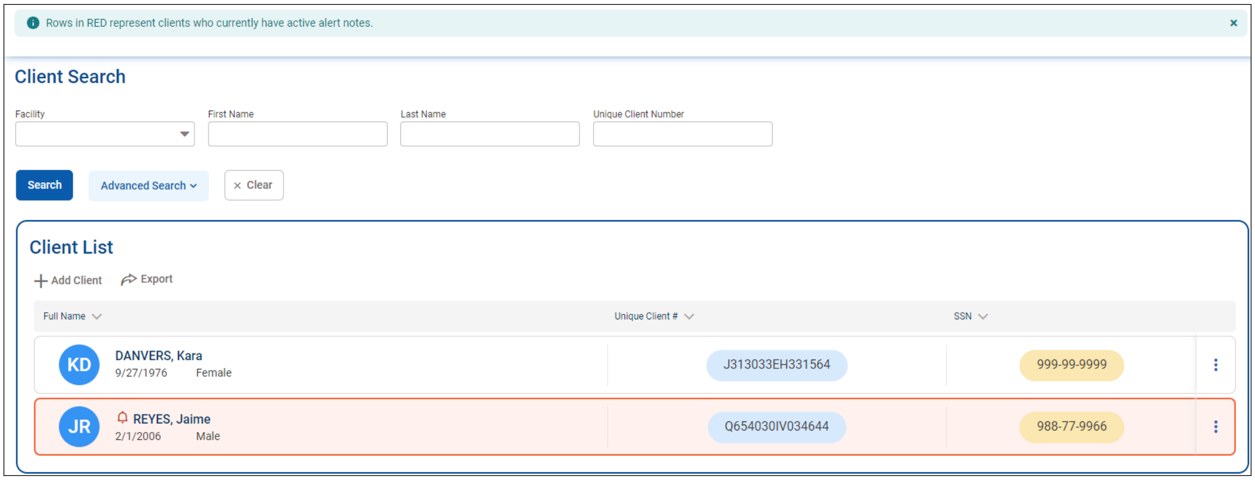


Figure 143: Client - Mark Alert

- **Sign Note** – Any note added to the Unsigned Notes text box will be added to the Signed Notes box when this button is clicked.
- **Allow Disclosure** – This will make the note available to consented agencies if Yes is selected.
- **Add Note** – This will open the Append Miscellaneous Notes screen. Enter notes, and then click Finish. These are then added to the Unsigned Notes text box.

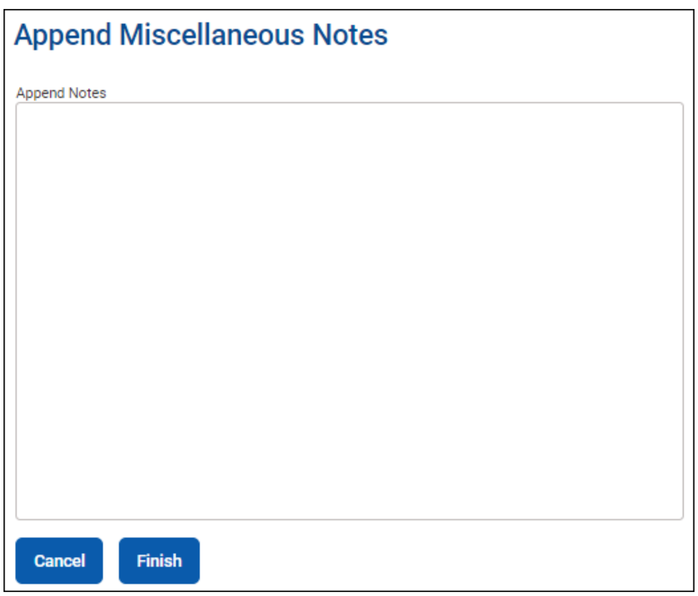


Figure 144: Append Miscellaneous Notes

Notes cannot be deleted once created. They can only be appended. This is done by clicking the **vertical ellipsis** to the right of the note, and then clicking **Review**.

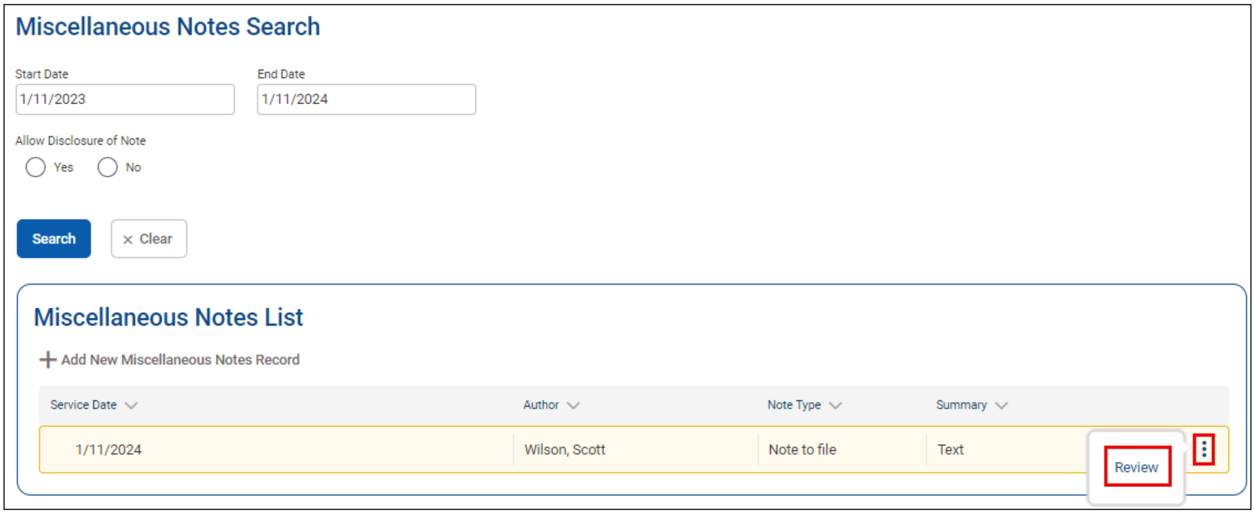


Figure 145: Edit Note

5.5. Clinical Dashboard

The Clinical Dashboard lists a user's clients with open cases. Supervisors can also use this to track their team's workload.

1. From the left navigation menu, click **Clinical Dashboard**.

Figure 146: Accessing Clinical Dashboard

2. The Clinical Dashboard screen will display.
    a. Perform a search as needed to filter results on this screen.
    b. Search results display in the Clinical Dashboard List section.

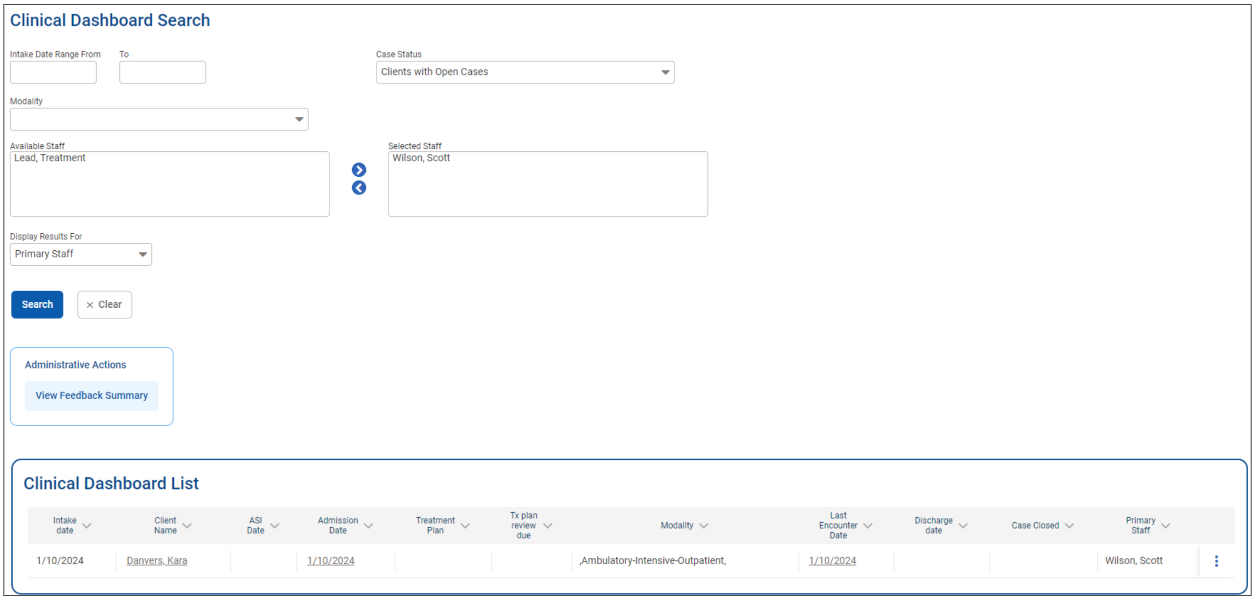


Figure 147: Clinical Dashboard

3. Fields in the Clinical Dashboard List are clickable and will navigate the user to the relevant screens.
4. Notes can be accessed by clicking the **vertical ellipsis** and then **Notes**.

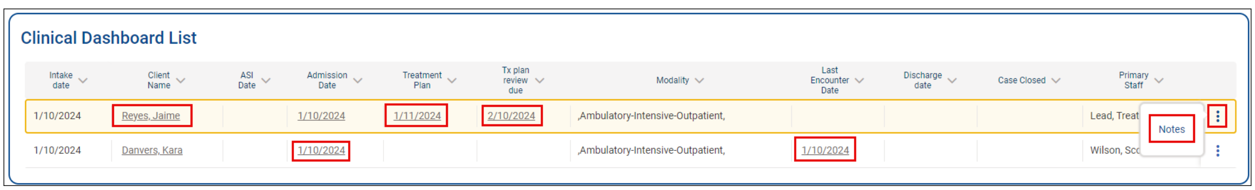


Figure 148: Clinical Dashboard List

5.6. Group List

This module allows the provider to create groups for treatment sessions. This is usually for group counseling sessions. This module also allows for the tracking of attendance as well as creating an encounter for clients attending the scheduled session.

Before a group can be created, group types must be setup.

5.6.1. Group Type

To create a group type:

1. From the left navigation menu, click **Group List**.

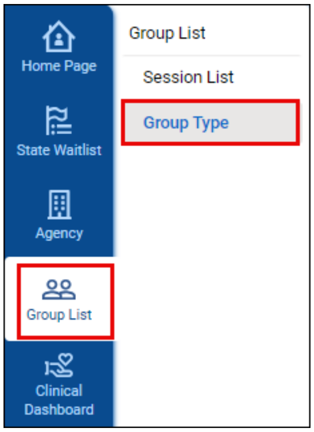


Figure 149: Accessing Group Type

2. Click **Group Type**.
3. The Group Type screen will display. Any existing group types will be listed.
    a. To **Edit** or **Remove** a group type, hover over the **vertical ellipsis**, and then click the desired action.

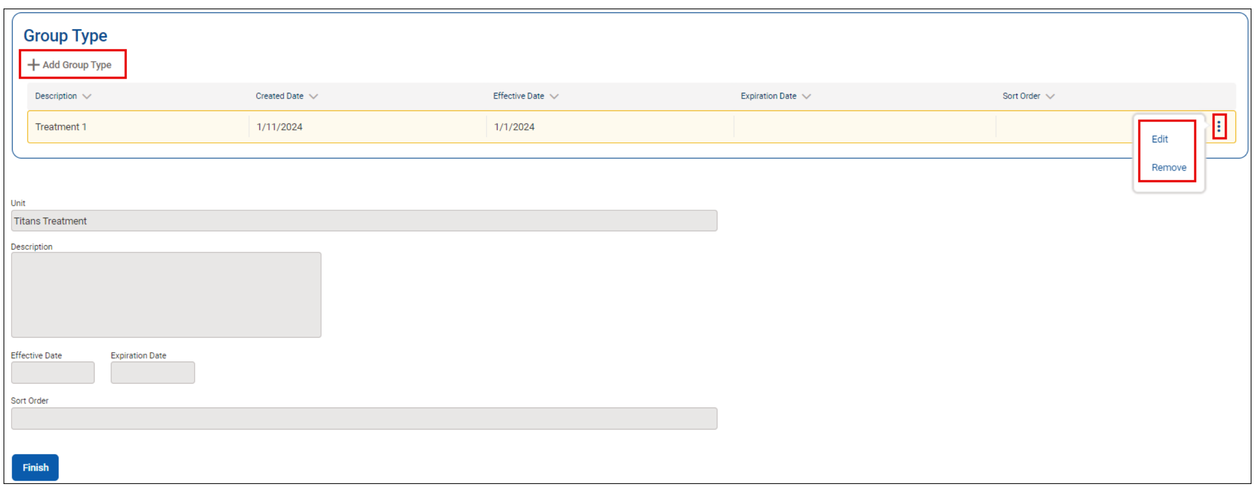


Figure 150: Group Type Actions

4. Click **+Add Group Type**.
5. The section below Group Type will become editable.
6. Complete the required and relevant fields.
    a. Unit – This field is always prepopulated based on the facility name.
    b. Description – A name or description for the group type being created.
    c. Effective Date – If the group is only in effect during a certain date range, set that here.
    d. Sort Order – If some group types should display in lists higher than other types, then assign them numbers. Lower numbers will show at the top of lists.

Figure 151: Group Type Fields

7. Click **Save and Finish**.

5.6.2. Create Group

Once the group types have been created, a treatment group can be setup and clients added to the roster.

1. From the left navigation menu, click **Group List**.

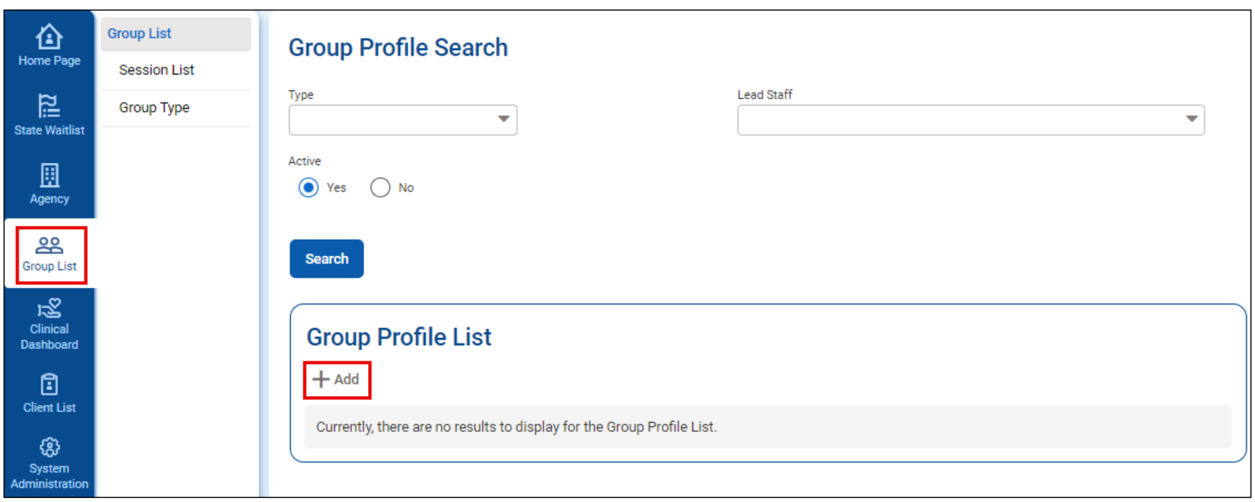


Figure 152: Accessing Group List

2. The Group Profile Search screen will display.
    a. Existing groups will be listed in the Group Profile List section.
    b. This list can be narrowed using the search functions.
3. Click **+Add**.
4. The Group Profile screen displays.

5. Complete all required and relevant fields.
    a. The information captured here relates to when and where the sessions are held and who will conduct them.
    b. The Roster List actions will not be available until the Group Profile is completed and saved.

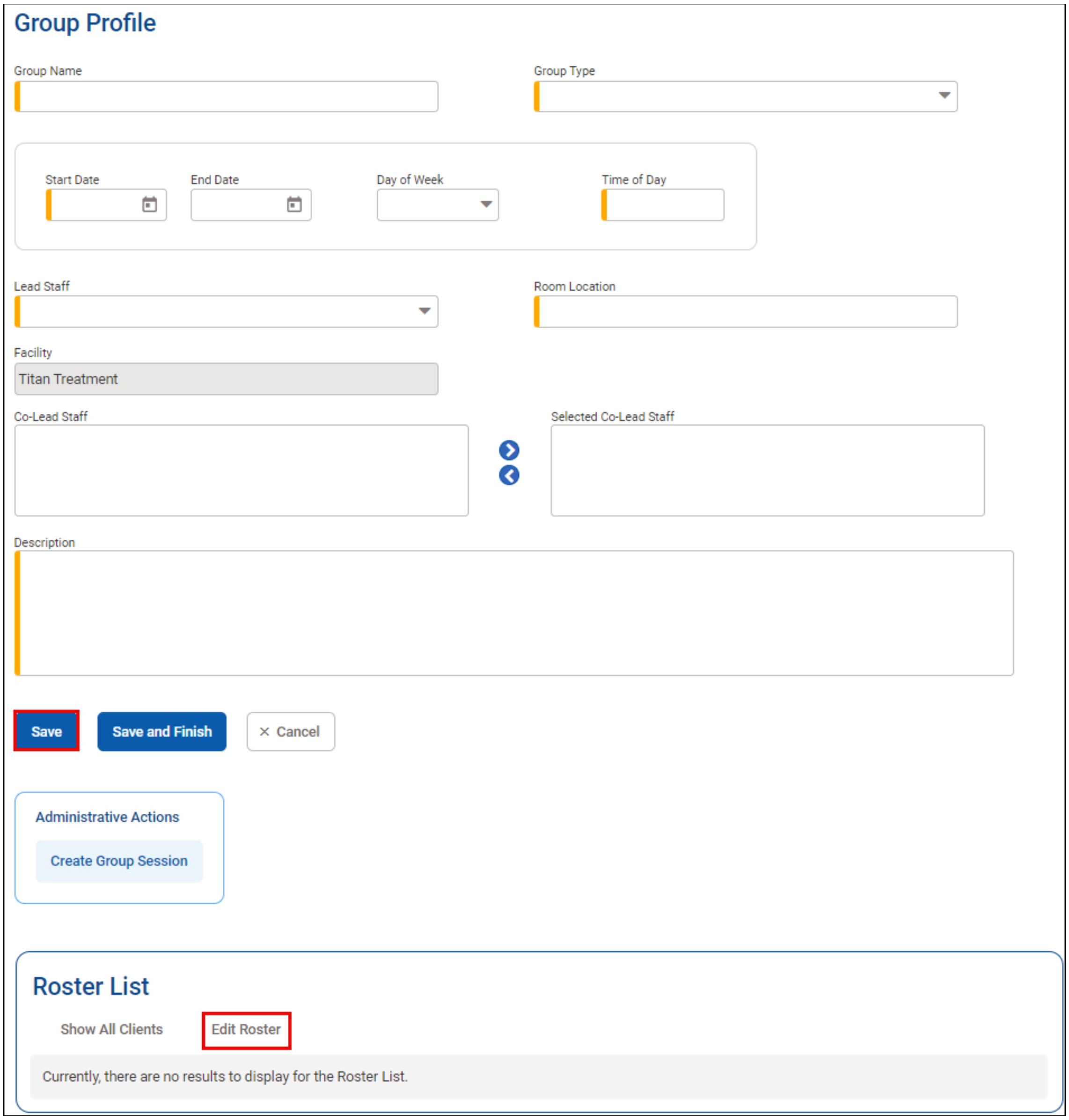


Figure 153: Group Profile

6. Click **Save**.
7. Click **Edit Roster**.
8. The Roster screen displays.
9. Click **+Add Member**.

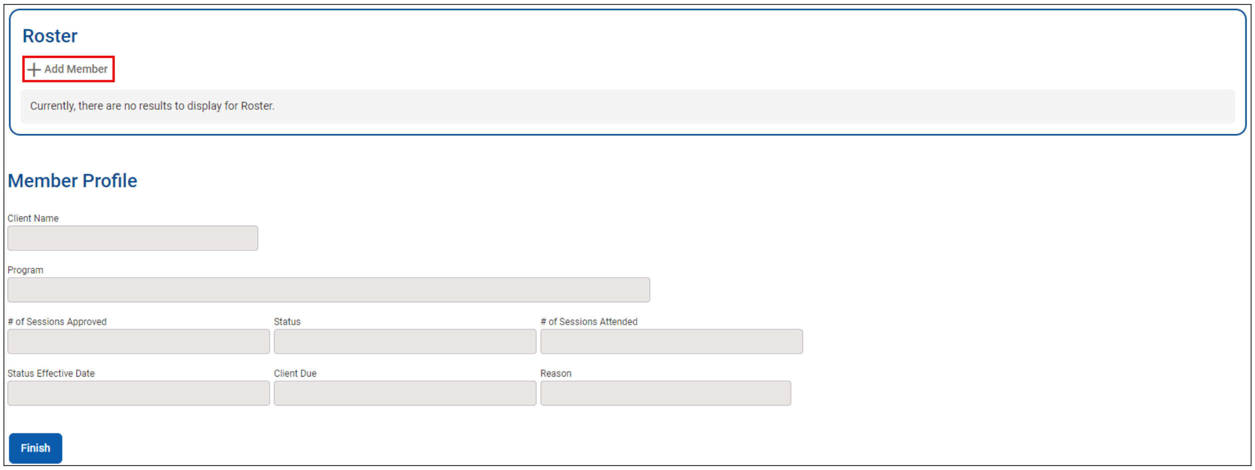


Figure 154: Roster Screen

10. The Member Profile becomes active.
11. Complete all required and relevant fields.

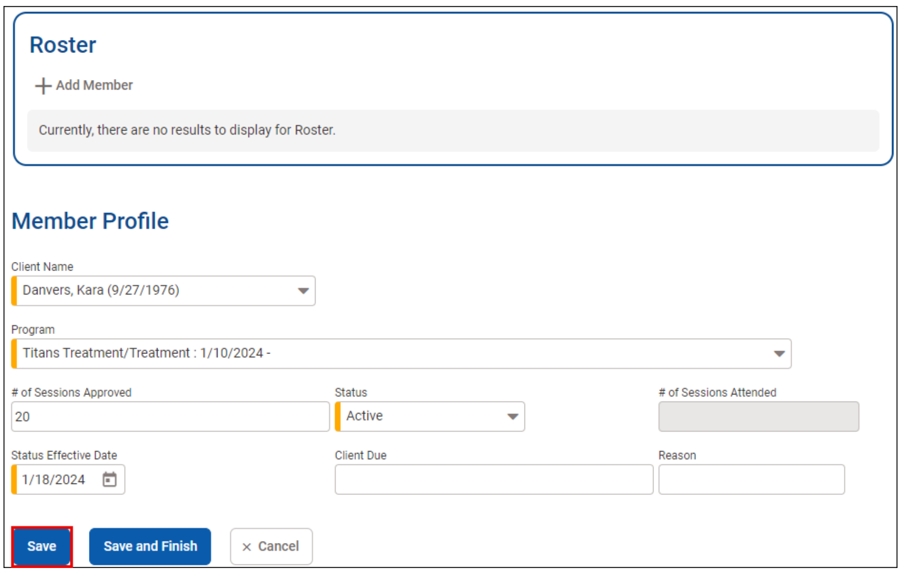


Figure 155: Member Profile

12. Click **Save**.
13. The client is added to the Roster section and the Member Profile will become read-only again.
14. Repeats steps to add clients to the roster.

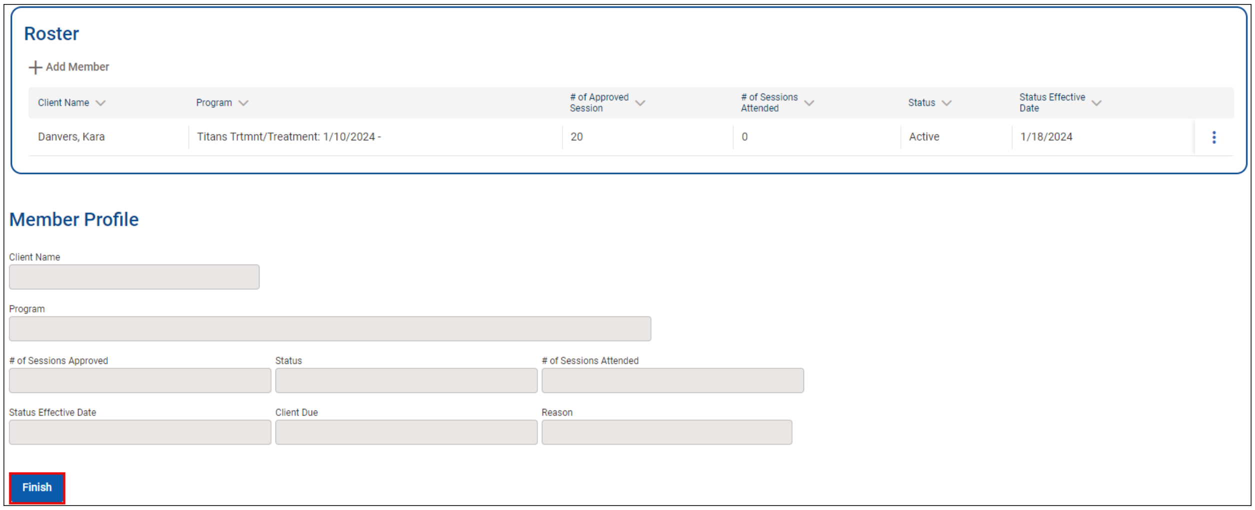


Figure 156: Client Added to Roster

15. Click **Finish** once all participating clients are added to the roster.
16. The user will be returned to the Group Profile screen.
17. Click **Save and Finish**.

Once a Group Profile has been created, several functions become available to aid in management and scheduling.

From the Group Profile Search screen, click the vertical ellipsis to the right of the group profile.

- Review – This option will take the user into the Group Profile record.
- Delete – If the group is no longer needed, select this to delete it.
- Session List – Selecting this will take the user to the Group Session Search screen for the management of group sessions.
- Group Roster – This option accesses the roster for the group to allow for roster management.

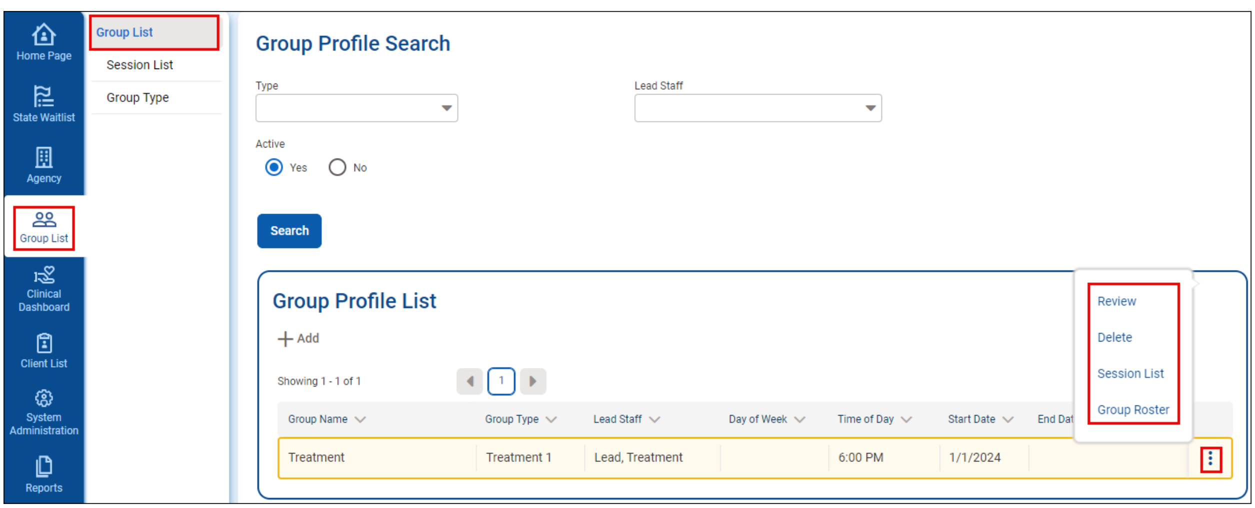


Figure 157: Group Profile Options

Administrative actions also become available to the user once a group profile is created. These are accessed by clicking **Review** for a Group Profile.

- Create Group Session – This action will take the user to the Group Session Notes screen. See Create Group Session for more information.
- Print Sign-In Sheet – Click this to create a sign-in sheet in a PDF format.

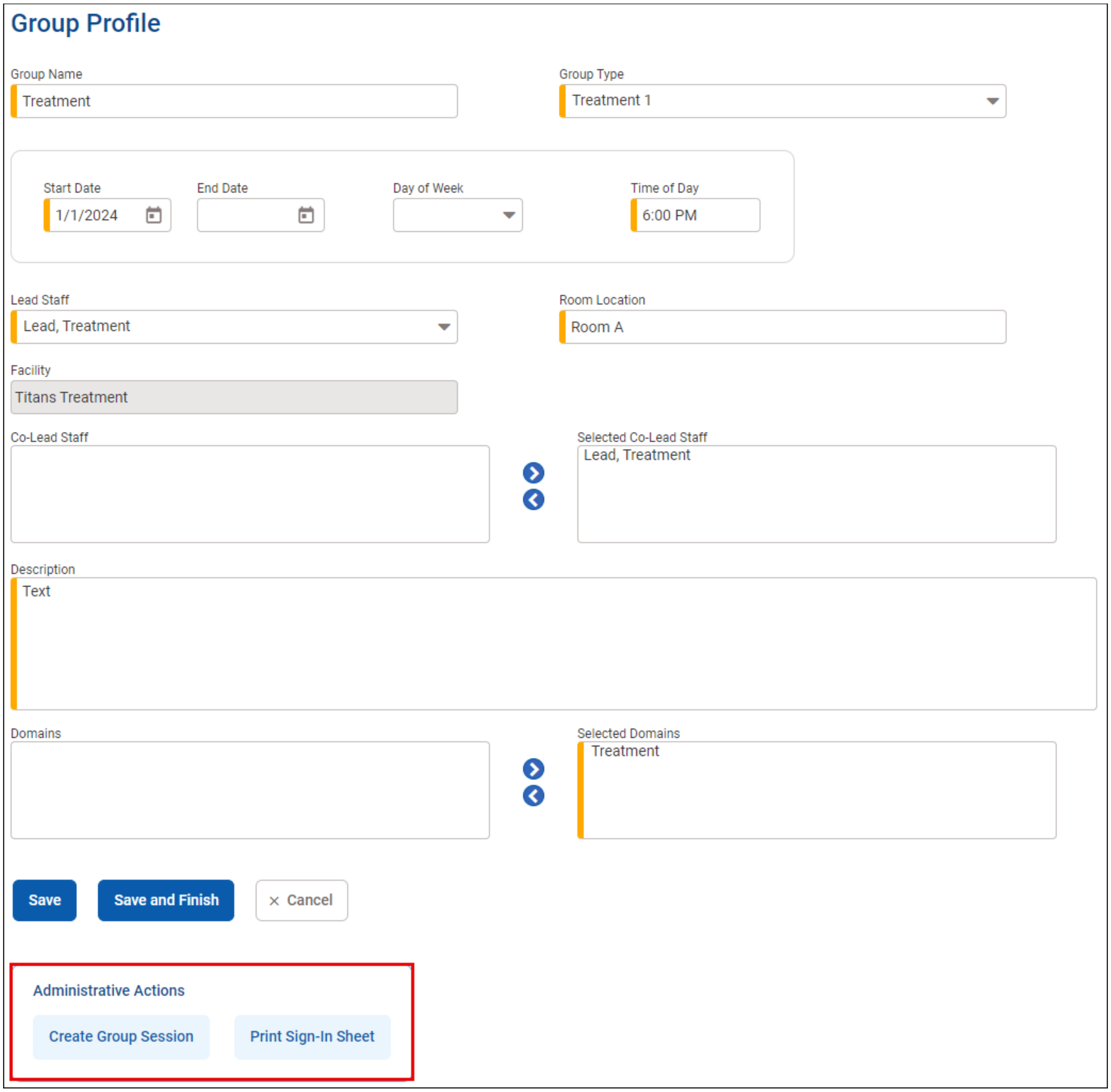


Figure 158: Group Profile Admin Actions

5.6.3. Create Group Session

Sessions are created from within the Group Profile screen.

1. Click **Create Group Session** under the Administrative Actions.
2. The Group Session Notes screen will display.
3. Complete all required and relevant fields.

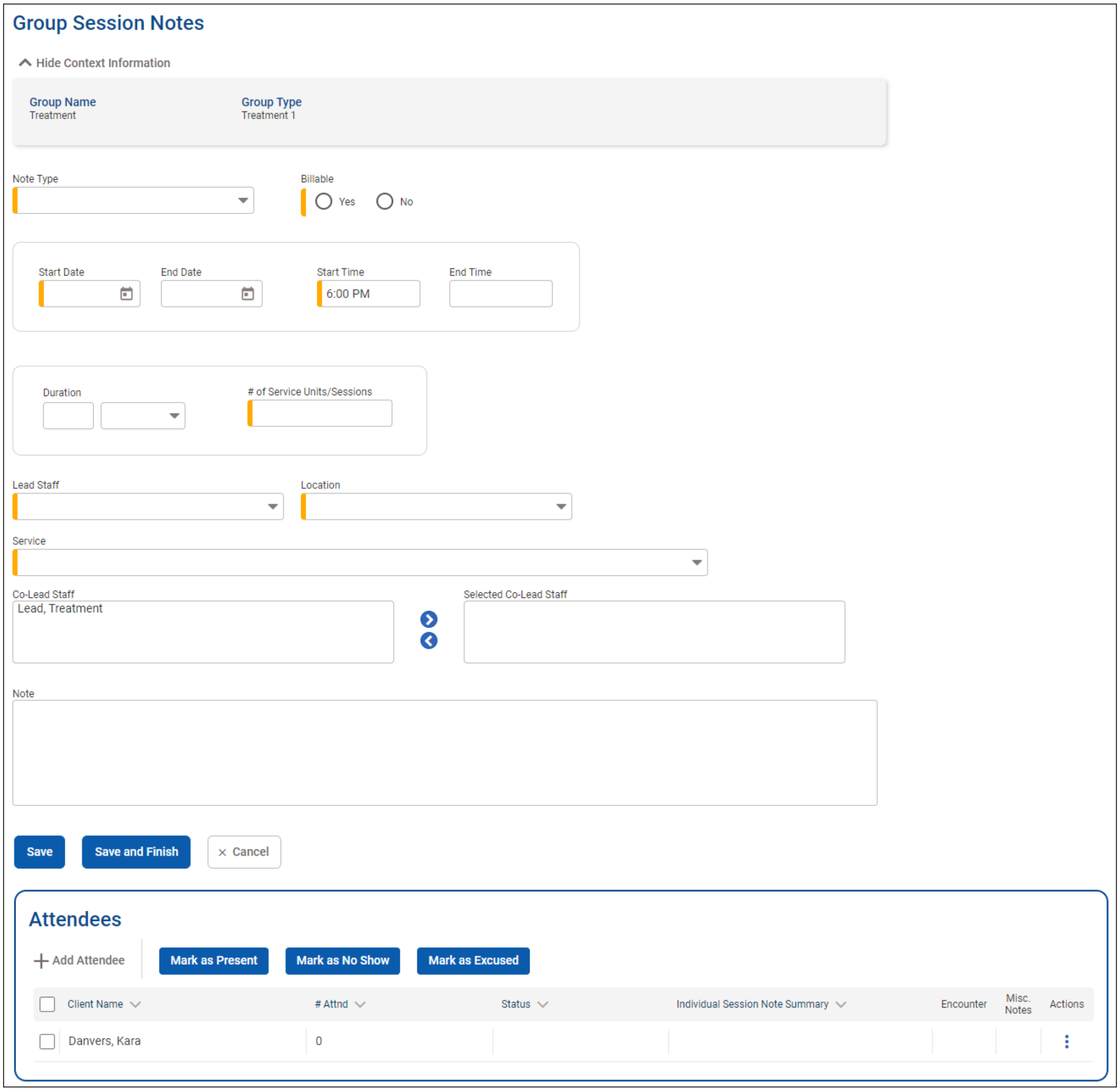


Figure 159: Group Session Notes

4. Click **Save**.
5. Scroll to the Attendees section.
6. If needed, click **+Add Attendee** to add more clients to the roster.
7. Check the box to the left of the client's name.
8. Once checked, the user can click one of three buttons for capturing attendance.
    a. Mark as Present – Selected if the client attended the session.

b. Mark as No Show – Selected if the client did not attend the session.

c. Mark as Excused – Selected if the client was unable to attend the session and received an exception.

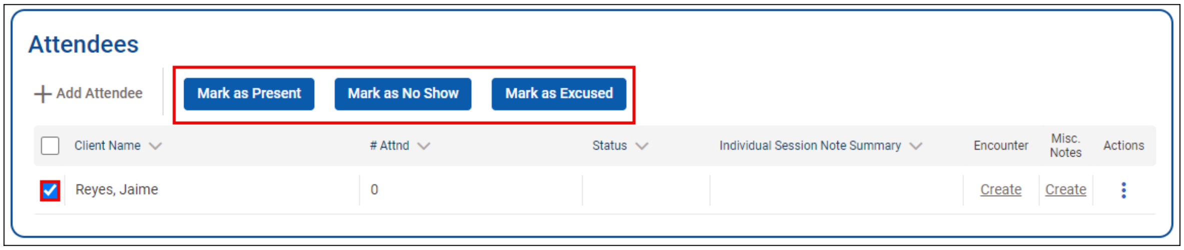


Figure 160: Capturing Attendance

9. Other actions can also be performed by clicking the vertical ellipsis under the Action column to the far right of the client's name.

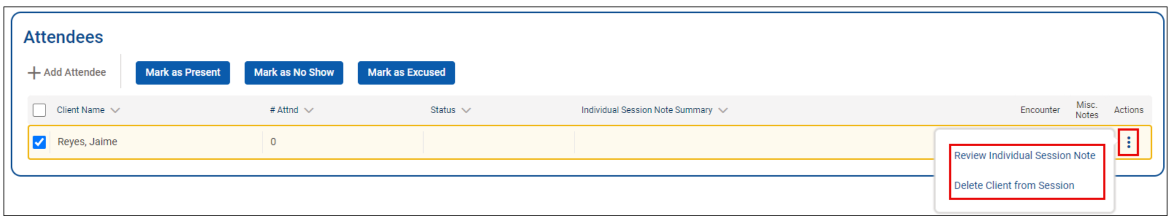


Figure 161: Attendees Actions

10. Review Individual Session Note will open the Individual Notes screen and allow the user to record notes specific to the client.
    a. **NOTE:** If templates have been setup by the agency administrator, the Individual Note comment box will prepopulate to guide the user in capturing their notes.

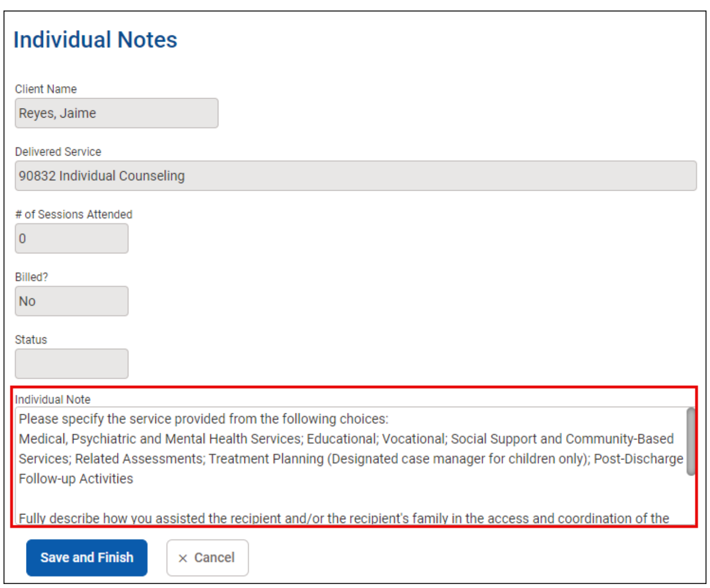


Figure 162: Individual Notes

11. If the client is no longer attending the sessions, click **Delete Client from Session**.
    a. The user will need to verify their action to remove the client.

Figure 163: Verify Client Removal

12. To add a Miscellaneous Note to the client's record, click Create under the Misc. Notes column.

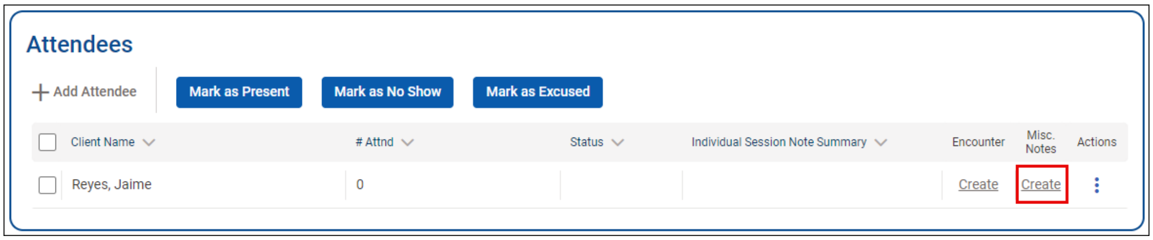


Figure 164: Create Misc Note

13. To create an encounter for billing purposes, click **Create** under the Encounter column.

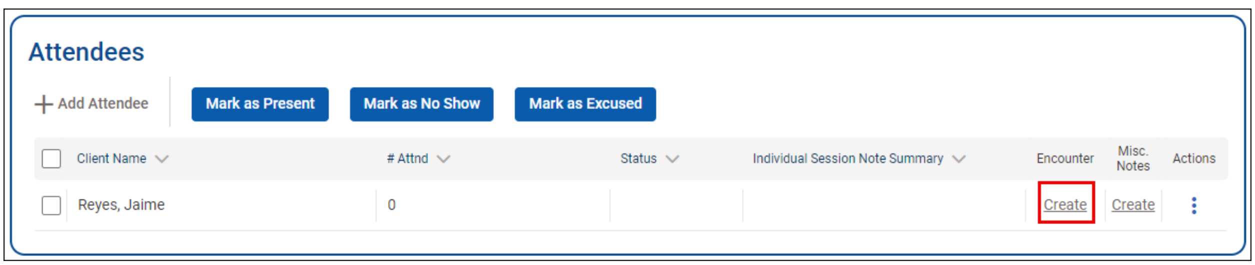


Figure 165: Create Encounter

5.6.4. Session List

This screen allows the user to view recorded sessions and print group notes.

NOTE: While there is an +Add button, it is not recommended that group sessions are recorded from this screen.

To access the Group Session screen:

1. From the left navigation menu, click **Group List**.
2. Click **Session List**.

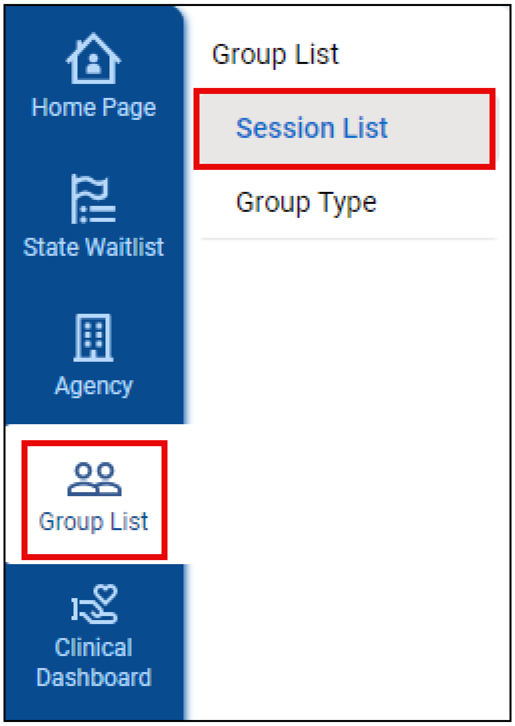


Figure 166: Accessing Session List

3. The Group Session Search screen will display.
    a. Existing sessions will be listed under Group Session List.
    b. The results can be filtered using the search option.

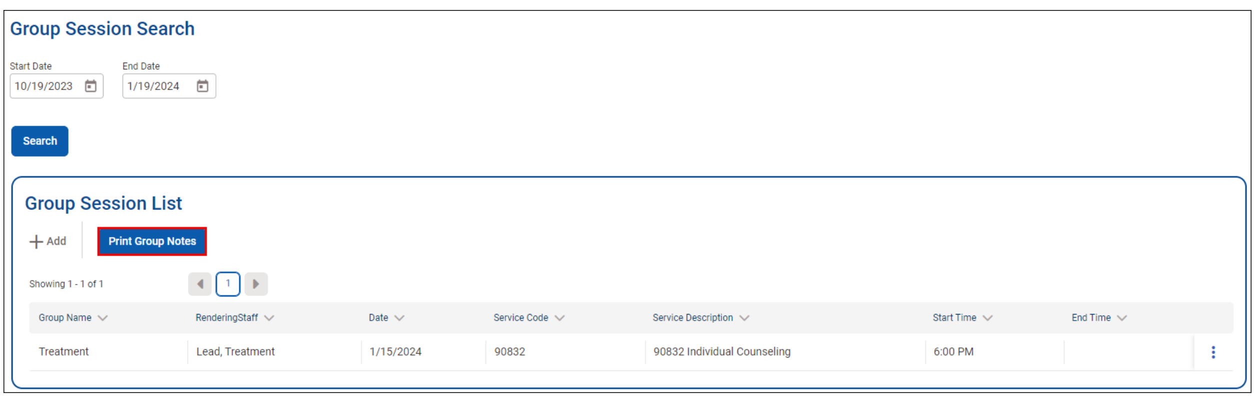


Figure 167: Group Session Screen

4. To print the group notes, click **Print Group Notes**.

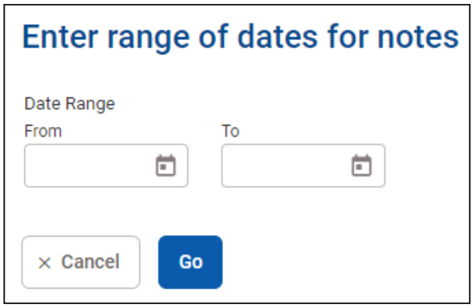


Figure 168: Print Group Notes

5. Enter a date range and then click **Go**.
6. The Group Session Notes Report screen displays.
7. Group Sessions that fall within the date range will be listed.
    a. If needed, the results can be further filtered using **Search**.

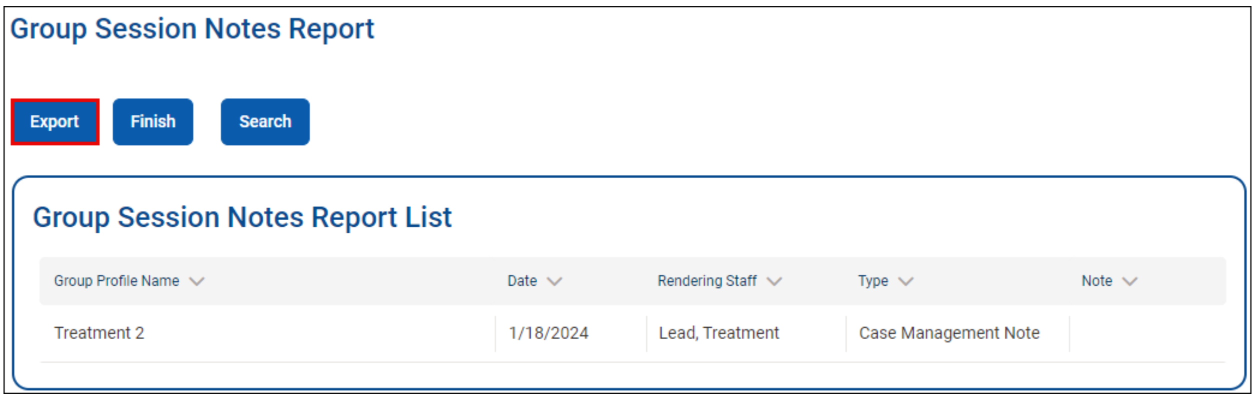


Figure 169: Group Session Notes Report

8. Click **Export** to save the file in an Excel format.

Appendix A: Acronyms

Table 4: Acronyms

Acronym	Literal Translation
ADMH	Alabama Department of Mental Health
AOD	Alcohol or Drugs
ASAIS	Alabama Substance Abuse Information System
ASAM	American Society of Addiction Medicine
CGE	Client Group Enrollment
EHR	Electronic Health Record
NOMs	National Outcome Measures
SUD	Substance Use Disorder
TEDS	Treatment Episode Data Set
TPL	Third Party Liability
TX	Treatment
UCN	Unique Client Number
WITS	Web Infrastructure for Treatment Services

Appendix B: Glossary

Table 5: Glossary

Term	Definition
Agency	The legal entity that a provider operates within; Some people refer to this as ‘Provider’.
CRAFFT	A screening used for clients under the age of 18.
Facility	The location (building) that an Agency/Provider uses to provide services or track Prevention Plans. A provider can have more than one facility.
Goals	The broad result that an individual wants to achieve by receiving services.
Intervention	The methods, strategies, and services that staff will use to help the client achieve their objectives.
Objectives	The specific measurable steps that the client should accomplish to meet their goals.
UNCOPE	A screening used for clients over the age of 18.