Residential Services Documentation Drug & Alcohol Services (DMC-ODS):

1. Bedboard: add client to Bedboard (My Office). Please do not open the client to the residential program outside of the BedBoard. The BedBoard enrolls the client into the program and also generates a daily charge related to the client's residential stay. Ensure that the correct admission date/time is chosen. Ensure the bed the client is assigned to has their correct program associated with the client's enrollment. Make sure to note any leaves on the BedBoard so that there are not charges for days that the client was not at the program.
    a. When a client transfers level of care within the facility (3.2WM to 3.1 or 3.5 LOC), this transfer must be entered on the BedBoard. This will change the client's program enrollment and will also ensure that the correct daily charge is generated.
2. LPHA Review: If diagnosis, assessment, and level of care was completed by the County: The Provider's LPHA will document that they reviewed the most recent ASAM Assessment (CA ASAM (Client)), Problem List (Client Clinical Problem Details (Client)) and Diagnosis(es) (Diagnosis Document (Client)) in a Non-Billable Srvs Must Document Service Note.
3. Complete CalOMS Admission: CalOMS Admission (Client).
4. CalOMS Updates: CalOMS Standalone Discharge/Update (Client).
    a. Completed by clinical lead and will be completed when the client completes current LOC (3.2 WM LOC, 3.1 LOC, 3.5 LOC).
    b. When a client completes 3.2 WM, clinical lead will complete CalOMS Admission (Client) for the new LOC (3.1/3.5) dated with first day of new LOC.
    c. When a client transitions to new LOC (3.1/3.5) residential staff will email DAS HIT (Dana Adoptante).
    d. Completed by clinical lead and will only be completed when the client is still open to treatment at the same level of care & same site a year after the admission. Done each year on the "anniversary" date of admission for each year they remain open.
5. Add Diagnosis Form for Correct Program: Diagnosis Document (Client).
6. Update Problem List as needed: Client Clinical Problem Details (Client).

7. Document Daily Service notes (document all services provided for the day, including childcare): For Progress Notes, select the procedure Residential Daily Note.
8. Document Case Management/Care Coordination notes (including transportation, connecting a client to another resource/service/health need), separate from daily service notes, for case management reimbursement: TCM/ICC- Targeted Case Management/Care Coordination Service Note
9. Document reauthorization requests for Residential Treatment Services every 30 days, as applicable:
    a. Update ASAM: CA ASAM (Client)

Discharge Documentation Drug & Alcohol Services (DMC-ODS):

1. Discharge Plan Session: Use Non-Billable Srvc Must Document Service Note- Select this procedure in a Service Note to document Discharge Plan
    a. Client to sign Discharge Plan Progress Note and Clinical Lead to offer a copy of the Discharge Plan Note to Client). Follow appropriate template in Appendix. Staff can enter "Discharge Planning Session" in their service note.
2. Discharge Summary: Use Non-Billable Srvc Must Document Service Note- Select this procedure in a Service Note to document Discharge Summary.
    a. Follow appropriate template in Appendix. Staff can enter "Discharge Summary Session" in their service note.
3. CalOMS Discharge: CalOMS Standalone Discharge/Update (Client)
    a. Completed by clinical lead.
4. When a client is discharged from the program, residential staff will email DAS HIT (Dana Adoptante).
5. Update Diagnosis as needed: Diagnosis Document (Client).
6. Update Problem List as needed: Client Clinical Problem Details (Client).
7. Bedboard: discharge client on the Bedboard (My Office).

Appendix: Templates

DMC-ODS Discharge Plan Progress Note Template

Description of the treatment episode (duration of treatment with admission date and discharge date, narrative summary of the treatment episode, description of recovery services completed):

Current alcohol and/or other drug use:

Current medications prescribed by Behavioral Health (including dosage and response, plan for continued medication, and list other medical issues/medications prescribed by other providers):

Vocational and educational achievements (achievements, scheduled time, structured time, activities such as volunteering, caring for family, or note no change since admission):

Legal status and comments:

Current living situation (status at discharge, recovery environment support):

Reason for discharge (indicate one of the following: Client not appropriate for treatment, Discharged against medical advice, Disengaged from services/Non-compliant with treatment, Involuntary discharge, Moved out of area, Services no longer needed, Successful completion, Transfer to a higher level of care, Transfer to a lower level of care, or Transferred to a different program):

Discharge Plan Comments (for close reasons 1, 2, 3, 5) narrative for discharge reason, collaboration with other agencies regarding close, transfers and referrals, recommendations for future services including other levels of SUD care):

Client's relapse triggers and plan to assist client to avoid relapse when confronted with each trigger:

Client's Discharge/Support Plan for Continued Recovery (people, organizations, Recovery Support Services) and comments at the close of treatment:

Was client offered/provided a copy of their Discharge Support Plan (yes, no, explanation if necessary):

DMC-ODS Discharge Summary Progress Note Template

Description of the treatment episode (duration of treatment with admission date and discharge date, narrative summary of the treatment episode, description of recovery services completed):

Current alcohol and/or other drug use:

Current medications prescribed by Behavioral Health (including dosage and response, plan for continued medication, and list other medical issues):

Vocational and educational achievements (achievements, scheduled time, structured time, activities such as volunteering, caring for family, or note no change since admission):

Legal status and comments:

Current living situation (status at discharge, recovery environment support):

Reason for discharge (indicate one of the following: Administrative discharge, Client not appropriate for treatment, Deceased, Discharged against medical advice, Disengaged from services/Non-compliant with treatment, Incarcerated, Involuntary discharge, Moved out of area, Services no longer needed, Transfer to a higher level of care, Transfer to a lower level of care, or Transferred to a different program):

Discharge Summary Comments (for close reasons 4, 6, 7, 8) narrative for discharge reason, collaboration with other agencies regarding close, transfers and referrals, recommendations for future services including other levels of SUD care):

Was an NOABD Termination Notice sent to the client (N/A, yes, no, explanation if necessary):