Guidance for Finalization of Departed Staff Clinical Documentation

Due to technological impacts, resulting from the InSyst to SmartCare transition, providers were advised to complete their clinical documentation in Clinician's Gateway- InSyst (CG-I) as "draft" and later import and finalize the documentation in Clinician's Gateway –SmartCare (CG-S). Alternatively, providers were permitted to complete their documentation outside of CG-I and enter the note in CG-S once it became operational.

This document provides guidance to agencies that have notes created by staff during the SmartCare transition, who are no longer employed at their agency, and unable to sign and finalize their clinical documentation in CG-S.

The information in this guide is tailored to ACBHD's electronic health record (EHR), Clinician's Gateway (CG). ACBHD contractors that do not use CG may adapt the concepts to their programs.

I. Can a Current Employee Complete the Documentation?

Certain activities may allow current staff to complete documentation. For all notes that need to be finalized for a staff member who is no longer with the agency, providers should consider asking a current staff member to complete the documentation when it is permitted, per below:

- Per BHIN 23-068, only one progress note is required to document group services provided by multiple providers. If one of the facilitators remains employed by the agency, they should complete the group notes. Alternate facilitators can rewrite the notes and submit a CG Note Delete request for the original notes.
- Per BHIN 23-068, only one progress note is required to document activities involving multiple providers. If one of the staff remains employed by the agency, they should complete the progress notes. Alternate facilitators can rewrite the notes and submit a CG Note Delete request for the original notes.
- Residential daily notes may be authored and signed by any staff member that provided a clinical service that day, or by a program supervisor who oversaw clinical services on the day of claiming. If needed, IS staff can transfer the note to a different staff member.

Note: If you are aware that the staff member who provided the service is currently employed at another ACBHD affiliated program, please contact HCSASupport@acgov.org to discuss additional approval options, as available.

II. Finalization of Clinical Documentation- Overarching Guidelines

All documentation must be signed before it can be finalized in CG-S. In cases where the rendering provider is no longer with the agency and a current employee cannot create or sign a note, another clinician will need to sign/approve the note so that it can be finalized.

Compliant clinical documentation that cannot be signed by the rendering staff in CG-S may be signed by the following individuals, in order of preference:

- The departed staff's clinical supervisor.
- A clinical supervisor/director who oversaw/was aware of the clinical services delivered to the beneficiary.
- A clinical program manager or administrator.

In general, the following guidelines must be followed when finalizing departed staff's clinical documentation:

- Claims must be submitted with the rendering staff's information (e.g., NPI, taxonomy, etc.).
- The rendering staff must have authored the clinical content prior to their departure.
- The rendering staff's original clinical content cannot be modified in any way; however, approvers may clarify content by adding addendums.
- Errors with "administrative data" can be corrected without the input of the original clinical author. "Administrative data" is non-clinical data required for billing, such as client name, client ID, procedure code, duration, location, program, mode of delivery.
- If adequate documentation was not completed prior to the staff's departure, then the activity may not be claimed.
- Supervisor attestation should only be used when no other allowable rendering staff is available to finalize the clinical documentation.

III. Finalization of Clinical Documentation – CG-S Addendum

A generic Addendum will be created in CG-S and attached to each finalized note that is signed by a non-rendering provider. The CG-S addendum will read as follows:

"*Due to the SmartCare transition, the rendering clinician documented but was unable to sign this note. To finalize the note, a different clinician at the agency is signing the note and attests that no changes were made to the clinical content of the note.*"

IV. Guidelines for Finalization of Clinical Documentation Based on Different Scenarios

Below are examples of different scenarios and what is required for each.

- **Documentation was created outside of CG-I on paper and includes the rendering provider's signature.** Steps to follow:

    - The clinician finalizing the note will re-create the record in CG-S, making sure not to alter the clinical content of the note in any way, and adjust any required administrative fields.
    - The agency will retain a copy of the original signed records and provide it as evidence if requested for auditing or other confirmation purposes by ACBHD or DHCS.
    - The clinician will manually add an addendum referring to the agency's stored record.
    - The CG-S addendum referenced in section III will appear on these notes. No additional attestations are required.

- **Documentation was created outside of CG-I and does not include the rendering provider's signature.** Steps to follow:

    - The clinician finalizing the note will re-create the note in CG-S, making sure not to alter the clinical content of the note in any way, and adjust any required administrative fields.
    - The CG-S addendum referenced in section III will appear on these notes.
    - Given that there is no rendering provider signature on the documentation, the provider signing the note on behalf of the departed staff member will need to attest that the service occurred and include an attestation to that effect in the body of the saved note.

Prior to attesting to the validity of a note or service, the agency will make clinically appropriate and reasonable efforts to verify services with the client. The attestation statement will indicate the verification actions taken, and if feasible, client signature on external documentation. Evidence of client service verification will be retained in the agency's medical record.

Below is an example of an acceptable Attestation note:

"Due to the SmartCare transition, the rendering clinician was unable to sign and finalize this note. By approving and signing this note, the approver attests that to the best of my knowledge, the information documented reflects the services provided and that the rendering agency has made reasonable attempts to verify this prior to attestation through the following means: ----"

In situations where the agency does not feel comfortable attesting to a note written by a departed staff member, the provider should document the note in the medical record using a non-billable template.

- **Documentation was created in CG-I and saved as "draft"**. Although the rendering provider's signature is not saved on the documentation, the original time stamp and name of the rendering provider are saved in the system. Steps to follow:

- Submit a list of departed staff and the individual to whom the documentation should be transferred using the Departed Staff spreadsheet. The spreadsheet is also posted on the SmartCare and CG provider sites. Please submit the completed spreadsheet to HCSASupport@acgov.org **by no later than 4/19/24** using SUBJECT: Departed Staff Spreadsheet
- Using the completed Departed Staff spreadsheet, CG developer will change the departed staff's profile to "Review Required" (as needed) and will submit the departed staff's unfinalized documentation to the identified supervisor for review/approval/signature by placing it in the identified supervisor's Pending Services queue.
- Once in the queue, the clinician finalizing the note will make sure not to alter the clinical content of the note in any way and will adjust any required administrative fields.
- The CG-S addendum referenced in section III will appear on these notes. No additional attestations are required.

V. Required configuration of mental health CG and its impact to MAA reports

To allow for the above process to be completed, CG developers will change the application configuration in the mental health system (MHS) CG-S so that supervisor approval triggers finalization. This will impact MHS only, as SUD CG is already configured in this way.

The required configuration will change the way documentation is finalized in MHS CG-S as follows:

- MHS users will no longer have to finalize clinical documentation after supervisor approval.
- MHS users that must report MAA billing will need to remember to go to Daily Approval to print out their staff logs by selecting the View Report button.