Avatar Corrections Quick Guide

If you make a mistake, you can request to have your document reverted back to draft, deleted, or in the case of some progress notes, we can make changes for you.

Copy and paste your correction request into an email, fill out the template, and then send it to askqi@santacruzcounty.us

Progress Note Deletion and Revert to Draft Template

(fill out completely and send to AskQl@santacruzcounty.us)

Client name & number:

Episode number & name:

Service Date:

Data Entry Date and Time*:

Total Duration time:

Service code:

Is the episode still open (Y/N):

Clinician:

Action requested (delete, revert to draft, etc.):

, Danasani

Reason:

Is this a group note? (Y/N): N

*We might need the data entry date/time to distinguish your note from others in the chart. If your note is unique, then we don't need this information.

Group Progress Note Deletion and Revert to Draft Template

For group note deletions we need information on the entire group, so that we can change the Group Count for the remaining notes.

Client name & number:

Episode number & name:

Service Date:

Data Entry Date and Time*:

Total Duration time:

Service code:

Is the episode still open (Y/N):

Clinician:

Action requested (delete, revert to draft, etc.):

Reason:

Is this a group note? (Y/N): Y

Group Count

*We might need the data entry date/time to distinguish your note from others in the chart. If your note is unique, then we don't need this information.

Progress Notes must be finalized and cosigned for us to correct. We cannot correct draft notes or notes pending co-signature.

 If you need help, talk to your supervisor, your agency's QI staff or contact County Behavioral Health QI at

AskQI@santacruzcounty.us

 For more detailed information about corrections, see the <u>Avatar Clinicians</u> <u>Manual</u> on the On the <u>Santa Cruz County</u> <u>Health Services Avatar Information</u> <u>Resources Pages</u> If the problem with your progress note is with the text only, consider using Append Documents to add information to the end of your progress note. It might avoid having to revert your note to draft. See the Avatar Clinicians Manual for more information.

Service Charge Deletion Template

(fill out completely and send to AskQI@santacruzcounty.us)

Client name & number:

Episode number & name:

Date(s):

Service code:

User:

Reason:

Service Request and Disposition Log
Deletion and Revert to Draft Template

(fill out completely and send to AskQl@santacruzcounty.us)

Program:

Client name & number:

Date of SRDL:

Clinician:

Reason:

Treatment Plan Deletion and Revert to Draft Template

(fill out completely and send to AskQl@santacruzcounty.us)

Plans that are not valid can be deleted. If you need a treatment plan deleted, follow these instructions. If the plan is signed/finalized, it cannot be deleted or reverted to draft.

Treatment Plan Form (pick one):

[] SC SUD Treatment Plan

[] SC MH Episodic Treatment Plan

[] SC MH Short Term Treatment Plan

Client name & number:

Episode number & name:

Plan Type:

EXACT Plan Name:*

Authorization Start Date:

Clinician:

Action requested (revert to draft, other

correction):

Reason:

*Plan name must be exact. We don't want to delete the wrong plan!

Double check your template before you send it. This makes it easier for us to process your request and it will get done faster.

Re-Opening Episodes

(fill out completely and send to AskQl@santacruzcounty.us)

The most common reason to reopen an episode is to complete progress notes and other documentation. Don't forget to close your episode once you have completed your notes.

Episode Reopening Template Client number:

Client name:

Episode name and number:

Reason for reopening the episode:

If you are requesting a reopening to complete notes, once you have completed your notes, use the Discharge form (or Pre-Admit Discharge form) to close the episode ASAP.

Deleting Episodes

(fill out completely and send to AskQI@santacruzcounty.us)

If there is no data in the episode, it can be deleted entirely. Before you send in your request, close the episode to prevent users adding information to it.

Episode Deletion Template

Client number:

Client name:

Episode name and number:

Reason for deleting the episode:

Program Transfer

(fill out completely and send to AskQI@santacruzcounty.us)

Request a program transfer to switch an episode between Sequestered and non-Sequestered.

Program Transfer Template

Client number:

Client name:

Episode name and number:

Change Episode name to:

Reason for deleting the episode:

Scanned Document Deletions

(fill out completely and send to AskQl@santacruzcounty.us)

Client name & number:

Document Category or Form Name*:

Document Description (be EXACT)**:

Document Date:

Episode:

Reason:

*e.g. CLN – Outside Records or MED – Lab Results

**This is the name the scanned document was given, e.g. 112510 Lab Result.

Other Documents

(fill out completely and send to AskQI@santacruzcounty.us)

We can revert many other types of documents (but not all) back to draft.

Form Type (e.g. Psychosocial Assessment, CANS/ANSA):
Client name & number:
Episode number & name (if applicable):
Date of form or note:
Date and time submitted:
Action (delete or revert to draft):
Clinician:

Reason:

You can delete many draft documents yourself, including assessments and service request and disposition log entries.

- 1) Open the document from the Home Console.
- 2) Select the episode.
- On the next screen, CLICK
 ONCE on the document row to highlight it. Do not open.
- 4) Click "Delete" at the bottom of the page.

Document Rerouting Template

(fill out completely and send to AskQI@santacruzcounty.us)

If you have routed a document for cosignature to the wrong person, we can reroute the document to the correct person.

Unfortunately, if you forgot to route it completely, we cannot make changes. In this case, request that the document get put back to draft and then you can route it.

Document Type:

Plan Type (for treatment plans):

Client number:

Client name:

Service Date (for progress notes):

Authorization Start Date (for treatment plans):

EXACT Plan Name (for treatment plans):

Data Entry Date and Time:

Total Duration time (for progress notes):

Service code (for progress notes):

Episode name/number:

Clinician's name and user number:

Reason for rerouting:

Action (Route from A to B):

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