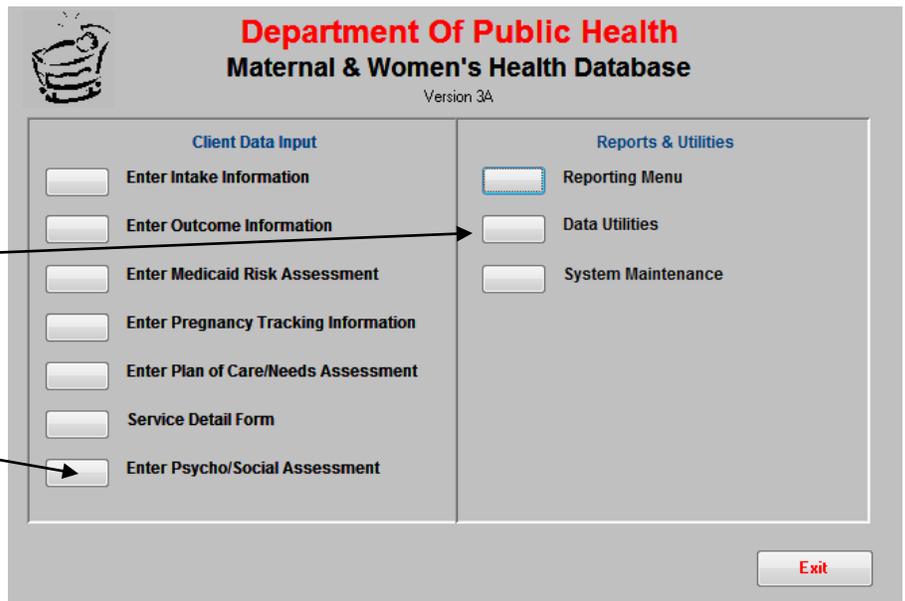


WHIS Database Revision November 2014 Release Notes

Changes have been made to several of the WHIS database forms.

The Main Menu will look a little different. All of the import/export and data transfer functions will now be accessed from the *Data Utilities* form. The System Maintenance button will be used mainly for changing and setting up passwords and other little used system functions.

A *Psycho/Social Assessment* form has been added to the database and can be accessed from the main menu. This is not a required form.



Changes to the Intake form-

The ability to enter Dental Only and Presumptive Only clients has been added to the database. When assigning a referral you may now choose from 5 different programs. Each program displays different screens. The program options are listed below.

Maternal Health- Used for most Maternal Health client input. Some fields have been removed from screens for this program. Several of the list options have also changed.

Women's Health- No field changes have been made to screens for this program. These clients are not transferred to the state.

Postpartum Only- Used for those clients receiving only a postpartum visit. Several fields have also been eliminated from these screens.

Dental Only- This is a new program for input of Maternal clients seen only for the dental program and not followed for Maternal Health.

Presumptive Only- This is a new program used for input of Maternal clients seen only for presumptive eligibility determination.

Entering clients as Dental Only or Presumptive Only allows contractors to bill for those services for clients who are not served in the Maternal Health program. You may change programs at any time during service. If you find that a Dental Only client will receive Maternal Health services you will just change the program to Maternal Health and enter the additional required information.

Medicaid ID is now stored in a separate field. The ID table is still available for other IDs you would like to store.

Limited information is required for the Dental and Presumptive programs. Discharge information is entered at the same time as intake.

Changes to the Discharge form-

You will no longer see an "Add Discharge" button. Enter the discharge date and indicate whether the services were terminated prior to delivery. If the response to this question is "yes", you will see a form with the required discharge questions only. If "no" all of the discharge questions will be displayed.

The Data Utilities Menu-

The only change here is the name of the menu. You will now open the "Data Utilities" menu to import/export data, create the service detail export to Excel, or delete records.

The screenshot shows a window titled "Data Utilities" with three main sections:

- Import/Export Records:** A button labeled "Import/Export For Subcontractor".
- Audits and Billing Exports:** Two buttons labeled "Create Data Exports to Excel" and "View Records for Audit".
- Delete Or Reactivate Records:** A button labeled "Delete Or Reactivate Records".

Changes to the Service Detail form-

Several new service codes have been added.

Additional questions are now required for some services.

If dental screenings are being entered a form for screening results will be displayed.

This screenshot shows the "Services" section of the form for a record with "Category: Oral Health Services" and "Service: Initial screening evaluation by an RDH". The "Screening Results" section includes the following questions:

- Was decay present (obvious or suspicious)?
- Were restored teeth (fillings/crowns) present?
- Was gingivitis present (gum bleeding, swelling or pain)?
- Oral health risk level:
- Name of dentist referred to:
- What is client's referral need?

If care coordination records are entered a form for additional information will be displayed.

This screenshot shows the "Services" section of the form for a record with "Category: Care Coordination". The form includes several text input fields for additional information:

- Service provided by:
- Place:
- Spoke to (if other than client):
- Link to Medicaid eligible service provider:
- Other referrals provided:
- Follow up:

If presumptive eligibility several additional questions are required.

This screenshot shows the "Services" section of the form for a record with "Category: Outreach" and "Service: Presumptive Eligibility Determination". The form includes several checkboxes for additional information:

- Client explained she is eligible for ambulatory medical and dental services and verbalizes understanding
- Client requests assistance with insurance coverage
- Copy of application in client's file
- Client given copy of NOA

The Psycho/Social Assessment Form

The psycho/social form is not a required form, but may be used to store psycho/social assessments completed on existing clients. An intake must have been completed before the form will be available.

Click on the Add a New Assessment button to open the input forms.

Select Client: Demo, Ima | 145200543 | Admission ID: 145200567

History | Contact Info

Below is the psycho/social assessments completed for the selected client's most current participation

Admission ID	Survey Date	Form Completed By
145200567		

Buttons: Delete, Print, View Survey, Add A New Assessment

Once you have completed the assessment you may access by clicking on the "View Survey" button.

Psycho/Social Assessment for Ima Demo

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Contact Date: [] Time in: [] Time out: [] Time spent: [] Initial Visit?

Who was present: []

Select address to copy to location: []

Location: []

Goal: []

Narrative: []

Affect: not indicated []

Mood: not indicated []

Dress: not indicated []

Hygiene: not indicated []

Substance Use: not indicated [] Self harm: [] Homicidal: [] EPDS completed? []

Health comments: []

The quality of interaction for each family member is stored for every assessment.

Prior to entering the interaction the family members need to be added for the client. Family members are entered only once. Click on the "Add/Update Family Members" to open the form for the input of family.

Psycho/Social Assessment for Ima Demo

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Risk Tracking: [] Risk Comments: []

Patterns of Functioning

Support System: []

Financial Needs/Concern: []

Current Living Situation: []

Family Composition

If the family member does not exist in the list below, or information on that family member needs to be edited, click on "Add/Update Family Members" and enter new or edit information. If the record exists, select the name and enter interaction information below.

Add/Update Family Members

Name	Relationship	Living W/ Client	Birthdate	Age	Interaction
[]	[]	[]	[]	[]	not indicated []

Comments: []

Family members are entered by typing information in the last line of the table. Once entered the record will be available for enter of the quality of interaction.

Family Members

Family Members for Ima Demo

Add new family members by entering information in the last row below.

First Name	Middle	Last Name	Relationship	Living W/ Client	Birthdate	Age	Gender	Status
0			Not Indicated	[]	[]	[]	[]	[]

Comments: []

Close

Psycho/Social Assessment for Ima Demo

Page 1 | Page 2 | Page 3

Adjustment to pregnancy and future parenting: []

Plan of Care: []

Counseling/Anticipatory Guidance: []

Referrals: [] Referral Comments: []

Follow up visit date: [] Follow up comments: []

Add "see client chart" to report:

Form Completed by: [] Date entered: []

Data entered by: [] Date entered: []

QA inspection by: [] Date of inspection: []