



**The Department Of Public Health
Maternal Health And Women's Health
Client Database**

User's Manual

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The Maternal & Child Health database was developed to store information from the input forms required by the Department of Public Health. The following information may be beneficial to help you understand some of the design elements and protocol for using the database.

A *Client* refers to each individual. Each receives a unique **CLIENT ID** generated by the system. The **CLIENT ID** remains with the individual forever. The Client ID is assigned by the software. The first five digits of this ID indicate the contracting agency and the subcontractor providing service.

Each client is also assigned a **REFERRAL ID**. This is simply a unique identifier for each referral. It is possible that a client may receive a referral ID, but then not meet the requirements for service. This client is not assigned an admission ID and remains a referral only client.

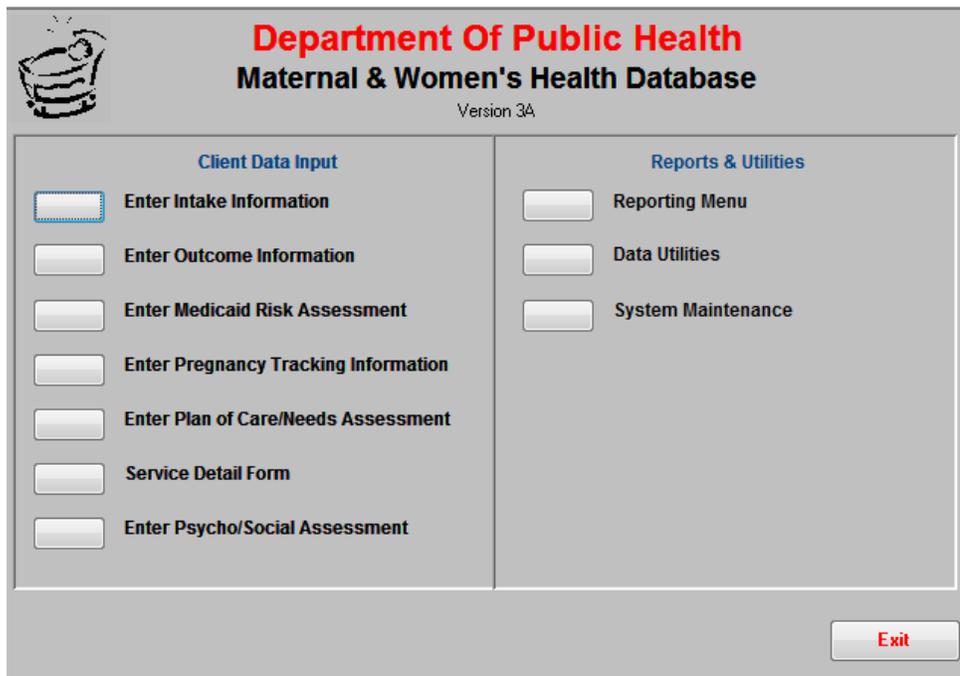
An *Admission* is a client who is receiving services. Each time a client enters the system for services, a new **ADMISSION ID** is assigned. A client may have several Admission IDs if they have received services for more than one pregnancy. An admission ID is assigned once the client agrees to services and a client release form has been signed. Each child born to the client receives a unique **Child ID**. This ID is assigned by the system.

Each contractor is responsible for input of client data into the Maternal Health Database installed on a computer at their site. The main database for each contractor will be installed on their server or on a single PC which has been designated by the agency to act as the host for the main database.

Data entry may be done at a subcontractor's site and the information transferred to and appended into the main database at regular intervals. If data is input at a subcontracting agency and transferred to the main database, special care must be taken to prevent overwriting data. If subcontractors are used, only the subcontractor serving the client should be doing regular entering or editing of client information. Information should be transferred from the subcontractor to the main database on a regular basis. Transfer of data will be discussed in this manual.

Both the contractor and the subcontractor are responsible for making regular backups of their data. Failure to do so may result in a loss of data.

To backup your data create a backup directory and copy the DPHDAT.mdb file into that directory. This is the only file that needs to be regularly backed up. The DPHEXE.mdb is the executable file and the DPHSUP.mdb contains all of the supporting tables. It would be a good idea to have one back up copy of these files also so that they can be restored should they become corrupted.



When you open the DPH Maternal and Women's Health Client database the main menu will appear. It is from this menu that you access all of the data input forms.

Each of the buttons on the Main Menu open either an input form, maintenance screen or another menu. Each will be discussed in this manual in the order that they appear on the main menu.

Adding Records

There are several types of records created in the Maternal Health database system.

Adding A Client Record:

When a client initiates service for the first time a new client record will need to be added. To add a new client record click on the Enter Maternal Health Intake button from the main menu. From the intake form click on the ADD CLIENT button and an empty set of screens will appear for you to enter new client information.

Do not add a new client record if this client has received services in the past. If a client record exists for this client, but they are seeking services for a new pregnancy, select the existing client record and add a new referral record.

Adding A Referral Record:

Once you have entered new client information or selected an existing client, you must click on the **ADD REFERRAL** button. This button is found on the Referral tab of the Maternal Health Intake form. Clicking on this button will create a blank record for entering the referral information for the client.

Each time a client initiates service for a new pregnancy a new referral record must be added. If it is determined that the client does not meet the criteria for service, that client remains a referral only client. If services will be provided you must create an admission record for the client.

Adding An Admission Record:

Once you have completed all of the referral information and have determined that services will be provided, it is time to add an admission record. If you answer “yes” to the prompt *Will services be provided* on the referral tab located on the Maternal Health Intake form, new fields and buttons will appear at the bottom of that tab.

Enter all of the information in the fields that appear. Click on the ASSIGN ADMISSION button. An admission ID will be assigned and all of the admission records will be created for the client.

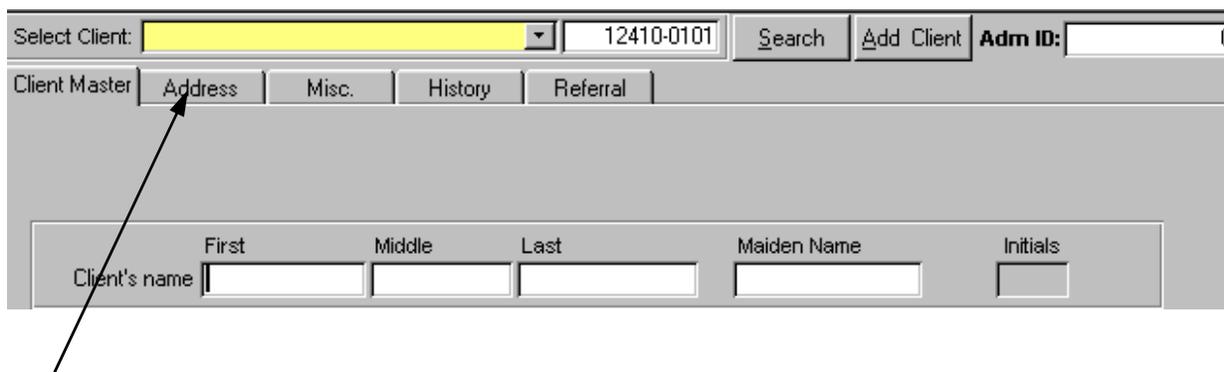
The Intake Form



The screenshot shows the top section of the intake form. It includes a 'Select Client:' dropdown menu with a yellow background, a 'Search' button, an 'Add Client' button, and an 'Admission ID:' text input field.

When the Maternal Health Intake form opens a blank screen will appear. From this screen you have three options. You may select an existing client by clicking on the arrow to the right of the SELECT CLIENT box, or beginning to type the client's last name; you may click on the search button to open the search screen and find a client; or you may click on the ADD CLIENT button and an empty set of screens will appear for you to enter new client information.

Depending on the client's program different tabs and questions will appear for data input.



The screenshot shows the main interface of the intake form. At the top, there is a 'Select Client:' dropdown menu with a yellow background, a text input field containing '12410-0101', a 'Search' button, an 'Add Client' button, and an 'Adm ID:' text input field containing '0'. Below this is a row of tabs: 'Client Master', 'Address', 'Misc.', 'History', and 'Referral'. The 'Address' tab is selected and highlighted. Below the tabs is a section for 'Client's name' with five input fields: 'First', 'Middle', 'Last', 'Maiden Name', and 'Initials'. An arrow points from the 'Address' tab to the 'Client's name' section.

The information on the hard copy intake form has been divided into a series of screens on the computerized entry form. Each input screen is on a tab. When you are doing data entry, after entering the last prompt on one screen you will automatically go to the first prompt on the next screen. To move between screens you may use your mouse to click on one of the tabs.

The Search Utility

Client Master - Search

Search Criteria:

First Name	<input type="text"/>	Client ID	<input type="text"/>
Last Name	<input type="text"/>	Birth Date	<input type="text"/>
Maiden Name	<input type="text"/>	Soc. Sec. Number:	<input type="text"/>

Enter search criteria in fields to the left. The wildcard "*" may be used in any of the fields in the left column. Click on the Begin Search button at the bottom of the form to execute the search. To see more detail on a specific record, double click on the Client ID.

Rec Typ	Client ID	SSN	First Name	Middle Name	Last Name	Maiden Name	Birthdate
C	125100109	657-11-2222	Carin	Marie	Alot		8/15/84
C	125100107	121-22-3333	Ima	Good	Demo	Jones	1/1/77
C	125100111	888-88-8888	Bea		Good	Notso	1/1/80
A	125100109		Sharon	Lynn	Jones		
C	125100110	333-33-3333	Betty		Kant	Could	1/1/76
C	125100112		Shirley		Knot		
C	125100113		Anita		Shrink		
A	125100110		Susan		Smith		

Begin Search
Exit

If you are unable to locate a client in the list, but believe they may have been entered, it is a good idea to use the Search utility before adding a new client record. It is possible that the client was entered incorrectly or the last name has changed. This utility allows you to search the database by several different criteria to locate difficult to find records.

There are several fields available to use for search criteria. Those fields are *First Name*, *Last Name*, *Maiden Name*, *Client ID*, *Birthdate*, or *Social Security Number*. You may enter a response in any or all of the fields.

If you are unsure of spelling or other information, you may use the wildcard (*). For example, if you can't remember whether the client's last name is Johnson or Jackson enter "J*" at the *Last Name* prompt. You will see a list of all of the client's who's last name's begin with "J". After entering your search criteria use your mouse to click on the **Begin Search** button. Once the search has been completed a box will appear with the message **Search Complete**. Click on **OK**.

All of the records that meet the criteria you indicated will appear on the screen. The *Record Type* field indicates whether the record is a client or alias. **C** represents *Client* and **A** represents *Alias*. Double click on the Client ID of the record that you wish to view.

Enter Client Master Information

Client ID

The client ID is shown in the box to the right of the client's name. It is assigned by the system. This is an eight digit number. The first three digits indicate the contractor and the county providing services. The client ID remains with the client through out time and will remain the same each time the client is admitted for service.

Admission ID

The admission ID appears in the box in the upper right corner of the screen. It is assigned by the system. This ID will be 0 until you indicate that a client release form has been signed and the client is to receive services.

You will need to enter the following information for the client:

Client Name

Enter the client's first name, middle name and last name at the appropriate prompts.

Maiden name

Enter the client's maiden name.

Birth date

Enter the client's birth date in the mm/dd/yyyy format.

Medicaid ID

Enter the client's Medicaid number if one exists.

Other IDs

Indicate the type of ID and enter the number for each for this client. To delete an option selected in error, click on the button with the red X to the right of that option. If the client is not eligible for Medicaid, type "Not Eligible" in the ID Number and select Medicaid as the type.

If the client is known under a different name, click on the ADD ALIAS button and enter the following information:

Client Alias

If the client goes by a name other than their legal name, enter the client's alias first name, middle name and last name at the appropriate prompts.

Alias Client ID

If the client has been admitted before under a different name, enter the client ID assigned to the other name here.

Enter Client Address Information

Count of addresses for client: 1		Address ID: 1		◀ ▶ Add New Address	
Address Type:	Current Home ▼	Address Status:	Active ▼		
Street Address:	223 N. 9th Street	Apt #:		County:	Story ▼
City:	Any	State:	Iowa ▼	Zip Code:	555555
Cell Phone:	(555)555-5555	Alternate Phone:			
Emergency contact:				Phone:	(555)555-5555
Emergency contact relationship:					

Enter all of the address information for the client's current home. If the client moves, change the address type of the first address to previous home and add the new address.

To add the new address click on the Add New Address button. Enter the new address in the address fields. In the NUMBER OF ADDRESSES field you will see a count of the number of addresses stored for this client. The ADDRESS # field shows the address ID of the address currently being displayed. To scroll through the addresses for this client click on the arrows to the left of the ADD NEW ADDRESS button.

Street address Enter the client's street address.

Apt Number Enter the client's apartment number if applicable.

County Enter the county that the client resides in. If the client is from out of state, select the *out of state* option from the list.

City Enter the city that the client resides in.

State Enter the state that the client resides in.

Zip Code Enter the client's zip code.

Cell Phone Enter the client's cell phone number.

Alternate Phone Enter an additional phone number if applicable.

Emergency Contact Enter the full name of the person to contact in case of emergency for this client.

Emergency Contact Phone Enter the phone number for the emergency contact person for this client.

Emergency Contact Relationship Enter the relationship to the client of this emergency contact.

Enter Misc. Client Information

Client	Client Info	History	Referral	Intake	Preg Info	Health	Comments
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Primary race: <input type="text" value="American Indian/Alaska Native"/>	Hispanic/Latino descent? <input type="text" value="yes"/>
Other race (specify): <input type="text" value="uui"/>	Country of origin: <input type="text"/>
If multi-racial: Asian <input type="text"/> <input type="button" value="X"/> Black <input type="text"/> <input type="button" value="X"/> <input type="text"/> <input type="button" value="X"/>	Other country (specify): <input type="text"/>
	Ethnicity: <input type="text" value="Hispanic/Latino"/>
	Other ethnicity (specify): <input type="text"/>

Languages spoken: Bosnian <input type="text"/> <input type="button" value="X"/> English <input type="text"/> <input type="button" value="X"/> <input type="text"/> <input type="button" value="X"/>	Other language (specify) <input type="text"/>
	Is English the primary language? <input type="text" value="no"/>
	Is a translator needed? <input type="text"/>
	If yes, what language? <input type="text"/>

Primary Race

Select from the list the one primary race that the client considers herself.

Race

Select from the list any race that the client considers herself. If the client is multi-racial, select the races that apply. If the race is not one of the options available, select *other* and enter that race at the OTHER RACE (SPECIFY) prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Hispanic/Latino Descent

Select from the list the ethnicity that the client considers herself. If the ethnicity is not one of the options available, select *other* and enter that ethnicity at the OTHER ETHNICITY (SPECIFY) prompt.

Ethnicity

Select from the list the ethnicity that the client considers herself. If the ethnicity is not one of the options available, select *other* and enter that ethnicity at the OTHER ETHNICITY (SPECIFY) prompt.

County of Origin

If the client's ethnicity is Hispanic/Latino, select the country of origin for this client. If that country of origin is not on the list, select *other* and enter that country at the SPECIFY prompt.

Languages Spoken

Select from the list all of the languages that the client speaks. If the language is not one of the options available, select *other* and enter that language at the OTHER LANGUAGE (SPECIFY) prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Is English the primary language?

Indicate whether or not English is the primary language for this client.

Is a translator needed?

Indicate whether or not a translator is needed for this client.

If yes, what language?

If a translator is needed, enter the language that the client needs a translator for.

Viewing Client History

Select Client: **Demo, Ima** 12320-0002 Admission ID: 123200002

Client Client Info **History** Referral Intake Preg Info Health Comments

ID	Referral Date	Admission Date	Discharge Date	Subcontractor/Program	Received Service?
<input type="button" value="View"/> 123200002	9/20/2000	9/21/2000	3/20/2001	Test Subcontractor Maternal Health	<input checked="" type="checkbox"/> <input type="button" value="Print Page 1"/> <input type="button" value="Print Page 2"/>

The History screen shows a list of all referrals and admissions that a client has had at this contracting agency. In each line you will see the Referral ID, the contact date and the subcontractor that was assigned to serve this client and the program to which the client was admitted. There is also a box that shows whether or not the client was served. If the box under RECEIVED SERVICE? is checked, then the client was admitted and served. If the box is not checked, then the client made an initial contact, but did not meet the requirements for service.

To view the client information associated with an admission or referral click on the VIEW button to the left of the record. The information for that service period will appear on the screens. You may also print a copy of the record for your files by clicking on the Print button and then sending to your printer.

Entering Referral Information

Each time a client initiates service for a new pregnancy they are become a referral. If the client does not meet the criteria for service they remain a referral. If service is to be provided, they become an admission and receive an admission ID.

To enter referral information click on the Add Referral button. Enter the referral information on the screen.

The screenshot shows the 'Add Referral' form with the following data:

- Referral ID: 112100281
- Date of contact: 6/17/2004
- How did client hear of services?: WIC
- Will services be provided?: yes
- Client consent form signed?: yes
- Date signed: 6/17/2004
- Program: Maternal Health
- Agency assigned: Taylor County Public Health Nursing, MCH Center of SW Iowa
- Subcontractor assigned: Taylor County Public Health Nursing, M
- County assigned: Taylor

Has the client been seen at any other agency with this pregnancy?

Indicate whether or not this client has received services with another DPH contracting agency for this pregnancy.

How did client hear of services?

Choose the response that indicates how the client became aware of the Maternal Health services. If the correct response is not on the list, choose other and enter the correct response at the *other (specify)* prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Hospital (specify)

If the client was referred to Maternal Health services by a hospital, enter the name of the hospital.

Other agency (specify)

If the client was referred to Maternal Health services by another agency, enter the name of that agency.

Will services be provided?

Indicate whether or not services will be provided to this client.

Reason Not Served

If services will not be provided, indicate the reason. If the reason is not on the list, choose other and enter the specific other reason at the appropriate prompt.

A screenshot of a web form. At the top, there is a dropdown menu labeled 'Will services be provided:' with 'no' selected. Below it is another dropdown menu labeled 'If no, reason not served:'. The main part of the form has three rows: 'Referral form completed by:' with a text input field and a 'Date:' field; 'Data entered by:' with a text input field and a 'Date:' field; and 'Quality assurance by:' with a text input field and a 'Date:' field.

Referral Form Completed By

Enter the name of the person who completed the referral form and enter the date that it was completed.

Data Entered By

Enter the name of the person who entered the data into the database and enter the date that it was entered.

Quality Assurance Inspection

Enter the name of the person who inspected the data for accuracy and enter the date that it was inspected.

A screenshot of a web form. At the top, there is a dropdown menu labeled 'Will services be provided:' with 'yes' selected. Below it are several fields: 'Client consent form signed?' with a dropdown menu, 'Date signed:' with a text input field, and 'Program:' with a dropdown menu. Below these are 'Agency assigned:' with the text 'Test Agency', 'Subcontractor assigned:' with a dropdown menu showing 'Test Subcontractor', and 'County assigned:' with a dropdown menu. At the bottom, there are two buttons: 'Assign Admission' (green text) and 'Cancel' (red text). An arrow points to the 'Client consent form signed?' dropdown menu.

If services will be provided, choose yes at the prompt. Enter all of the information in the fields that appear. Click on the ASSIGN ADMISSION button. An admission ID will be assigned and all of the admission records created.

Client Consent Form Signed

Indicate whether or not the client has signed the consent form.

Date Signed

Enter the date that the consent form was signed. Enter the date in the mm/dd/yyyy format.

Program

When assigning a referral you may 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.

Women's Health- Used for Women's Health program. These clients are not transferred to the state.

Postpartum Only- Used for those clients receiving only a postpartum visit.

Dental Only- Used for input of Maternal clients seen only for the dental program and not followed for Maternal Health.

Presumptive Only- Used for input of Maternal clients seen only for presumptive eligibility determination.

Agencies are not to provide "Presumptive Only" services to a woman. All pregnant women should be enrolled in the Full Maternal Health program. However, if an agency sees a client, enrolls her in the Maternal Health program, helps her complete a Presumptive Eligibility application, and then the client is lost to follow up, an agency is able to change her client type to Presumptive Eligibility. This will eliminate the need for further data collection and allow the record to be closed.

Again, all women should be enrolled in the full program, this should only be used in situations where a woman is lost to follow up.

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.

Subcontractor Assigned

Indicate the subcontractor that has been assigned to provide services to this client.

County Assigned

Indicate the county where the client will be receiving services.

Entering Intake Information

Enter all of the admission information at the appropriate prompts. (Tip: If you prefer using your keyboard rather than your mouse, hit CTRL + TAB to move out of a subform such as PAYMENT SOURCE.)

Primary Payment Source

Choose the primary payment source for this client.

Payment Source

Choose all of the payment sources that apply. To delete an option selected in error, click on the button with the red X to the right of that option. Options include:

Medicaid/Title XIX - client eligible for and receiving Medicaid health insurance coverage

Medicare - health care insurance program for people ≥ 65 years of age, some disabled people <65 , and people with End-Stage Renal Disease

Presumptive eligibility - Medicaid coverage for prenatal care while Health Services Application for Medicaid is processed

Private insurance - commercial health insurance, not an HMO or managed care plan

Self pay/sliding scale - client pays out-of-pocket for health care services

Title V - Coverage from Title V Block Grant provided through local maternal health contractor

Uninsured - no known health insurance

Other - if option is not available choose "other" and put the type of other insurance in the **Specify** prompt.

Secondary Payment Source

Choose any secondary payment sources for this client.

WIC certified at admission?

Has the client been certified to receive WIC services prior to admission.

Employment

Select from the list the employment status of the client at admission.

Current Marital Status

Indicate the marital status of the client at the time of admission. If the client is married by common law, select the married option. If the client has a partner, but is not married, select the single option.

Highest Grade Completed

Indicate the highest grade completed by selecting the option from the list.

How many children does client have?

Indicate how many other children the client has at the time of admission including stepchildren and foster children.

Age Range Of Children

Enter the age range of the children, beginning with the youngest, hyphen, then the age of the oldest.

How many children are living in the home?

Indicate the number of children currently living in the client's home. Include any stepchildren and foster children in this count.

Father's Name

Enter the first, middle and last name of the baby's father. If the father is unknown, enter *Unknown* at the FATHER'S FIRST NAME prompt.

Father's Race

Select from the list the race of the baby's father. If the father is multi-racial, select the races that apply. If the race is not one of the options available, select *other* and enter the applicable race at the OTHER SPECIFY prompt.

Father's Ethnicity

Select from the list the ethnicity of the baby's father. If the ethnicity is not one of the options available, select *other* and enter the applicable ethnicity at the OTHER SPECIFY prompt.

Father's Relationship To Mother

Select from the list the type of relationship the baby's father has with the client.

Father Living With Participant?

Indicate whether or not the baby's father is living with the client.

Father Involved With Child?

Indicate whether or not the baby's father is involved with the pregnancy/child.

Father Employed?

Indicate whether or not the baby's father is employed.

Father Comments

Enter comments about the baby's father.

Entering Pregnancy Information

Enter all of the admission information at the appropriate prompts.

Client	Client Info	History	Referral	Intake	Preg Info	Health	Comments
<p>Previous Pregnancies</p> <p>Last pregnancy end date: <input type="text"/> How many previous pregnancies? <input type="text" value="0"/></p> <p>How many live birth <input type="text" value="0"/> How many neonatal deaths? <input type="text" value="0"/></p> <p>How many fetal deaths? <input type="text" value="0"/> How many therapeutic abortions? <input type="text" value="0"/></p> <p>How many spontaneous abortions? <input type="text" value="0"/></p>							
<p>Pregnancy Information</p> <p>Has client been seen at any other agency with this preg <input type="text" value="no"/></p> <p>Was this a planned pregnancy? <input type="text" value="yes"/> Using birth control? <input type="text" value="yes"/></p> <p>Birth control type? <input type="text" value="birth control pills"/> Specify other birth control: <input type="text"/></p> <p>Due date: <input type="text" value="2/1/2005"/> Date of last menses: <input type="text" value="4/15/2004"/></p> <p>When was pregnancy first identified? <input type="text" value="1st trimester"/> Receiving prenatal care? <input type="text" value="yes"/></p> <p>When was first care received? <input type="text" value="1st trimester"/></p> <p>Prenatal care provider's name: <input type="text" value="Dr. Spock"/></p> <p>Taking prenatal vitamins including folic acid? <input type="text" value="yes"/></p>							

Last Pregnancy End Date

If the client has had previous pregnancies, enter the date the last pregnancy ended regardless of outcome.

How many previous pregnancies?

Indicate the number of pregnancies that the client has had prior to the current pregnancy.

How many live births?

Indicate the number of pregnancies that resulted in live births the client has had prior to the current pregnancy. A live birth is defined as a birth that shows any sign of life after delivery.

How many fetal deaths?

Indicate the number of pregnancies that resulted in fetal deaths the client has had prior to the current pregnancy. A fetal death is defined as a birth which fails to show any sign of life after delivery with a gestational age greater than 20 weeks.

How many neonatal deaths?

Indicate the number of pregnancies that resulted in neonatal deaths the client has had prior to the current pregnancy. A neonatal death is defined as the death of a live-born infant within the first 27 days, 23 hours, 59 minutes of life.

How many spontaneous abortions?

Indicate the number of pregnancies that resulted in a spontaneous abortion the client has had prior to the current pregnancy. A spontaneous abortion is defined as the termination of a pregnancy prior to 20 weeks gestation with no intervention.

How many therapeutic abortions?

Indicate the number of pregnancies that resulted in therapeutic abortions the client has had prior to the current pregnancy. A therapeutic abortion is defined as the termination of a pregnancy with intervention.

Was this a planned pregnancy?

Indicate whether or not the current pregnancy was planned.

Was client using birth control?

Indicate whether or not the client was using birth control at the time of conception.

Birth control type

If the client was using birth control at the time of conception, indicate the type of birth control used. If the type of birth control is not on the list, choose other and enter this birth control type at the *other (specify)* prompt.

Due Date

Enter the baby's due date in the mm/dd/yyyy format.

Date of last menses

Enter the end date of the last menses prior to this pregnancy. If an exact date is not known, enter an approximate date.

When was pregnancy first identified?

Indicate the trimester when this pregnancy was first identified.

Is client receiving prenatal medical care?

Indicate whether or not the client has received prenatal care prior to admission.

When was first care received?

Indicate the trimester that prenatal care was first received for this pregnancy. If client has not seen a medical provider for this pregnancy select *no care*.

Provider's Name

Enter the name of the practitioner providing prenatal care for the client.

Is client taking prenatal vitamins, including folic acid?

Indicate whether or not the client is taking prenatal vitamins including folic acid.

Entering Health Information

Enter all of the health information at the appropriate prompts.

The screenshot shows a web-based form with the following sections and fields:

- Allergies?** [no] Specify allergies: [text input]
- Is client taking regular medications?** [no] What medications? [dropdown] [red X]
- Other meds (specify): [text input]
- Smoke cigarettes?** [no] How many? [dropdown]
- Alcohol use in 3 mo prior to pregnancy?** [yes] Current alcohol use? [no] How often? [dropdown]
- Illicit drug use in 3 mo prior to pregnancy?** [no] Current illicit drug use? [no]
- What drugs: [dropdown] [red X] Other drug (specify): [text input]
- Does client have STDs?** [no] What STDs? [dropdown] [red X]
- Other STDs (specify): [text input]
- Is client being treated for STDs?** [no] Partner treated for STDs? [no]
- Was client screened for domestic abuse?** [yes] substance abuse? [no] depression? [no]
- Does client have regular dentist?** [dropdown] Name of dentist: [text input]
- When was last dentist visit? [dropdown]
- Barriers to dental care: [dropdown] [red X] Other barriers (specify): [text input]
- Dental insurance: [not indicated] Other (specify): [text input]
- Does client have any oral concerns or problems?** [dropdown] Specify: [text input]
- Dental comments: [text input]

Allergies?

Indicate whether or not the client has any allergies.

Specify Allergies

If the client has allergies, enter the type of allergies.

Is client taking regular medications?

Indicate whether or not the client is currently taking regular medications.

What Medications?

If the client is currently taking regular medications, select the type of medication from the list. If the medication is not on the list, select other and enter that medication at the *other (specify)* prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Smoke Cigarettes?

Indicate whether or not the client smokes cigarettes.

How many cigarettes per day?

If the client smokes cigarettes, indicate how many cigarettes the client smokes daily.

Use alcohol in the 3 months prior to pregnancy?

Indicate whether or not the client drank alcohol in the 3 months prior to becoming pregnant.

Current alcohol use?

Indicate whether or not the client drinks alcohol.

How often does client drink alcohol?

Indicate how often the client drinks alcohol by selecting a response from the list.

Use illicit drugs in the 3 months prior to pregnancy?

Indicate whether or not the client used illicit drugs in the 3 months prior to becoming pregnant.

Current illicit drug use?

Indicate whether or not the client uses illicit drugs.

What Drugs?

Select from the list all of the drugs that the client uses. If the correct choice is not on the list, select *other* and enter the drug at the *other (specify)* prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Does client have STDs?

Indicate whether or not the client has any sexually transmitted diseases. If the client refuses to answer select *client declines*.

What STDs?

Select from the list all of the STDs that apply to this client.

Is partner being treated for STDs?

Indicate whether or not the client's partner is currently being treated for a sexually transmitted disease. If the client refuses to answer select *client declines*.

Was client screened for domestic abuse?

Indicate whether or not this screening was done on the client at admission.

Was client screened for substance abuse?

Indicate whether or not this screening was done on the client at admission.

Was client screened for depression abuse?

Indicate whether or not this screening was done on the client at admission.

Does client have a regular dentist?

Indicate whether or not client has a dental care provider that they see on a regular basis.

Name of dentist

Enter the name of the client's dental care provider

When was last dentist visit?

Indicate how long it has been since the client saw a dentist

Barriers to dental care

Select all the barriers that prevented the client from receiving dental care, if the barrier is not in the list enter it in the Other barriers (specify) field.

Dental Insurance

Select the dental insurance at the time of intake. If the client's insurance is not in the list, enter it in the Other (specify) field.

Does client have oral concerns or problems?

Indicate whether the client has oral concerns or problems at intake. Specify the problem/concern in the Specify field.

Dental Comments

Enter any additional dental comments

Client	Client Info	History	Referral	Intake	Preg Info	Health	Comments
Comments:							
<input type="text"/>							
Form completed by:	<input type="text"/>	Date completed:	<input type="text"/>				
Data entered by:	<input type="text"/>	Date entered:	<input type="text"/>				
QA inspection by:	<input type="text"/>	Date of inspection:	<input type="text"/>				

Comments

Comments are provided for the convenience of the provider. Information from the comments will not be exported to the state.

Referral Form Completed By

Enter the name of the person who completed the referral form and enter the date that it was completed.

Data Entered By

Enter the name of the person who entered the data into the database and enter the date that it was entered.

Quality Assurance Inspection

Enter the name of the person who inspected the data for accuracy and enter the date that it was inspected.

The Plan of Care/Needs Assessment Form

The client master screen has been provided on this form so that you can verify this information. If an address has changed you may enter a new address. To do this change the ADDRESS STATUS of the old address to *previous home* and click on the ADD NEW ADDRESS button. Enter the new address information at the appropriate prompts.

This screenshot shows the 'Client Master' tab in a software interface. It contains several input fields for client information:

- Client's name:** Fields for First (lma), Middle, Last (Demo), and Maiden Name.
- Birthdate:** An empty text field.
- Social Security Number:** An empty text field.
- Address Management:** A section showing 'Number of Addresses: 2' and 'Address #: 1'. It includes an 'Add New Address' button and dropdown menus for 'Address Status' (set to 'Active') and 'Address Type' (set to 'Current Home').
- Address Details:** Fields for Street Address (123 Any Street), Apt # (1), County (Benton), City (Ames), State (IA), Zip Code (50010), Home Phone ((555)222-3333), Work Phone, and Emergency contact (Test).

History Client Master Optional Notes Goals & Actions

Below is a list of all participations for the selected client. Click on the button to the left of the participation to open the Case Plan/Needs Assessment record for that participation.

Participant ID	Assigned	Discharge	Agency Assigned	Subcontractor Assigned
View				
View				

The history screen allows you to view all of the needs/goals and action steps that have been completed for this client. If a client has received services in the past for another pregnancy and you would like to view that information you can locate that admission on the history screen and click on the VIEW button. Information from that admission will appear on the screens. To print a report of the client's needs click on the Print button. The report will appear in preview mode. You may view the report or send it to the printer.

The Optional Notes tab allows you to enter any notes or comments you would like to store concerning the client's care plan. On this tab you may also enter the date the case plan was developed and the date last updated. This information is for agency use only and is not used in reports to the state.

This screenshot shows the 'Optional Notes' tab in the software interface. It features:

- Two date input fields: 'Date care plan developed:' and 'Date last updated:'.
- A large, empty text area labeled 'Case Plan Notes:' for entering detailed information.

This form must be completed at admission and updated at discharge. It may also be update throughout service as needed.

The Goals & Actions tab is where needs and goals are entered. Start by selecting a need category from the list. Enter the date the need was identified and the goal to meet the need. The goal is free form text. Throughout service you may update the status of your goal as the client's needs are met or change. If there has been no progress toward meeting a goal you may indicate the reason in the last column. Multiple needs and goals may be entered on the form. To add a new need go to the last line (line number 0) and select a need. A new need record will be created for you. You cannot delete a goal once entered, but may change the status to "entered in error".

Select a Client: **Demo, lma** 133100247 Admission ID: 133100254

History Client Master Optional Notes **Goals & Actions**

Line	Need Category	Date Identified	Goal	Goal Status	If Change or No Progress, Reason
1	1	11/11/2009	Test Goal 1	NI	NI
0	0			NI	NI

Actions Steps for: Test Goal 1
Line No: 1

Item	Action	Referral	Mode	Status
1	This is a demo action step	back to referant	appointment r	Complete
0				NA

Actions Steps for: Test Goal 1
Line No: 1

Item	Action	Referral	Mode	Status
1	This is a demo action step	back to referant	appointment r	Complete
0				NA

The bottom half of the form is used for entering the action steps planned to meet each goal. To enter action steps for a specific goal, click on that goal on the top half of the form. Before you can enter action steps a need and goal must be identified. Referrals made to meet a need and the mode of the referral are entered in the bottom section of the form. You may also enter whether or not the action has been completed in the "Status" field.

The Medicaid Risk Assessment Form

Information is entered into the Medicaid Risk Assessment form at admission and again at reassessment. Following is a description of the input screens.

This screenshot shows the 'Client Master' form for 'Cummings, Ima'. The 'Adm ID' is 124100109. The form includes tabs for Address, Misc., History, General, Group A, Group B, and Group B2. The 'Client's name' section contains fields for First (Ima), Middle (Good), Last (Demo), Maiden Name (Jones), and Initials (GD). Below this is the 'Client Alias' section with fields for First Name, Middle Name, Last Name, and Status (Active). There is also a field for 'If this client has an existing record in the database under a different name, enter that client ID:'. At the bottom, there are fields for Birthdate (1/1/1981) and Social Security Number (555-55-5551).

The client master, address and misc. screens have been provided so you may edit client information if necessary. All questions on these screens were asked on the Intake form. There is no new information to enter on these screens.

This screenshot shows the 'Address' form for 'Cummings, Ima'. The 'Adm ID' is 124100109. The form includes tabs for Client Master, Address, Misc., History, General, Group A, Group B, and Group B2. It shows 'Number of Addresses: 1' and 'Address #: 1'. The 'Address Type' is 'Current Home' and 'Address Status' is 'Active'. The 'Street Address' is '123 123rd', 'Apt #' is '123', and 'County' is 'Benton'. Other fields include 'City: Ames', 'State: Iowa', 'Zip Code: 55555', 'Home Phone: (444)444-4454', 'Work Phone: (444)444-4444', and 'Emergency contact: Justin Time' with 'Phone: (444)444-4488'.

If an address has changed you may enter a new address. To do this change the ADDRESS STATUS of the old address to *previous home* and click on the ADD NEW ADDRESS button. Enter the new address information at the appropriate prompts.

This screenshot shows the 'Microsoft Access - [RA_mst_Master : Form]' window. The 'Select Client' is 'Demo, Ima G.' and 'Adm ID' is 125100119. The form includes tabs for Client Master, Address, Misc., History, General, Group A, Group B, and Group B2. The 'ID Number' section shows '121223333' for 'Social Security' and '45673434K' for 'Medicaid'. The 'Race' section includes 'Asian' and 'White'. The 'Ethnicity' is 'Other'. The 'Languages spoken' section includes 'American Sign Language', 'Chinese', and 'English'. There are also fields for 'Other language (specify)', 'Is English the primary language?', 'Is a translator needed?', and 'If yes, what language?'. An 'Exit' button is at the bottom.

If you did not enter a Medicaid ID for the client on the intake form you will want to enter it now. It will be used in the print out of the Medicaid Risk Assessment form. To enter the ID go to the MISC. screen. At the ID NUMBER prompt enter the Medicaid ID number and choose *Medicaid ID* at the TYPE prompt.

Select Client: Demo, Ima G. 12510-0107 Adm ID 125100119

Client Master | Address | Misc. | History | **General** | Group A | Group B | Group B2

Primary provider name: Dr. Doom Medicaid provider #: 3939393939
 Provider phone #: (333)333-3333
 Client address for form: 123 Sesame ▼
 Gestational age at initial assessment: 0 Weeks Initial assessment date:
 Gestational age at rescreen: 0 Weeks Rescreen date:

Additional risk factors indicating need for enhanced services? ▼

Explain addition risk factors:

High Risk Antepartum Mgm't. Primary Provider

Care Coordination ▼	Dr. Doom	
Psychosocial ▼	Dr. Pepper	
 ▼	 	

Primary provider sign date:

Client release sign date:

Date refer to WIC:

- Client name:** Select the client's name from the drop down list
- Primary provider name:** Enter the name of the primary care provider
- Medicaid provider #:** Enter the enter the Medicaid number of the primary care provider
- Provider phone number:** Enter the phone number of the primary care provider
- Address:** Select from the addresses stored for this client the address that you want to appear on the Medicaid Risk Assessment form.
- Gestational age at initial assessment:** Enter the gestational age of the child at the time of the initial assessment
- Date of initial assessment:** Enter the date of the initial assessment
- Gestational age at rescreen:** Enter the gestational age of the child at the time that the Risk Assessment was readministered
- Date of rescreening:** Enter the date of the rescreening
- Additional risk factors:** Indicate whether or not additional risk factors exist that indicate the need for enhanced services
- Explain Additional Risk Factors:** Use this memo field to explain any additional risk factors that exist.
- High risk care to provide:** Select from the list the high risk care that will be provided and enter the name of the provider for that care
- Primary provider signature date:** Enter the date that the primary provider will sign the form
- Client signature date:** Enter the date that the client will sign the form
- Date of referral for WIC services:** Enter the date that the client was referred to WIC for services

Select each *Risk Factor* that applies to the client on the Group A, Group B and Group B2 tabs. You need only select risks with scores. Risks with 0 values need not be selected. Each of these tabs are completed in the same manner. After selecting the *Risk Factor*, select the score from the box on the right that applies to that risk. The value that you selected will appear in the *Risk Value* column. *Risk Factors* on tabs Group A and Group B are answered at admission. *Risk Factors* on the tab Group B2 are answered at the time of rescreening. The scores for each risk group are totaled at the bottom of the tab. If you go to the History tab you will see the totals for all of the groups. From the History form you may print out the Medicaid Risk Assessment Report ready for signatures and submission.

Upon opening you will see one blank line on the Group A, Group B or Group B2 risk value tabs.

This screenshot shows the 'Risk Group A - Initial' form. At the top, there are fields for 'Select Client' (Demo, lma) and 'Adm ID' (11310-0467). Below these are tabs for 'Client Master', 'Address', 'Misc.', 'History', 'General', 'Group A', 'Group B', and 'Group B2'. The main area contains three input fields: 'Risk Factor', 'Risk Value', and 'A Score Initial', all of which are currently empty. At the bottom, there is a label 'Risk Group A Subtotal:'.

Click on the arrow to the right of the *Risk Factor* prompt. A dropdown list containing all of the possible risks for this tab will appear. Select the risk that applies to the client or begin typing the risk at the *Risk Factor* prompt.

This screenshot shows the 'Risk Group A - Initial' form with the 'Risk Factor' dropdown menu open. The dropdown list contains the following items: Maternal Age, Education, Marital Status, Height, PrePreg VWeight, AB 1st Trimester, AB 2nd Trimester, and Cone Biopsy. The 'Risk Value' and 'A Score Initial' fields remain empty. The 'Risk Group A Subtotal:' label is visible at the bottom.

After selecting the risk, click on the arrow to the right of the score prompt. A dropdown list containing all of the possible scores for this risk will appear. Select the appropriate score.

This screenshot shows the 'Risk Group A - Initial' form with 'Marital Status' selected in the 'Risk Factor' field. The 'A Score Initial' dropdown menu is open, showing two options: '0' and '2'. The '2' option is highlighted, and a tooltip is visible next to it with the text 'married = 0' and 'single.div. sep = 2'. The 'Risk Value' field is empty. The 'Risk Group A Subtotal:' label is at the bottom.

Select Client: Demo, lma **Adm ID**

Client Master | Address | Misc. | History | General | **Group A** | Group B | Group B2

Risk Group A - Initial

Risk Factor:	Risk Value:	A Score Initial:
Marital Status	single,div, sep = 2	2
Education	<=11 = 2	2
Cone Biopsy	yes = 3	3

Risk Group A Subtotal: 4

Repeat this process for each risk that applies to the client. A subtotal for all risks will appear at the bottom of the page. The Group A, Group B and Group B2 tabs are completed in the same manner except Group A and Group B are completed at admission and Group B2 is completed at the time of rescreening.

The following two pages contains a description of each of the risk fields.

Risk	Description	Value
Maternal age	Age of client at admission	20-40 =0 16-19 or >40 =4 ≤ 15 =10
Education	Grade client has completed at time of admission	GED or 12=0 ≤ 11=2 ≤ 8=4
Marital status	Marital status of client at admission	Married =0 Single, divorced, separated =2
Height	Height of client in feet	> 5 feet =0 ≤ 5 feet =3
Prepreg weight	Weight of client prior to conception in kilograms	Low(BMI<19.8) =2
AB 1 st trimester	More than 3 spontaneous or induced abortions at less than 13 weeks gestation. Does not include ectopics.	< 3 =0 ≥ 3 =1
AB 2 nd trimester	Spontaneous or induced abortion between 12-19 weeks gestation.	None =0 1 =5 ≥ 2 =10
Cone biopsy/LEEP	History of cone biopsy of cervix	No =0 Yes =3
Uterine anomaly	Bicornate, T-shaped, Septate uterus, etc.	No =0 Yes =10
Previous SGA baby	Prior pregnancy resulted in a baby small for gestational age.	No =0 Yes =10
Hx preterm labor	Spontaneous pre-term labor or pre-term delivery during any previous pregnancies whether or not it results in pre-term or term	No =0 Yes =(#x10)
Bleeding gums/never been to dentist		No =0 Yes =5
Cigarette use/day	Number of cigarettes smoked per day	1-10 cigarettes =1 >10 cigarettes =4
Illicit drug use	Any illicit or street drug use during this pregnancy, e.g. speed , marijuana, cocaine, heroin (includes methadone).	No =0 Yes =5
Alcohol use	Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking.	No =0 Yes =2
Initial prenatal visit	First prenatal visit at or after 16 weeks gestation.	< 16 weeks =0 > 16 weeks =2
Poor social situation	Personal or family history of abuse, incarceration, homelessness, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support	No =0 Yes =5
Children ≤ 5yrs at home	Number of other children under five years residing in client's home.	0 or 1 =0 ≥ 2 =2
Employment	Light work = part time and/or sedentary work or school, Heavy work = work involving strenuous physical effort standing or continuous nervous tension, i.e. nurses, sales staff, cleaning staff, baby sitters, laborers.	None =0 Light work =1 Heavy work =3

Risk	Description	Value
Last preg. within 1 yr of present pregnancy	The end date of the last previous pregnancy was within one year of the beginning date of current pregnancy	No =0 Yes =1
Bacteriuria, Chlamydia, GC this pregnancy	Any symptomatic or asymptomatic UTI, i.e. 100,000 colonies in urinalysis. . Positive culture for chlamydia or gonorrhea.	No =0 Yes =3
Pyelonephritis	Diagnosed pyelo in current pregnancy., Points are given of pyelo only, not both pyelo and Bacteriuria.	No =0 Yes =5
Fibroids	History of uterine fibroid tumors.	No =0 Yes =3
Presenting part engaged < 36 weeks	Presenting fetal part, i.e. head or breech, engaged in pelvis prior to 36 weeks gestation	No =0 Yes =3
Uterine bleeding ≥ 12 weeks	Vaginal bleeding or spotting after 12 weeks gestation of any amount, duration or frequency which is not obviously due to cervical contact.	No =0 Yes =4
Cervical length < 1cm<34 weeks	Diagnosed short cervical length.	No =0 Yes =4
Dilation ≥ 1 cm	Cervical dilation of the internal os of 1cm or more at 34 weeks gestation.	No =0 Yes =4
Uterine irritability ≤ 34 weeks	Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks.	No =0 Yes =4
Placenta previa at <30 weeks	Diagnosed placenta previa prior to 30 weeks gestation.	No =0 Yes =4
Oligohydramnios	Diagnosed with abnormally small amount of amniotic fluid.	No =0 Yes =10
Polyhydramnios	Diagnosed with abnormally large amount of amniotic fluid.	No =0 Yes =10
Multiple pregnancy	Current pregnancy has been diagnosed as a multiple pregnancy (more than one fetus).	No =0 Yes =10+
Surgery (abdominal ≥ 18 wks cerclage)	Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy.	No =0 Yes =10
Depression	- Over the pas 2 weeks have you ever felt down, depressed or hopeless? - Over the past 2 weeks have you felt little interest or pleasure in doing things?	(to either) No =0 Yes =10
Weight gain at 22 wks	Maternal weight gain of less than 7 pounds, or greater than or equal to 7 pounds, at 22 weeks gestation.	≥ 7lb =0 < 7lb =2
Weight loss	Any documented maternal weight loss.	< 5lb =0 ≥ 5lb =3
Urine protein	Documented protein in urine via urine dipstick.	None-Trace =0 1+ =2 >1+ =5
Hypertension or HTN medications	Rise of syst BP of 30 mgHg or > and /or rise of dias BP 15 mgHg or > above baseline X2	No =0 Yes =10
Hemoglobin- Hematocrit	Hemoglobin < 11 or Hematocrit < 33	Hemoglobin < 11 =3 Hematocrit < 33 =3

The Pregnancy Tracking Form

Information may be entered into the Pregnancy Tracking form as often as desired for a client. The information on the Pregnancy tracking form is for the use of the individual agencies in monitoring clients. This information is not downloaded to the State's Maternal & Child Health database. How often or if the Pregnancy Tracking form is used is left to the discretion of each agency.

Select a Client: Adm ID:

Below is a list of all the the times that a client has received Maternal Health services. You will see the participant ID, the admission date and the subcontractor that provided the service. If a client has been in service more than once the most recent service information will be at the top of the list. Select the record that you wish to view or enter information for by clicking on the "View" button.

	ID	Admission Date	Subcontractor
<input type="button" value="View"/>	125100119	1/1/1999	SubContractor 01

An arrow points from the bottom left towards the "View" button in the table.

To enter information into the Pregnancy Tracking form, first select the client from the list. The form will open to the **History** tab. All of the admissions that a client has had will appear on the list. The most recent admission will be at the top of the list. Click on the **View** button to the left of the admission that you want to edit or enter information for.

Pregnancy Tracking Stages

To review an existing record click on the **Open** button to the right of the record.

To add a new record, scroll to the bottom and indicate the contact date, then click on the **Open** button.

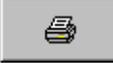
Contact Date	
6/1/1999	Open
9/1/1999	Open
	Open

Cancel

A screen listing all of the tracking records that have been entered for the client will appear on the screen. To edit or view a record, find the date of the record you would like to access and click on the **Open** button to the right of that date.

Select a Client: **Demo, Ima G.** 125100107 **Adm ID:** 125100119

Master | **History** | **Misc.** | **Assessment** | **Comments**

 Contact Date: **6/1/99** Stage of pregnancy: **2nd Trimester**

WIC certified? **yes**

Taking prenatal vitamins, including folic acid? **yes**

Attending childbirth education classes? **yes**

Attending parenting education classes? **yes**

Is client receiving prenatal care? **yes**

How many prenatal visits scheduled? **4** How many kept? **4**

To print out a report showing the information entered on the Pregnancy Tracking form click on the button with a picture of a printer. The report will appear in print preview. You may view the report or send it to the printer.

Stage Of Pregnancy: Select from the list the trimester of the client's pregnancy at the time of this tracking record.

WIC Certified: Indicate whether or not the client is WIC certified at the time of this tracking record.

Taking Prenatal Vitamins: Indicate whether or not the client is taking prenatal vitamins including foic acid.

Attending Childbirth Education Classes: Indicate whether or not the client is attending childbirth education classes at the time of this tracking record.

Attending Parenting Education Classes: Indicate whether or not the client is attending parenting education classes at the time of this tracking record.

Is Client Receiving Prenatal Care: Indicate whether or not the client is receiving prenatal care at the time of this tracking record.

How Many Prenatal Visits Scheduled: Indicate the number of prenatal visits that have been scheduled for this client at the time of this tracking record.

How Many Prenatal Visits Kept: Indicate the number of prenatal visits that have been kept for this client at the time of this tracking record.

Allergies?

Indicate whether or not the client has any allergies.

Specify Allergies

If the client has allergies, enter the type of allergies.

Is client taking regular medications?

Indicate whether or not the client is currently taking regular medications.

What Medications?

If the client is currently taking regular medications, select the type of medication from the list. If the medication is not on the list, select other and enter that medication at the *other (specify)* prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Smoke Cigarettes?

Indicate whether or not the client smokes cigarettes.

How many cigarettes per day?

If the client smokes cigarettes, indicate how many cigarettes the client smokes daily.

Drink Alcohol?

Indicate whether or not the client drinks alcohol.

How often does client drink alcohol?

Indicate how often the client drinks alcohol by selecting a response from the list.

Use Illicit Drugs?

Indicate whether or not the client uses illicit drugs.

What Drugs?

Select from the list all of the drugs that the client uses. If the correct choice is not on the list, select *other* and enter the drug at the *other (specify)* prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Select a Client:	Demo, Ima G.	125100107	Adm ID:	125100119
Master	History	Misc.	Assessment	Comments
Comments:				
<input type="text" value="this is a comment"/>				
Form completed by:	Joe	Date completed:	12/1/1999	
Data entered by:	Jim	Date entered:	12/1/1999	
QA inspection by:	Julie	Date of inspection:	12/1/1999	

Comments

Comments are provided for the convenience of the provider. Information from the comments will not be exported to the state.

Form Completed By

Enter the name of the person who completed the referral form and enter the date that it was completed.

Data Entered By

Enter the name of the person who entered the data into the database and enter the date that it was entered.

QA Inspection By

Enter the name of the person who inspected the data for accuracy and enter the date that it was inspected.

Select a Client:	<input type="text" value="Demo, Ima G."/>	<input type="text" value="125100107"/>	Adm ID: <input type="text" value="125100119"/>	
<u>M</u> aster	<u>H</u> istory	<u>M</u> isc.	<u>A</u> ssessment	<u>C</u> omments
Client ID <input type="text" value="125100107"/>				
Client's name	First <input type="text" value="Ima"/>	Middle <input type="text" value="Good"/>	Last <input type="text" value="Demo"/>	Maiden Name <input type="text" value="Jones"/>
Birthdate	<input type="text" value="1/1/1977"/>		Social Security Number: <input type="text" value="121-22-3333"/>	
Number of Addresses:	<input type="text" value="1"/>	Add New Address		<input type="button" value="◀"/> <input type="button" value="▶"/>
Address Status	<input type="text" value="Active"/>	Address Type:	<input type="text" value="Current Home"/>	Address #:
				<input type="text" value="1"/>
Street Address:	<input type="text" value="123 Sesame"/>	Apt #:	<input type="text" value="123"/>	County:
				<input type="text" value="Benton"/>
City:	<input type="text" value="Ames"/>	State:	<input type="text" value="Iowa"/>	Zip Code:
				<input type="text" value="55555"/>
Home Phone:	<input type="text" value="(333)333-3333"/>	Work Phone:	<input type="text" value="(444)444-4444"/>	
Emergency contact:	<input type="text" value="June Demo"/>		Phone:	<input type="text" value="(222)222-2222"/>

The client master screen has been provided so you may edit client information if necessary. All questions on this screen were asked on the Intake form. There is no new information to enter on this screen.

The Outcome Summary Form

The Outcome Summary form should be completed within six weeks of delivery. Select the client that you want to enter this discharge information for. After indicating whether or not services were terminated prior to delivery the input tabs will display.

Master History Misc.

Discharge Date: Were services terminated prior to delivery?

Master History Misc.

Discharge Date: Were services terminated prior to delivery?

If yes, reason: Other reason (specify):

Does client have a primary medical care provider? (medical home)

Comments:

Form completed by:	<input type="text"/>	Date completed:	<input type="text"/>
Data entered by:	<input type="text"/>	Date entered:	<input type="text"/>
QA inspection by:	<input type="text"/>	Date of inspection:	<input type="text"/>

If services were terminated prior to delivery, the only information required is the discharge date, reason for termination, primary care provider, comments, and the information about form completion and input.

If services were not terminated prior to delivery, different tabs will be displayed depending upon the program that the client is enrolled in. To change the program go back to the intake form and change it there.

The following example is for the Maternal Health program. Other programs require fewer fields be completed.

Postpartum Only, Dental Only and Presumptive Eligibility discharge into can be entered on the intake form at the time of intake or on the discharge form.

Begin entering the discharge information on the Misc. screen.

The screenshot shows a web-based form with the following fields and options:

- Master | History | **Misc.** | Child Info | Outcome | Comments
- Discharge Date: 1/1/2015
- Were services terminated prior to delivery? no
- Were services terminated prior to postpartum follow-up? [dropdown]
- Will client receive postpartum home visit? [dropdown]
- Postpartum follow-up: [dropdown]
- Date postpartum referral was sent: [text box]
- Date of postpartum home visit completion: [text box]
- Primary payment source: [dropdown]
- Other payment source (specify): [text box]
- Secondary payment Source: [dropdown]
- (select all that apply)
- WIC certified? [dropdown]
- Delivery date: [text box]
- Multiple birth? [dropdown]
- How many births? 0
- Complications with pregnancy? [dropdown]
- Did mother begin breastfeeding? [dropdown]
- Comments: [text area]

Discharge Date

Enter the date that the client was discharged from service.

Were services terminated prior to delivery?

Indicate whether or not services were terminated prior to childbirth.

Were services terminated prior to postpartum followup?

Indicate whether or not services were terminated prior to a postpartum contact. This would be used if you do have some of the delivery information, but not all can be captured.

Reason Services Were Terminated?

Select from the list the reason that services were terminated prior to childbirth. Options are:

Fetal death- a birth which fails to show any sign of life after delivery with a gestational age greater than 20 weeks.

Neonatal death- the death of a live-born infant within the first 27 days, 23 hours, 59 minutes of life.

Client moved out of area- The client has relocated outside of the service area

Spontaneous abortion- termination of a pregnancy prior to 20 weeks gestation with no intervention.

Transferred to another contractor- The client will be served by a different contracting agency

Transferred to other care- Other more appropriate services have been arranged for the client

Services refused- The client no longer either wants or needs Maternal Health services

Unable to locate- The client has relocated and the contractor is unable to find her to continue services.

Other- If the reason for termination of services is not on this list, select other and enter the reason at the *other reason (specify)* prompt

Will client receive postpartum home visit?

Indicate whether or not the client will be receiving postpartum home care visit.

Postpartum followup

Enter the type of postpartum followup completed. Choices are care-coordination, clinic visit or refused.

Date postpartum referral was sent

Enter the date the postpartum referral was sent

Date of postpartum home visit completion

Enter the date of the postpartum contact.

Primary Payment Source

Choose the primary payment sources applicable at discharge. If the payment source is not on the list, select *other* and enter that payment source at the *other (specify)* prompt.

Secondary Payment Source

Choose all of the secondary payment sources applicable at discharge. To delete an option selected in error, click on the button with the red X to the right of that option.

WIC Certified?

Indicate whether the client was WIC certified at discharge

Did client attend childbirth education classes?

Indicate whether or not the client attended childbirth education classes.

Delivery Date

Enter the delivery date in the mm/dd/yyyy format.

Multiple Birth?

Indicate whether or not this pregnancy resulted in a multiple birth.

How Many Births?

If this was a multiple birth, indicate how many births

Complications With This Pregnancy?

Indicate whether or not there were complications with this pregnancy.

Did mother begin breastfeeding?

Indicate whether or not the mother began breastfeeding.

Pregnancy Comments

Enter comments that you want to store about this pregnancy/delivery. Comments are for the convenience of the caseworker only and will not be forwarded to the state.

The screenshot shows the top portion of the software interface. At the top, there is a 'Select a Client:' dropdown menu with 'Time, Justine' selected, and an 'Adm ID:' field with '125100120'. Below this are several tabs: 'Master', 'History', 'Misc.', 'Child Info', 'Health', 'Outcome', and 'Comments'. The 'Child Info' tab is active. In this tab, there is a 'Number of children:' field with the value '0' and a 'Child ID#' field with the value '0'. To the right of these fields are two arrow buttons (left and right) and an 'Add New Child' button. An arrow points from the text on the right to the 'Add New Child' button.

Click on the Add New Child button to enter the information specific to the child. If this was a multiple pregnancy, click on the **ADD NEW CHILD** button and create a record for each child. The *Child ID#* is the ID assigned to the child. The *Number of Children* box shows the number of children entered for this client's pregnancy. If this was a multiple pregnancy and more than one child record has been entered you may use the arrow buttons to move to a different child record.

The screenshot shows the full child information form. At the top, there is a 'Number of children:' field with the value '1' and a 'Child ID#' field with the value '125100111'. To the right are two arrow buttons and an 'Add New Child' button. Below this are several input fields: 'First name:', 'Middle name:', and 'Last name:'. There is a 'Gender:' dropdown menu, a 'Birthdate:' field, and a 'Gestational age at birth (weeks):' field with the value '0'. There are two more dropdown menus: 'Outcome:' and 'Type of delivery:'. Below these are 'Birthweight (grams):' and 'Length (cm):' fields, both with the value '0'. There is a section for 'Infant IDs:' with a table-like structure. The table has two columns: 'ID Number:' and 'Type:'. Below this is a dropdown menu for 'Abnormalities or health problems?' and a large text area for 'Describe:'. There is also a small 'X' icon in a box next to the 'Type:' dropdown.

Child's Name

Enter the first name, middle name and last name at the appropriate prompts. If this was a multiple birth, add a new child record for each child.

Child's Birthdate

Enter the child's birth date in the mm/dd/yyyy format.

Child's Gender

Enter the gender of the child.

Child's Gestational Age At Birth

Enter the child's gestational age (in weeks).

Pregnancy Outcome

Indicate the outcome for the pregnancy. Choose either *live birth* or *stillborn*.

Type Of Delivery

Indicate the type of delivery for this child. Choose either *vaginal* or *caesarian*.

Child's Birth Weight

Enter the child's weight at birth in grams. (-99 will appear if the weight is not indicated)

Child's Length

Enter the child's length at birth in inches.

ID Type

Indicate the type of ID and enter the number for each for this child.

Abnormalities Or Health Problems

Indicate whether or not the child has any abnormalities or health problems.

Describe Health Problem

If a health problem exists, describe the problem.

The screenshot shows a web-based form with the following sections:

- Smoke cigarettes?** (dropdown) **How many?** (dropdown)
- Drink alcohol?** (dropdown) **How often?** (dropdown)
- Use drugs?** (dropdown) **What drugs?** (dropdown) [X]
- Other drug (specify):** (text input)
- Attending parenting education classes?** (dropdown)
- Family planning arrangements:** (dropdown) **Other birth control (specify):** (text input)
- Does client have a primary medical care provider? (medical home)** (dropdown)
- Did client have dentist visit during pregnancy?** (dropdown)
- If yes, what was reason for dentist visit?** (dropdown) [X]
- Dental payment source:** (dropdown) **Other payment source (specify):** (text input)
- Does client understand the need for her child to have a dentist visit by age 1?** (dropdown)
- Does client have any oral concerns or problems?** (dropdown) **Specify:** (text input)
- Dental comments:** (text input)

Smoke Cigarettes?

Indicate whether or not the client smokes cigarettes.

How many cigarettes per day?

If the client smokes cigarettes, indicate how many cigarettes the client smokes daily.

Drink Alcohol?

Indicate whether or not the client drinks alcohol.

How often does client drink alcohol?

Indicate how often the client drinks alcohol by selecting a response from the list.

Use Illicit Drugs?

Indicate whether or not the client uses illicit drugs.

What Drugs?

Select from the list all of the drugs that the client uses. If the correct choice is not on the list, select *other* and enter the drug at the *other (specify)* prompt. To delete an option selected in error, click on the button with the red X to the right of that option.

Attending parenting education classes?

Indicate whether or not the client will be attending parenting education classes.

Family Planning Arrangements

Indicate the type of family planning arrangements that have been made. If the correct option is not on the list, select *other* and enter that response at the *other (specify)* prompt.

Does client have a primary medical care provider?

Indicate if the client has a primary care provider or medical home.

Did client have dentist visit during pregnancy?

Indicate whether or not the client saw a dentist during her pregnancy

If yes, what was the reason for the dentist visit?

Select all the reasons for the dental visit if one occurred during pregnancy

Does client understand the need for her child to have a dentist visit by age 1?

Indicate whether or not the client received information on and understands the importance of a dentist visit by age 1

Dental Insurance

Select the dental insurance at the time of discharge. If the client's insurance is not in the list, enter it in the *Other (specify)* field.

Does client have oral concerns or problems?

Indicate whether the client has oral concerns or problems at intake. Specify the problem/concern in the *Specify* field.

Dental Comments

Enter any additional dental comments

Select a Client: Time, Justine 125100108 Adm ID: 125100120

Master History Misc. Child Info Health Outcome Comments

Comments:

Form completed by: _____ Date completed: _____
Data entered by: _____ Date entered: _____
QA inspection by: _____ Date of inspection: _____

Comments

Comments are provided for the convenience of the provider. Information from the comments will not be exported to the state.

Form Completed By

Enter the name of the person who completed the referral form and enter the date that it was completed.

Data Entered By

Enter the name of the person who entered the data into the database and enter the date that it was entered.

QA Inspection By

Enter the name of the person who inspected the data for accuracy and enter the date that it was inspected.

The Service Detail Form

The *Time Input* form is used to enter service and time billing information.

Contact Dates for Admission 133100254

	Contact Date	Contact #	
View All Services For Contact Date	2/1/2010	1	Print All Services
View All Services For Contact Date	2/5/2010	2	Print All Services

To add a new contact click on the Add a New Contact Date button.

Click on the View All Services for Contact Date button to display all services that have been entered for this date. Services will be displayed on the bottom half of the form.

You may print all of the contact information for an admission by clicking on the Print All Services button.

If you want to limit the report to only the time and service information for one contact day click on the Print Contact Info for Service Date button.

The History tab shows all participations for this client. The most recent participation is displayed on opening. If you want to view a previous participation go to the history tab and click on the view button.

The top half of the "Contact Info" tab shows all of the contact dates for the most current admission. You may either view the services for an existing contact date or add a new contact date.

Create a new contact record for each new contact date. Click "Add A New Contact Date" to create a new contact record. Enter the Contact Date, County of service and payment source information for each contact.

Services

Service Category: Oral Health Services Service: Initial screening evaluation

Interaction type: Oral Health visit Time in: Time out: Time spent:

Add "see client chart" to report: Comments:

Screening Results Was decay present (obvious or suspicious)? yes Were restored teeth (fillings or crowns) present? yes

Was gingivitis present (gum bleeding, swelling or pain)? yes Oral health risk level: Low

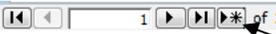
Name of dentist referred to: What is client's referral need? Immediate

Notes:

Record: 1 of 2

Multiple services may be entered for each contact date on the bottom half of this tab. The first blank service record has been created for you. First select the service category. Next select the service option for that category. Enter the Interaction Type and the Time In and Time Out. The Time Spent will be calculated for you. When entering time, enter the hour then a space or (:) and then the minutes. Be sure to enter an (a) for am or a (p) for pm. Depending on which service you select different options appear for data input.

If the (Add "see client chart" to report:) box is checked, then this text will appear on the record printout. Different fields will be available for data input depending on the service selected. For example, if you choose initial or periodic dental evaluation, you will see several *screening results* fields that are only available when these services are chosen. If you choose "care coordination" the fields *place, nature of service* and *service provided by* will be displayed.

Record:  1 of 2

Additional services for the current contact date are added using the buttons at the bottom of the form. Click on the button with "*" to add an additional service. Use the arrow buttons to scroll through all services. If entering services for a new contact date click on the "Add A New Contact Date" button at the top of the form.

Help

To view contact information for any other date click on the "View All Services For Contact Date" button to the left of the line with the date you want to view or edit. All services for that date will appear on the bottom half of the form.

To view a print out of all services for a date, click on the "Print All Services" button next to that record. You will see a report of all services the client received on that date.

If you enter a service in error you cannot delete it. You can change the service to "Not Indicated" and remove the Time In and Time Out. You can delete the entire contact date by going to the Data Utilities menu and changing the status of the contact date record to "delete". All times and services for that date will be eliminated from forms and reports.

History	Contact Info	Comments
Follow-up date: <input type="text" value="2/1/2008"/>		
Comments: <div style="border: 1px solid black; height: 100px; width: 100%;"></div>		
Service provided by: <input type="text"/>	Date entered: <input type="text"/>	
Data entered by: <input type="text"/>	Date of inspection: <input type="text"/>	
QA inspection by: <input type="text"/>		

Follow-up date is used to track next scheduled visits. You may run a report from the reporting menu showing follow-ups scheduled in a date range.

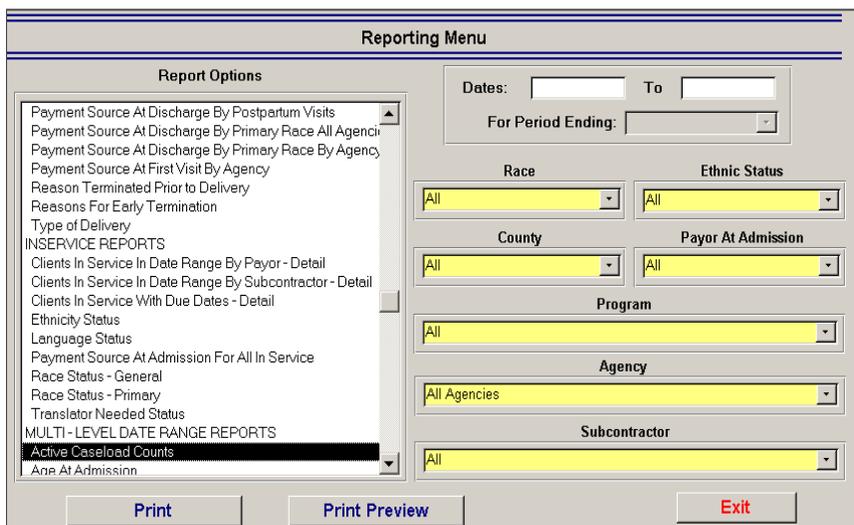
Enter service notes for the day in the **Comments** box.

Enter the name of the person providing the service for this contact in the **Service Provided By** field. If services are provided by two different people on the same day create a contact record for each.

Reports

Click on the **REPORTING MENU** button from the main menu

The list of all possible reports is in the *Report Options* box on the left. The reports are listed under either the admission, discharge, in service or multi range headings. All admission reports show counts of any clients admitted into service in the date range selected. Discharge reports show clients with a discharge date in the date range selected. In service clients are any clients in service for at least one day in the date range selected. They may have been admitted prior to the beginning date of the range and may or may not have been discharged by the end date. The multi-range reports show counts from each of these categories. **For a description of the report double click on the report name in the box.** In the category of “General Reports” you will see a report called REPORT LISTING. Print this report to see a brief description of all available reports.



After selecting the report and entering criteria, click on the **PRINT PREVIEW** button in order to view the report.

There are several possible variables for each report. You must click on the report name in order to enter into the variables. Once you click on the report name all of the variables applicable to the report will be highlighted. Those variables are:

Race You may run most reports by a specific primary race or you may select all to include all possible races.

Ethnic Status You may run most reports by Hispanic/Latino or non Hispanic/Latino or you may select all ethnic groups.

County You may run most reports one county at a time or by all counties together. This is the county indicated when assigning the admission and not necessarily the county from the client's address.

Payor At Admission You may run most reports by primary payor at admission or you may select all to include all payors on a report.

Program If you are entering data from more than one program into this database (i.e. Maternal and Women's Health) you will probably want to indicate the program before running any of the reports or your counts may not be accurate. Women's Health does not capture all of the same data as Maternal Health. For example if you choose "all" for program and are running a report showing postpartum visits, a question on Maternal Health, but not on Women's Health you will see the correct count of postpartum visits, but the percent will not be accurate as the total client count will include the number of Women's Health clients also. Any of the questions that pertain to both programs such as race or insurance may be run using "all" for the program.

Agency This variable will not be applicable for contractors and subcontractors but will be used at the state for reporting.

Subcontractor A contracting agency may choose to report on all data or only that from a specific subcontractor.

Data Utilities

Import and export of data and the deletion of records are accessed from the Data Utilities menu.

For Contractors

Data Utilities

<u>Import/Export Records</u>	<u>Audits and Billing Exports</u>
<input type="button" value="Import/Export For Contractor"/>	<input type="button" value="Create Data Exports to Excel"/>
<input type="button" value="Export Records To The State"/>	<input type="button" value="View Records for Audit"/>

For Subcontractors

Data Utilities |

<u>Import/Export Records</u>	<u>Audits and Billing Exports</u>
<input type="button" value="Import/Export For Subcontractor"/>	<input type="button" value="Create Data Exports to Excel"/>
	<input type="button" value="View Records for Audit"/>

Deleting Records

Because of the import/export process special procedures for deleting records have been established. There are many questions on the input forms that have multiple options available. If one of these options are entered in error they can be deleted on the input screen.

Click on the box with the red X to the right of the option to be deleted. If the record has not been previously exported, the option selected will be deleted. If the record has been previously exported, then a audit table is created. The record will be deleted from this database and the record will also be deleted from the main database on the next

The deletion process for Client, Referral, Admission, Tracking and Child records is handled in a different manner. To avoid the possibility of “orphan records” in the database, which can occur in a distributed database if records are improperly deleted, records are not removed only marked as deleted. Once the **STATUS** of these records are changed to “deleted”, they will not show up on any lists or reports. If the records are “deleted” in error, they may be reactivated by returning the **STATUS** to

Deleting A Client Record

If a client has been entered in error it may become necessary to delete that client record. Do not delete the client record if service was not provided. In this case you would enter the client and referral information and indicate why the client was not served. A client record should be deleted only if it was truly entered in error or if it is found to be a duplicate record.

To delete a client record click on the Data Utilities button on the Main Menu, then open the **Delete or Reactivate Records** form and change the **Client Status** to *Deleted*.

Client ID	Birthdate	Social Security #	Record Status
133100247			active

Select Client: **Demo, Ima G.** 125100107

Client Referral Admission Tracking Child

Below is a list of all of the referral records that have been created for this client that do not have an admission assigned. You may delete or reactivate a referral record by finding the record on the list and changing the record status.

To delete the record change the record status to "Deleted". The record will remain in the database, but will not appear on any lists or in any reports.

CHANGING THE STATUS OF A REFERRAL THAT HAS AN ADMISSION ASSIGNED WILL MAKE THE SAME CHANGE TO THE ADMISSION RECORD.

To reactivate a record that was deleted in error, change the record status to "Active". The record will then be accessible to edit and will be available for reports.

Referral ID	Contact Date	Subcontactor	Admission Assigned?	Record Status
125100119	1/1/1999	Marshalltown Medical & Surgical Center	<input checked="" type="checkbox"/>	active

Deleting A Referral Record

To delete a referral record click on the Data Utilities button on the Main Menu. Open the Delete and Reactivate Records form and select the client. Click on the *Referral* tab and change the status of the record to *deleted*. The record will remain in the database, but will not be accessible from any forms and will not appear in any reports. If you delete a referral record that has an admission assigned, that admission will also be deleted.

Select Client: **Demo, Ima G.** 125100107

Client Referral Admission Tracking Child

Delete admission information

Below is a list of all of the admission records that have been created for this client. You may delete or reactivate an admission record by finding the record on the list and changing the admission status. Use this form if you want to delete the admission record only and keep the referral record. An example of this is a client who applied for service, a participation was assigned, then it is found that they did not meet the criteria for service.

To delete the admission record change the admission status to "Deleted". The record will remain in the database, but will not appear on any lists or in any reports. If you would like to delete the referral as well as the admission go to the Referral tab. On this tab if you delete the referral record the corresponding admission record will be deleted also.

To reactivate a record that was deleted in error, change the status to "Active". The record will then be accessible to edit and will be available for reports.

Admission ID	Date Assigned	Date Discharged	Subcontactor	Admission Status
125100119	1/1/1999		Marshalltown Medical & Surgical Cen	active

Deleting An Admission Record

To delete an admission record click on the Data Utilities button on the Main Menu. Open the Delete and Reactivate Records form and select the client. Click on the *Admission* tab and change the status of the record to *deleted*. The record will remain in the database, but will not be accessible from any forms and will not appear in any reports. You should only use the delete admission option if the client was a referral, but did not receive services and the admission record was created in error. If you delete an admission, the referral record will remain in the database.

Select Client: Demo, Ima G. 125100107

Client Referral Admission Tracking Child

Below is a list of all of the tracking records that have been created for this client. You may delete or reactivate a tracking record by finding the record on the list and changing the record status.
 To delete the record change the record status to "Deleted". The record will remain in the database, but will not appear on any lists or in any reports.
 To reactivate a record that was deleted in error, change the record status to "Active". The record will then be accessible to edit and will be available for reports.

Admission ID	Contact Date	Stage Of Pregnancy	Record Status
125100119	6/1/1999	2nd Trimester	active ▼
125100119	9/1/1999	2nd Trimester	active ▼

Deleting A Tracking Record

To delete a tracking record click on the Data Utilities button on the Main Menu. Open the Delete and Reactivate Records form and select the client. Click on the *Tracking* tab and change the status of the record to *deleted*. The record will remain in the database, but will not be accessible from any forms and will not appear in any reports.

Select Client: Demo, Ima G. 125100107

Client Referral Admission Tracking Child

Below is a list of all of the child records that have been created for this client. You may delete or reactivate a referral record by finding the record on the list and changing the record status.
 To delete the record change the record status to "Deleted". The record will remain in the database, but will not appear on any lists or in any reports.
 To reactivate a record that was deleted in error, change the record status to "Active". The record will then be accessible to edit and will be available for reports.

Admission ID	Child ID	Child's Name	Birth Date	Gender	Record Status
125100119	125100107	George Demo	9/1/1999	Male	▼

Deleting A Child Record

To delete a child record click on the Data Utilities button on the Main Menu. Open the Delete and Reactivate Records form and select the client. Click on the *Child* tab and change the status of the record to *deleted*. The record will remain in the database, but will not be accessible from any forms and will not appear in any reports.

Admission ID	Contact Date	Contact ID	Record Status
122101004	1/1/2008	1	active
122101004	2/1/2008	2	active
122101004	3/1/2008	3	active
122101004	4/1/2008	4	active
122101004	5/1/2008	5	active
122101004	6/1/2008	6	active
122101004	7/1/2008	7	active
122101004	8/1/2008	8	active
122101005	2/1/2008	1	active
122101005	2/1/2008	2	active
122101005	3/1/2008	3	active

Deleting A Time Contact Record

To delete a time contact record click on the Data Utilities button on the Main Menu. Open the Delete and Reactivate Records form and select the client.

Click on the *Time Contact* tab and change the status of the record to *deleted*. The record will remain in the database, but will not be accessible from any forms and will not appear in any reports. All of the service and time records for the day will be deleted.

View Records for State Audit



The WHIS Review form has been created to assist agencies in accessing records to audit. To open the form click on *Data Utilities* from the main menu, then *View Records for State Audit*. A form will open that will allow you to select records to audit.



This form will display service detail records that meet the criteria that you enter. From the list displayed you will be able to select a random sample to audit.

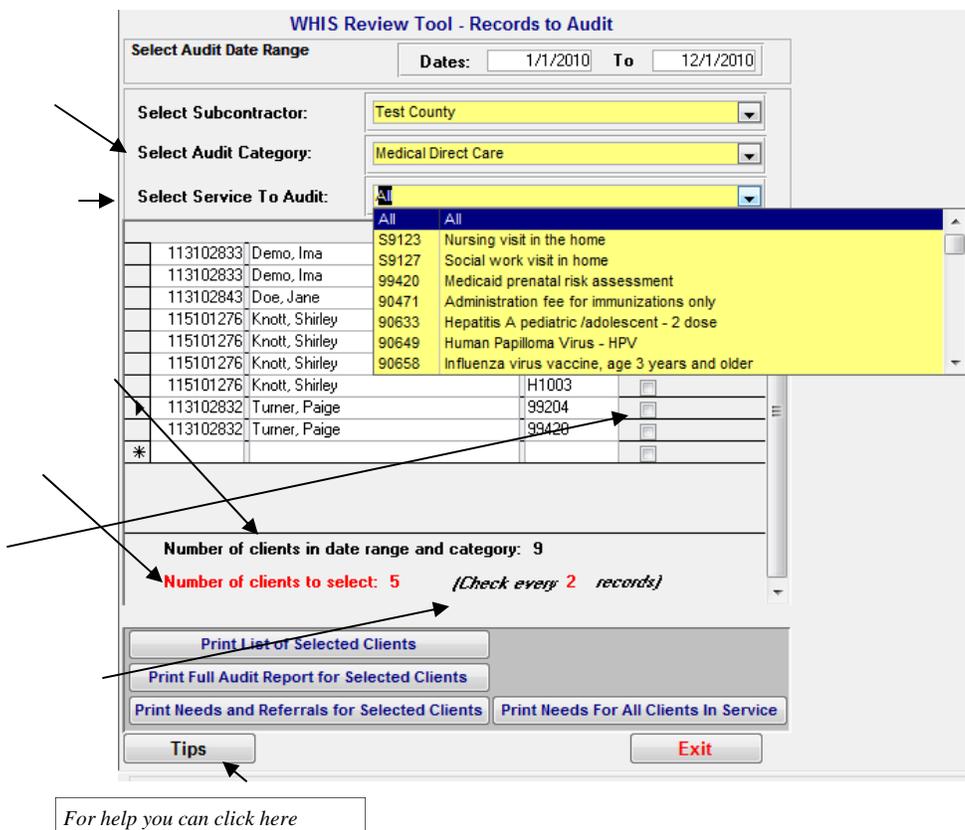
Several reports have been created to assist in your audit.

Print List of Selected Clients- This report displays a list of all services that have been checked. The report sorts alphabetically by client.

Print Full Audit Report for Selected Clients- This report displays information for all services that have been checked. A majority of the questions asked on the intake and discharge forms are shown in order to check for missing info. It shows the number of needs and referrals indicated as well as all the information for the service from the service detail form.

Print Needs and Referrals for Selected Clients- This report lists the needs and referrals for clients with a service that has been checked.

Print Needs for All Clients In Service in Date Range- This report shows all needs for clients in service in the date range. It does not look only at those with services checked. It looks at needs from the new Plan of Care/Needs Assessment as well as the form used in the earlier version of the software.



For help you can click here

1. Enter the date range for the records to audit
2. Select a subcontractor or "All" for all agency records.
3. Select a category to display. Once you select a category, services in that category will be available to choose from in the *Select Service to Audit* drop down list.
4. Select a service to audit. You may select "All" to display all services in the category selected.

All services meeting the criteria you selected will be displayed in the list box.

At the bottom of the screen you will see the number of client records that meet the criteria.

The number that should be audited will be displayed.

You will then check the box next to each record to audit.

It is possible that there will be a large number of records meeting the criteria you select. In order to help with the selection process the form will display which records could be checked in order to meet your audit requirement.

Create Data Exports to Excel

To create Excel exports used in auditing service detail information, click on "Data Utilities" and then "Create Data Exports to Excel".



On this screen you will find three different types of Excel exports.

Exports for Billing Records - These are the same export procedures that were previously accessed from the reporting menu. The following changes were made to these exports:

- Maternal health care coordination records will not show in the export if any other services other than dental, outreach, transportation or interpretation were completed on the same day.
- Dental care coordination records will not show in the export if any other dental services were completed on the same day.
- Presumptive Eligibility will only be exported once per pregnancy.
- Care provider was added to both exports. This comes from the "Services Provided By" field in the database.

Random Sample Exports for WHIS Audit Records - These export procedures are used for WHIS audits (*Service Note Reviews*). A random sample of service detail records meeting the selection criteria above will be created. The sample will be 5% of eligible records with a minimum of 5 and a maximum of 40 records. If there are less than 5 records meeting the criteria, all records will be displayed.

Each time you create an export you may create a different list of random service records, for that reason the "View All" will allow you to display a list of all service records meeting the criteria indicated.

Exports With Address Info - These export procedures are included only for your own reference. You will not be required to send this information to the state.

Service Detail Exports

Enter the criteria for the query in the fields to the right, then click on one of the export buttons below. Once the records appear, click on file, then export to Excel.

Record Selection Criteria

Select Date Range: **Dates:** **To**

Select Subcontractor:

Exports for Billing Records

These buttons are used to create Excel exports of service detail records to send to the state.

- Maternal health care coordination records will not show in the export if any other services other than dental, outreach, transportation or interpretation were completed on the same day.
- Dental care coordination records will not show in the export if any other dental services were completed on the same day.
- Presumptive Eligibility will only be exported once per pregnancy.

Random Sample Exports for WHIS Audit Records

These buttons are used to create Excel exports of service detail records for WHIS audits. A random sample of service detail records meeting the selection criteria above will be created. The sample will be 5% of eligible records with a minimum of 5 and a maximum of 40 records. If there are less than 5 records meeting the criteria, all records will be displayed. Each time you create an export you may create a different list of random service records.

The "View All" button prints a list of all service records meeting the criteria indicated.

Exports With Address Info

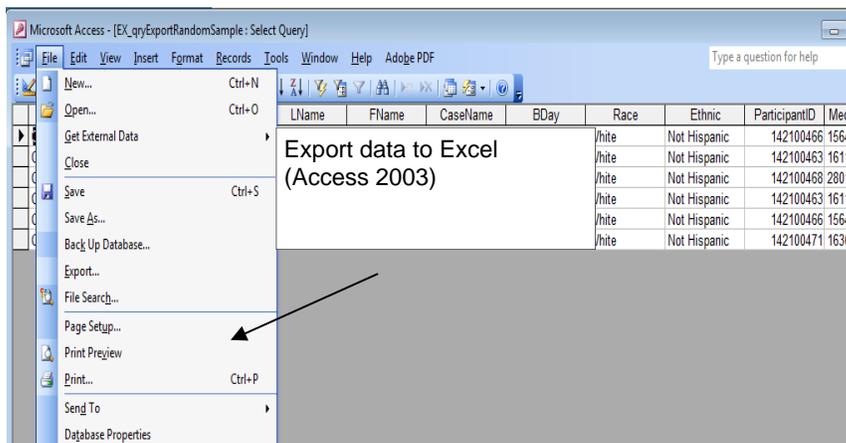
To Export:

Enter the date and subcontractor in the selection criteria. Click on the export button to create the query results.

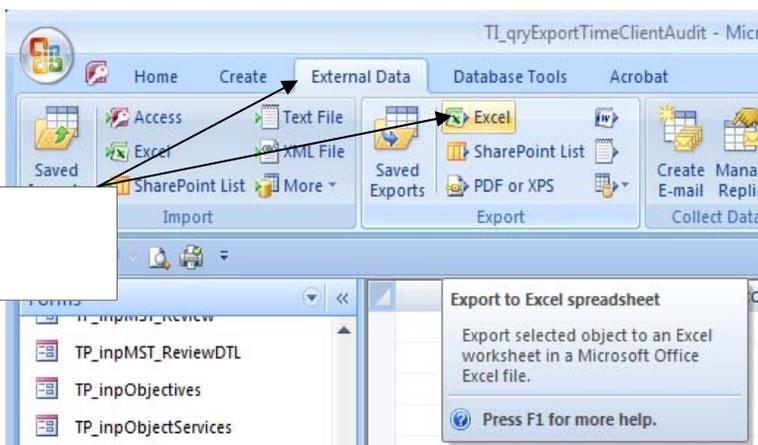
Export this query data to an Excel document and save to your computer.

In Access 2003- Click File, then export and save to your computer.

In Access 2007- Click External Data, then Excel and save to your computer.



Export data to Excel (Access 2007)



Copy Data to Data Workbook Template:

Open the Data Workbook Template (will say AG or AH). 'Save as' and rename per protocol. Open the data export file. Copy the data (no headers). Paste into the proper data sheet in the workbook (CC or PE). Repeat for the 2nd service if applicable but use same template. There is a tab for CC and PE.

Note: If the data will not paste into the template make sure that you only copy through column AH. Even if it looks like the note goes beyond it, the entire note is in column AH (or AG if applicable).

Send Copy of Data Workbook to State:

A copy of the saved data workbook must be securely sent to the State. This is best done using the Win-SCP program your agency uses to transmit monthly data files. The process is the same, drag/drop/copy. Please notify the State when transfer is complete. To notify us or if you need assistance call WHIS tech support (515) 281-5401. or email Brad: bradly.hummel@idph,iowa.gov.

Importing And Exporting Records

Contracting agency's that have subcontractors assigned to them that are doing data input at another location will need to import and export records to and from each subcontractor so that the contracting agency has a complete data set.

The import/export procedure works as follows:

- Each subcontractor does input at their own site, then exports the data to the contracting agency. The exported data is automatically put into the OUTBOX folder within the same folder that the data resides (at most sites this is the DPH folder).
- The subcontractor transfers the datafile from the OUTBOX folder to the contracting agency. This is done by sending the data to the State via a transfer utility such as WinSCP. The contracting agency can then access this file and move to their computer for import into the main database.
- The contracting agency receives the data by accessing their ftp folder on the State's server and moves it to the INBOX folder for that subcontractor (located within the DPH folder on their site). There should be a folder for each subcontractor in the INBOX folder on the contractor's computer. These folders are named Loc_?? with the ?? being the subcontractor's ID.
- The contracting agency imports the data from each subcontractor into their master database through the import utility in the database.

Once a month the data at the contracting agency is exported to the state database. This should be done after all of the data from the subcontracting agencies have been imported. This procedure is different from the import/export between contractors and subcontractors. There is no import of records from the state. Only those records that have been completed accurately can be sent to the state. If the record is missing information, it will not be sent. You should produce a validation report before exporting to the state so that you can see a list of the records with incomplete data. These must be completed before exporting or they will not be sent to the state database.

The following section discusses the import/export procedure. This procedure differs slightly depending on whether you are a subcontractor or a contracting agency. Be sure to follow the instructions that pertain to your type of agency.

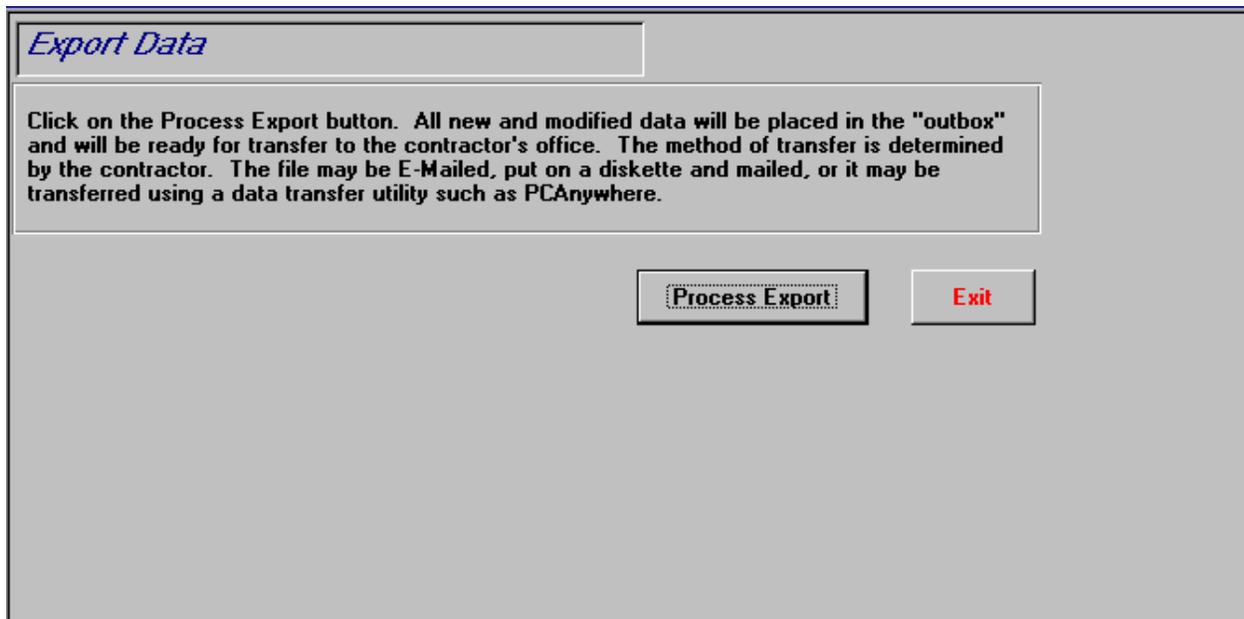
Export Procedure For The Subcontractor

To export data from the subcontractor site to the main database:

- Click on the *Data Utilities* button on the Main Menu
- Click on the *Import/Export From Subcontractor* button on the Data Utilities menu
- Click on the *Export Records* button.

An IMPORT RECORDS button exists for the subcontractor. This button is rarely used and only if data at the subcontracting site needs to be refreshed. If it is needed, instructions will be provided by the State.

Click on the EXPORT RECORDS button to open the export form.



Click on the PROCESS EXPORT button.

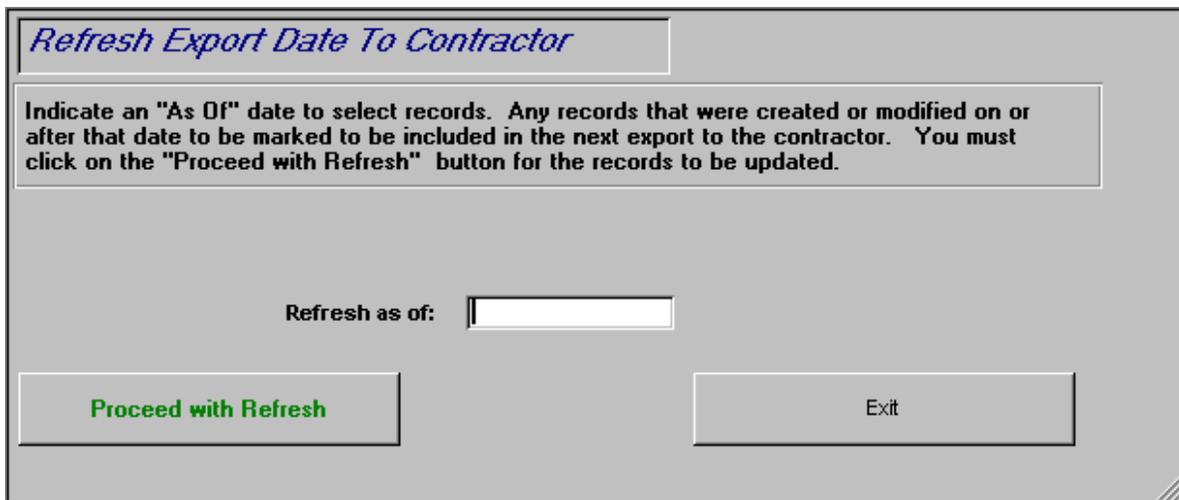
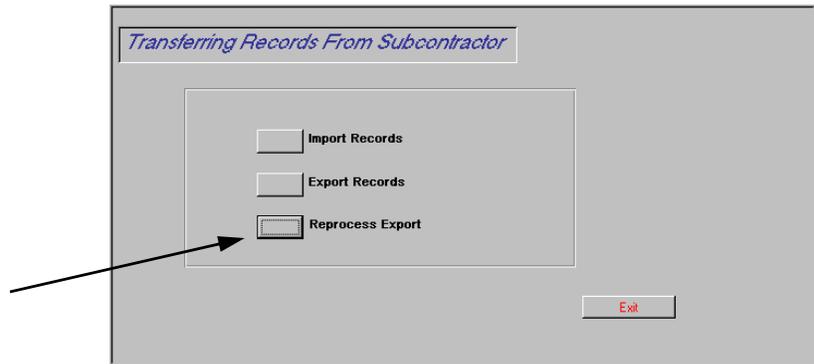
All records entered or changed since the last export procedure will be exported to a file in the C:/DPH/OUTBOX folder. This file must then be transferred to the contractor for import at their site. Use Win-SCP or another transfer utility to transfer the data to the state for pick up by the Contracting agency.

Note that only records changed or edited since the last export will be included in this export file. If for some reason your export file is lost before it is imported by the contractor you will need to reprocess this export. Reprocessing an export file will be explained on the following page.

Reprocess Export For The Subcontractor

To reprocess an export for the subcontractor site:

- Click on the *Data Utilities* button on the Main Menu
- Click on the *Import/Export From Subcontractor* button on the Data Utilities menu
- Click on the *Reprocess Export* button.

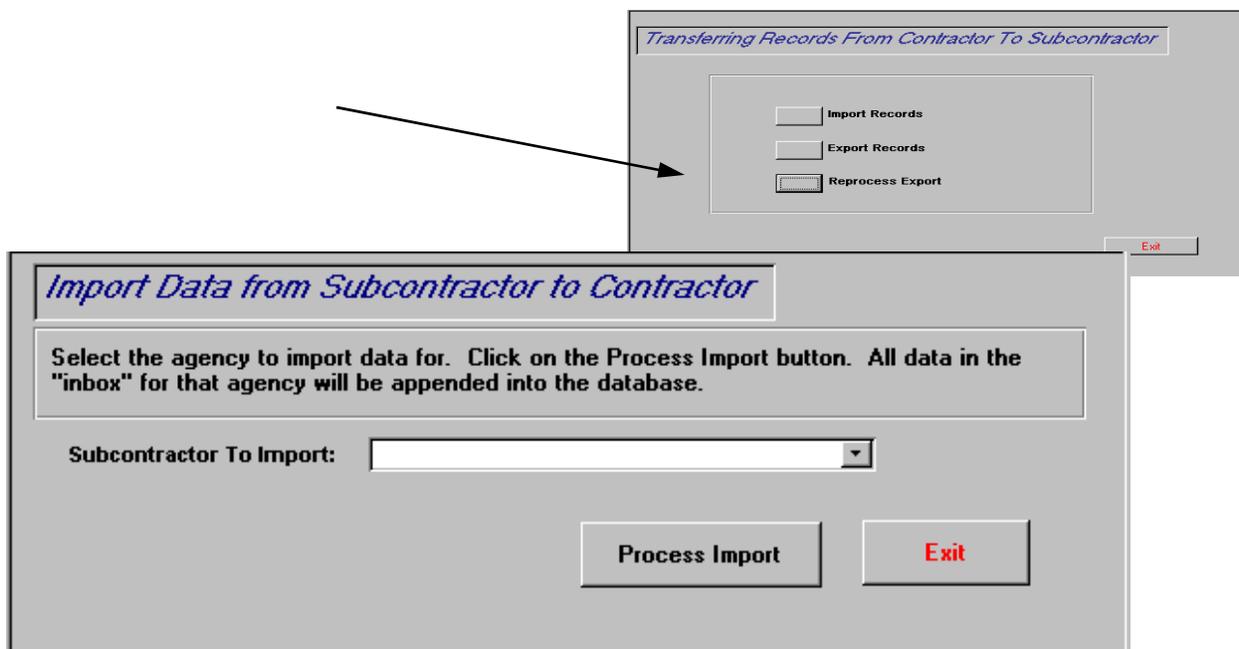


If for any reason you need to re-export records that have already been exported you may do that by clicking on the REPROCESS button on the *Import/Export From Subcontractor* form.

Enter the earliest date for which you want to re-export records. For example; if you exported on 4/1/2013 and also on 4/15/2013 and you want to re-export all of the records from both of these export procedure, enter 4/1/2013 at the **Refresh As Of** prompt.

Import Procedure For The Contracting Agency:

- Move the data file that has been exported and transferred from the subcontractor to the C:/DPH/INBOX/Loc_?? Folder using a transfer utility. Each subcontractor will have a folder identified by their subcontractor ID number located in the INBOX folder. Put the data from each subcontractor into their appropriate folder.
- Click on the *Data Utilities* button on the Main Menu
- Click on the *Import/Export For Contractor* button on the Data Utilities menu
- Click on the *Import Records* button.

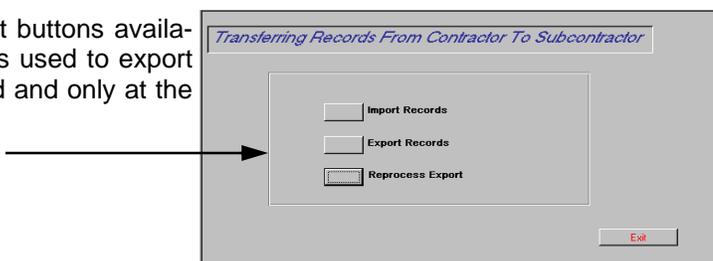


Select from the list the subcontractor that you want to import data for. Click on the PROCESS IMPORT button. All of the records in the file located in the subcontractor selected INBOX folder will be imported into the your database. If changes were made to a record at both the contractor's and subcontractor's sites since the last import, the record that was most recently modified will remain. Any other record will be overwritten. Any deletions made at the subcontractor's site will be deleted from the contractor's database.

Once the records have been imported, the file will be moved to the INBOX/Loc??/BACKUP folder.

Export Procedure For The Contracting Agency:

The Export Records and Reprocess Export buttons available to contractors are not the same buttons used to export to the state. These buttons are rarely used and only at the direction of the State.



Exporting Records To The State From The Contracting Agency

Information from the contracting agency's central database will need to be transferred to the state's Maternal and Child Health Database on a monthly basis. To run this procedure open the Data Utilities Menu and click on the *Export Records To State*.

You must have System privilege (set up on

System Maintenance

<p>Import/Export Records</p> <p><input checked="" type="checkbox"/> Import/Export For Contractor</p> <p><input type="checkbox"/> Export Records To The State</p>	<p>Audits and Billing Exports</p> <p><input type="checkbox"/> View Records for State Audit</p> <p><input type="checkbox"/> Create Data Exports to Excel</p>
<p>Other Functions</p> <p><input type="checkbox"/> Setup Security</p> <p><input type="checkbox"/> Delete Or Reactivate Records</p> <p><input type="checkbox"/> Transfer Subcontractor Assigned</p>	

Transferring Records to State DPH

The system will export only records that have passed validation. You will need to run the validation reports, resolve missing or inaccurate data before processing the export to the state database.

Validation Reports

Preview validation summary report

Preview validation detail report

Export Records To State Database

Reprocess Export

Export Procedures To The State

Before transferring to the state:

- make sure that current records have been imported from all of the subcontracting agencies
- run the validation report to check for incomplete records (client records that are missing data required by the state will not be included in the export)
- correct all missing data
- rerun the validation report to check for data accuracy
- Click on the *Export Records To State* button on the Data Utilities menu. You must have *Administrator* privilege (set up on the security form) in order to have access to this function.
- The Export menu will open. From this menu click on the *Export Records* button.

All records entered or changed since the last export procedure will be exported to a file in the DPH/Outbox_State folder.

Move the file located in the OUTBOX_State folder to that Department of Public Health's state office. You may use any ftp transfer utility. An example using WinSCP, a free downloadable utility, is included in this manual.

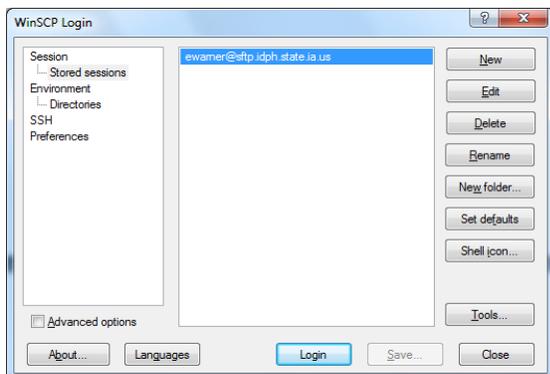
If for any reason you need to re-export records that have already been exported you may do that by clicking on the REPROCESS button on the *Export Records To State* form.

Enter the earliest date for which you want to re-export records. For example; if you exported on 4/1/2013 and also on 4/15/2013 and you want to re-export all of the records from both of these export procedure, enter 4/1/2013 at the **Refresh As Of** prompt.

Transferring Data Using the WinSCP Utility

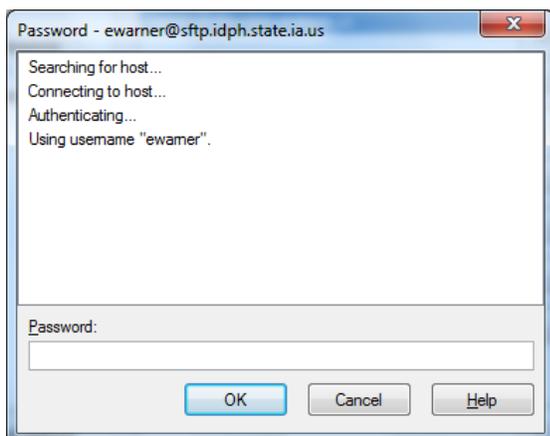
Any secure ftp software may be used to transfer the data. WinSCP is a free, open-source file transfer utility for Windows that enables the safe copying of files between a local and a remote PC. Instructions for downloading and installing WinSCP are available by contacting the Maternal Health Department. Following are instructions for transferring data using WinSCP. Other utilities follow much the same procedure.

Open the WinSCP software (Double-click on the WinSCP icon on your desktop).

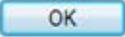


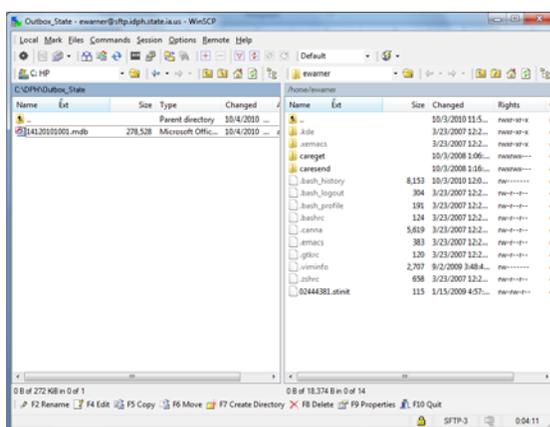
Highlight the saved session

Select 



Press the button on your security token and enter the number plus the 4-digit soft pin you assigned to the token.

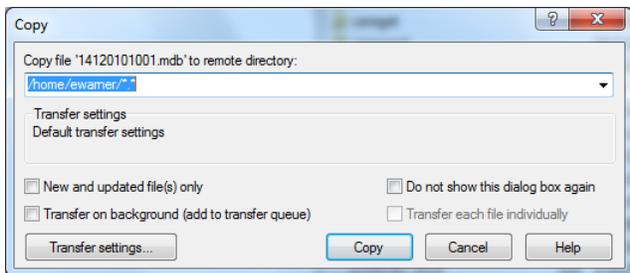
Select 



The left window displays the drive and folder on your computer. The right window displays your folder on the IDPH SFTP server.

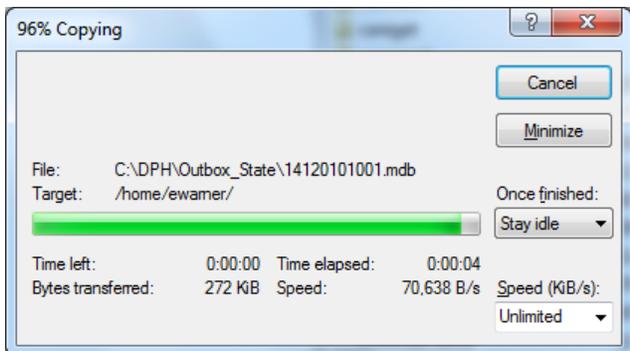
Change the drive/folder in the left window to where your data was exported to (usually **C:\DPH\Outbox_State**; if WHIS database on network, substitute network drive letter for **C:**).

Select/highlight the file in the left side window that you want to upload and drag it over to the right-side window.

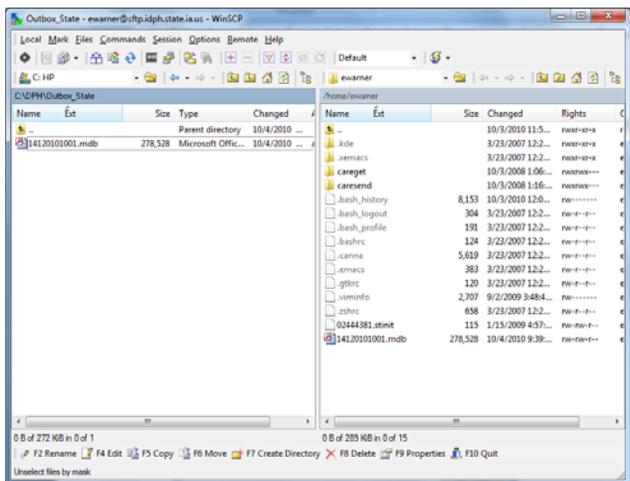


The file you selected to upload will appear in this window.

Select 

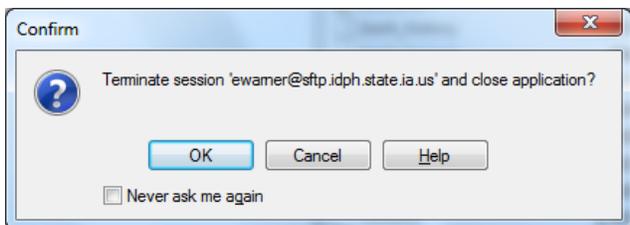


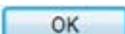
Wait for the file to finish copying.



The file you copied should now appear in the right side window. If the file name and file size on the right match the name and size on the left, you have successfully transferred your data file.

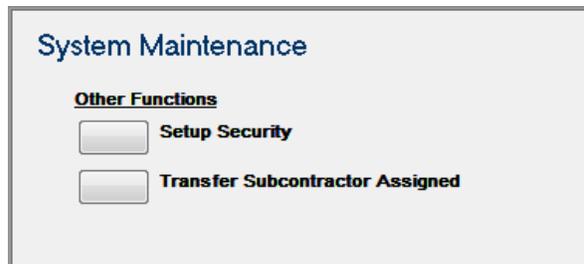
Click on the  in the upper right corner to exit the session.



Select  to terminate the session.

System Maintenance

Setting up passwords and new subcontractors is done from the System Maintenance menu. You must have "system" privileges applied to your log in to access this form.



Setting Up Passwords

To access, click on **Setup Security** from the System Maintenance Menu.

Menu level security may be implemented on this system. To do this set up each user on your system with a USER NAME, PASSWORD and WORKGROUP. The EMPLOYEE ID field has been provide only for the use of the agency. It need not be filled in.

There are three types of workgroups that you may choose from, System, Administrator and Data Entry. Users that are set up with the workgroup, Data Entry, will not have access to the System Maintenance or Data Utilities menu. Users that are set up with the workgroup, Administrator, will not have access to the System Maintenance menu, but will have access to the Data Utilities.

At least one person at each site must be set up with the workgroup System. This person will be able to change password.

Maintain Passwords

Enter the user's name and password. Assign the user to a workgroup. User's assigned to the "System" workgroup will have access to the system maintenance functions. Those assigned to the "Administrator" workgroup have access to some system functions, but not all. Most users should be assigned to the "Data Entry" workgroup. The Employee ID field is for agency use only.

ID	User Name	Password	Workgroup	Employee ID
▶ 2	System	*****	Systems	0
3	Administrator	*****	Administrator	0
4	Data Entry	*****	Data Input	0
* 0				0

Transfer Subcontractor Assigned (Contracting Agencies Only)

Click on the **Transfer Subcontractor Assigned** button from the System Maintenance menu. This function will be available to the System Manager only.

Upon creation an admission record is assigned to a specific subcontractor. If sometime during the service period that subcontractor should change, it will be necessary to transfer the client records to the new subcontractor. This is very important so that the client records are exported correctly from the main database to the new subcontractor.

Transfer Subcontractor Assigned

Select the client and admission that you want to transfer to a new subcontractor. Select the new subcontractor at the "Transfer To Subcontractor" prompt. You must click on the Apply Transfer button for the records to be updated.

Select a Client:

Select Admission:

Transfer To Subcontractor:

Comments:

Apply Transfer

Select A Client: Select the client that you wish to transfer to another subcontractor.

Select Admission: Select the admission that you are transferring. A client will have more than one admission if they have received services for more than one pregnancy.

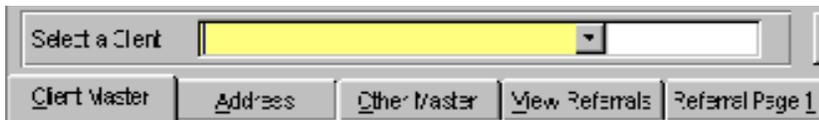
Transfer To Subcontractor: Select the subcontractor that will now be providing services for this client.

Comments: Enter any comments related to this transfer.

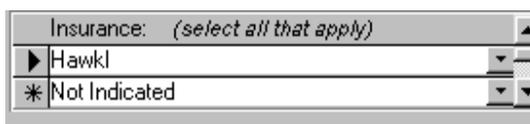
Apply Transfer: Click on this button to change the subcontractor assigned for this client.

Tips and Hot Keys

Using the keyboard to move between tabs: On each of the tabs one character is underlined. That is the "hot key" used to access that tab. To move to that tab using the keyboard, type **Ctrl +** (the underlined character). You will then move to that tab.

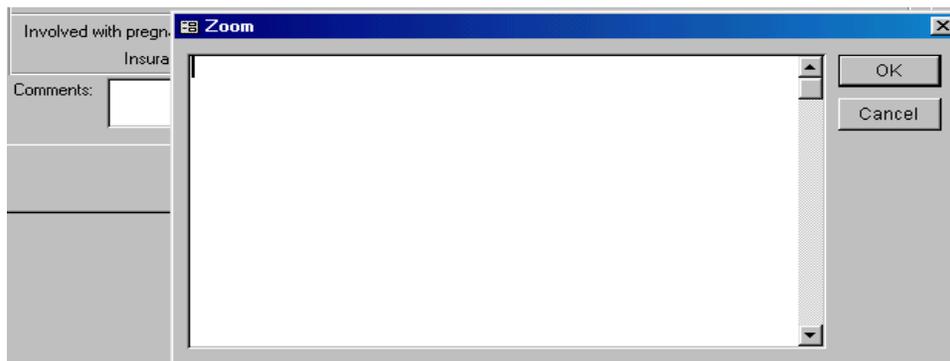


Moving out of a option box using the keyboard: When doing data entry most people use either the **Tab** or **Enter** keys to move to the next prompt. Once you are in a option box where you may choose more than one response to a question, the **Tab** and **Enter** keys will not work. To move to the next prompt you must type **Ctrl + Tab**.



Deleting an incorrect response in a option box: If you select an incorrect response in a option box where multiple choices are possible, hit the **Esc** key to remove the last selection.

Opening a memo box for typing comments: If you need additional space on any of the comments fields type **Shift + F2** and a memo box will appear. When typing into this box hitting the **Enter** key will close the box. If you want to create a new line you will need to type **Ctrl + Enter**.



Accessing a drop down list using the keyboard: If you would like to view the options possible in a drop down list but don't want to use your mouse to click on the arrow, you may type **Alt +** . This will display the options in the list.

