



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

User's Manual

The Maternal & Child Health database was developed to store information from the input forms required by the Department of Public Health. In 2003 it was expanded to include Women's Health information. These input forms must be completed for each client. Information is input into the system, then can be evaluated for reporting and transfer to the Department of Public Health's statewide database.

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/Women's 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. However, if it becomes necessary for data input or editing to be done at the main database site, this must be coordinated with the subcontractor. Information should be transferred to the main database, the necessary edits done there, then transferred back out to the subcontractor before the subcontractor does any more input.

Information should be transferred from the subcontractor to the main database on a regular basis (weekly is recommended). To transfer data click on the import/export button on the main menu. Click on the export records button. All of the data entered since the last export will be exported to a file called *Outbox* in the directory in which the software was installed. This file must then be transferred to the contractor. The method of data transfer is a decision that needs to be made by each contractor. The data file may be put on a diskette, sent by email, or a data transfer utility such as PCAnywhere can be used. This must be coordinated with the contacting agency.

Information may need to be transferred from the main database to the subcontractors. This transfer is necessary if records are edited or input at the contractor's site for clients served by a subcontractor. If there are more than one subcontractor, each will receive only the data for the clients they are serving. Care must be taken to assure data is not overwritten by following these steps:

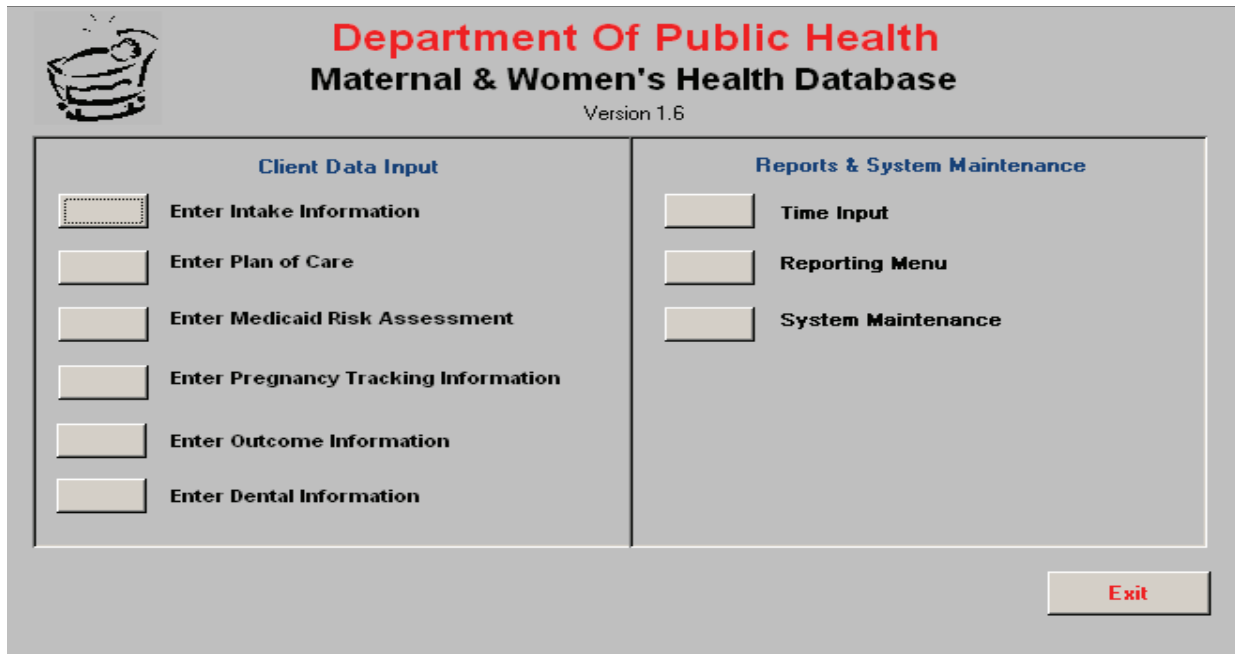
- The contractor needs to get the latest export from the subcontractor before making any changes to data.
- The subcontractor must stop doing data entry until the new data is exported back to them.
- Once the subcontractor has received the modified data from the contractor the following steps must be taken to import the changes:
 1. The datafile is put into the Inbox of the directory in which the program was installed.
 2. Click on the Import/Export button on the main menu
 3. Click on the Import button. All data in the file in the inbox will be appended into the subcontractor's database. (see the import/export section of 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 DHSDAT.mdb file into that directory. This is the only file that needs to be regularly backed up. The DHSEXE.mdb is the executable file and the DHSSUP.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.

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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.

Maternal Health records, *Women's Health* records and records for clients served *Postpartum Only* are entered using the same 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.

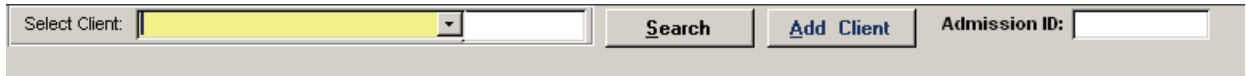
Each time a client initiates service for a new pregnancy a new referral record must be added. If it is determined that the client does not meet the criteria for service, that client remains a referral only client. If services will be provided you must create an admission record for the client.

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.

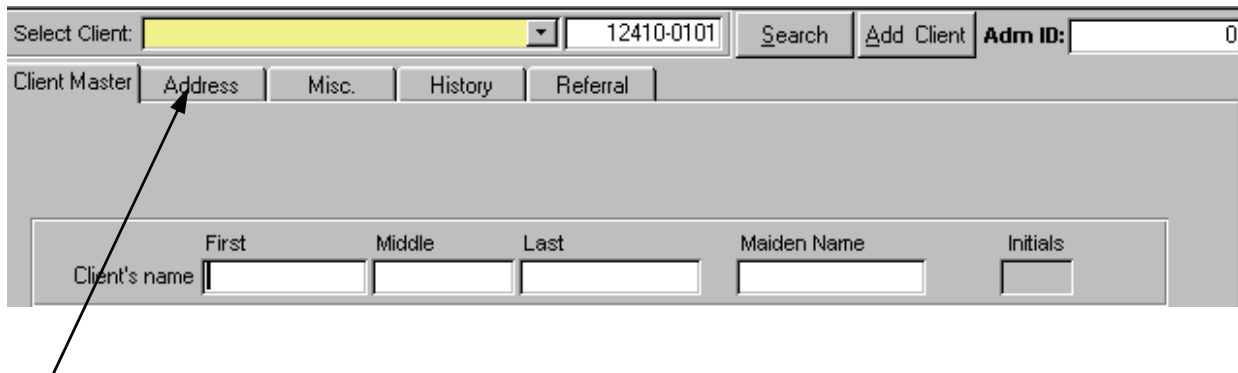
The Intake Form



Select Client: Admission ID:

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.



Select Client: 12410-0101 Adm ID: 0

Client Master | **Address** | Misc. | History | Referral

Client's name: First Middle Last Maiden Name Initials

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		Arita		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

Select Client:	<input type="text" value="12410-0101"/>	<input type="button" value="Search"/>	<input type="button" value="Add Client"/>	Adm ID:	<input type="text" value="0"/>																																				
Client Master	Address	Misc.	History	Referral																																					
<table border="1"> <tr> <td>Client's name</td> <td>First <input type="text"/></td> <td>Middle <input type="text"/></td> <td>Last <input type="text"/></td> <td>Maiden Name <input type="text"/></td> <td>Initials <input type="text"/></td> </tr> <tr> <td colspan="4">Alias ID: <input type="text" value="0"/></td> <td><input type="button" value="Add New Alias"/></td> <td></td> </tr> <tr> <td>Client Alias</td> <td>First Name <input type="text"/></td> <td>Middle Name <input type="text"/></td> <td>Last Name <input type="text"/></td> <td>Status: <input type="text" value="Active"/></td> <td></td> </tr> <tr> <td colspan="5">If this client has an existing record in the database under a different name, enter that client ID: <input type="text" value="0"/></td> <td></td> </tr> <tr> <td colspan="3"></td> <td colspan="3"><input type="button" value="Delete Alias"/></td> </tr> <tr> <td colspan="2">Birthdate <input type="text"/></td> <td colspan="4">Social Security Number: <input type="text"/></td> </tr> </table>						Client's name	First <input type="text"/>	Middle <input type="text"/>	Last <input type="text"/>	Maiden Name <input type="text"/>	Initials <input type="text"/>	Alias ID: <input type="text" value="0"/>				<input type="button" value="Add New Alias"/>		Client Alias	First Name <input type="text"/>	Middle Name <input type="text"/>	Last Name <input type="text"/>	Status: <input type="text" value="Active"/>		If this client has an existing record in the database under a different name, enter that client ID: <input type="text" value="0"/>									<input type="button" value="Delete Alias"/>			Birthdate <input type="text"/>		Social Security Number: <input type="text"/>			
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Birthdate <input type="text"/>		Social Security Number: <input type="text"/>																																							

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.

Social Security Number

Enter the client's social security number if one exists.

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

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.

Home Phone Enter the client's home phone number.

Work Phone Enter the client's work phone number if applicable.

Message Phone If the client has a phone number where messages can be left, enter that number here.

Message Place Indicate where the client is receiving messages

Message Contact Indicate who is receiving messages for this client

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	Address	Misc.	History	Referral	Intake	Preg Info	Health	Comments
--------	---------	-------	---------	----------	--------	-----------	--------	----------

ID Number:		Type:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Race:	<input type="text"/>	Other race (specify):	<input type="text"/>
Race:	<input type="text"/>	Hispanic/Latino descent?	<input type="text"/>
<input type="text"/>	<input type="text"/>	Ethnicity:	<input type="text"/>

Languages spoken:	<input type="text"/>	Other language (specify)	<input type="text"/>
<input type="text"/>	<input type="text"/>	Is English the primary language?	<input type="text"/>
		Is a translator needed?	<input type="text"/>
		If yes, what language?	<input type="text"/>

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.

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?

Viewing Client History

	ID	Admission Date	Subcontractor	Program	Received Service?		
View	122100550		Test Subcontractor		<input type="checkbox"/>	Preview	Print

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. If you would like to print out the information click on the button with a picture of a printer to the right of the record. The report will appear in print preview. You may review the information or send it to the printer by click on FILE then PRINT.

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 a software interface for entering referral information. At the top, there is a 'Select Client' dropdown menu with '12210-0493' selected, a 'Search' button, an 'Add Client' button, and an 'Admission ID' field with '0'. Below this are tabs for 'Client', 'Address', 'Misc.', 'History', and 'Referral'. The 'Referral' tab is active, showing an 'Add Referral' button and a 'Referral ID' field with '122100550'. To the right is a 'Date of contact' field. Below these are several sections for service details: 'How did client hear of services?' (choose all that apply) with a dropdown menu and a red X button; 'Hospital (specify)', 'Other agency (specify)', 'Media outreach (specify)', 'Literature (specify)', 'Street outreach (specify)', and 'Other (specify)' each with a text input field. Below these is a 'Will services be provided:' dropdown menu with 'yes' selected. At the bottom, there are fields for 'Client consent form signed?' (dropdown), 'Date signed:', 'Program:' (dropdown), 'Agency assigned:' (Test Agency), 'Subcontractor assigned:' (Test Subcontractor), and 'County assigned:' (dropdown). At the very bottom are two buttons: 'Assign Admission' (green) and 'Cancel' (red).

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.

Media (specify)

If the client was became aware of Maternal Health services through media, enter the name of that media.

Literature (specify)

If the client was became aware of Maternal Health services through literature, enter the name of that literature.

Outreach (specify)

If the client was became aware of Maternal Health services through outreach services, enter the type of outreach.

Other referral (specify)

If the correct response is not on the list of referral sources, choose other and enter the correct response at the *other (specify)* prompt.

Will services be provided:	no		
If no, reason not served:			
Referral form completed by:		Date :	
Data entered by:		Date :	
Quality assurance by:		Date :	

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.

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.

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.

Will services be provided:	yes				
Client consent form signed?		Date signed:		Program:	
Agency assigned:	Test Agency				
Subcontractor assigned:	Test Subcontractor	County assigned:			
Assign Admission		Cancel			

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

Select the program. Choices are Women's Health, Maternal Health and Postpartum Only. Depending on which program is selected different input screens appear.

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:

CHAMPUS - Government health insurance program for members of the 7 US uniformed military services

County funds - payment is from a county source

Eligible/not receiving Title XIX - meets Medicaid eligibility requirements, but not receiving Title XIX

Emergency Medicaid - Receiving (received) Medicaid Coverage for delivery and newborn hospital care only

Grant funds - payment from a grant source

HAWK-I - State children's health insurance program - "Healthy and Well Kids Iowa"

HMO - Health Maintenance Organization - managed care

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

MediPASS - coverage through Medicaid managed care program - "Medicaid Patient Access to Service System"

OB Indigent - coverage obtained through Title V maternal health contractor for indigent pregnant women not eligible for Title XIX

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

SSI - Supplemental Security Income - 65 or older, or blind, or have a disability. SSI can also go to children who are either disabled or blind

State papers - Resident of counties Clinton, Cedar, Scott, Muscatine, Louisa, Washington, Iowa, Johnson or Keokuk receiving maternal health services at University of Iowa Hospitals and Clinics

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

Uninsured - no known health insurance

How often are the services of the primary care provider utilized?

Indicate how often the client visits their medical care provider by selecting an option from the list.

Does client have primary dental care provider?

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

Name of dental provider

Enter the name of the client's dental care provider

How often are primary care dental services accessed?

Indicate how often the client visits their medical care provider by selecting an option from the list.

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.

Work Hours

If the client is employed, select from the list the time of day that the client works.

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.

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.

Insurance Status Of Father

Select from the list the applicable insurance or payment source of the baby's father. To delete an option selected in error, click on the button with the red X to the right of that option.

Father Comments

Enter comments about the baby's father.

Entering Pregnancy Information

Enter all of the admission information at the appropriate prompts.

Select Client:	Cummings, Ima	12410-0101	Search	Add Client	Adm ID:	124100109		
Client Master	Address	Misc.	History	Referral	Intake	Preg Info	Health	Comments
Previous Pregnancies								
How many previous pregnancies?			Last pregnancy end date:					
How many live births?								
How many fetal deaths?			How many neonatal deaths?					
How many spontaneous abortions?			How many therapeutic abortions?					
Pregnancy Information								
Was this a planned pregnancy?			Using birth control?					
Birth control type?			Specify other birth control:					
Due date:			Date of last mensus:					
When was pregnancy first identified?			Receiving prenatal care?					
When was first care received?			How many appointments kept?					
Practioner providing prenatal care:			Specify other practioner:					
Provider's name:								
Attending childbirth classes?			Attending parenting classes?					
Taking prenatal vitamins?			How does mother feel about pregnancy?					

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*.

Practitioner Providing Prenatal Care

Indicate the type of provider from whom the client has received prenatal care. If the provider type is not on the list, select other and enter that provider type at the other (specify) prompt.

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.

How does mother feel about pregnancy?

Indicate the type of attitude the mother has towards the current pregnancy by selecting a response from the list.

Entering Health Information

Enter all of the admission information at the appropriate prompts.

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.

Has client been tested for HIV/AIDS?

Indicate whether or not the client has been tested for HIV. If the client refuses to answer select *client declines*.

Were HIV test results positive?

If the client has been tested for HIV, indicate whether or not the test was positive. If the client refuses to answer select *client declines*.

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.

Specify other STD

If other was selected for STD, enter the name of that disease.

Is client being treated for STDs?

If the client has a sexually transmitted disease, indicate whether or not the client is currently being treated for that disease. If the client refuses to answer select *client declines*.

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*.

Is client a medical risk?

Indicate whether or not the client is a medical risk according to the Medicaid Risk Assessment.

Is client a nutritional risk?

Indicate whether or not the client is a nutritional risk according to the Medicaid Risk Assessment.

Is client a psychosocial risk?

Indicate whether or not the client is a psychosocial risk according to the Medicaid Risk Assessment.

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.

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 Form

Select a Client: **Cummings, Ima** 124100101 **Adm ID:** 0

Client Master | History | Assessment

Client ID: 124100101

Client's name: First: Ima, Middle: , Last: Cummings, Maiden Name: Going
 Birthdate: 1/1/1977, Social Security Number: 444-44-4444

Number of Addresses: 1 Add New Address ◀ ▶

Address Status: Active, Address Type: Current Home, Address #: 1

Street Address: 123 123rd, Apt #: 123, County: Benton
 City: Ames, State: IA, Zip Code: 55555
 Home Phone: (444)444-4454, Work Phone: (444)444-4444
 Emergency contact: Justin Time, Phone: (444)444-4488

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.

Select a Client: **Cummings, Ima** 124100101 **Adm ID:** 0

Client Master | History | Assessment

	ID	Admission Date	Subcontractor	
View	124100108	1/1/1999	SubContractor 01	

The history screen allows you to view all of the needs assessment forms 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 button with a picture of the printer. The report will appear in preview mode. You may view the report or send it to the printer.

The Needs Assessment form should be completed at intake and monitored throughout the pregnancy and at outcome. Select from the list the needs that the client has, who the client was referred to and how they were referred. Indicate the status of each need and if that need is met during the service period change the status to completed and enter the date completed.

Select a Client: Adm ID:

Client Master | History | Assessment

Need Category:

Specific Need	Status	Date Resolved	Referral	Referral Mode	Comments
<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text"/>

Need Category

All of the needs on the Need Assessment form have been listed by category. Before entering a need you must first indicate the category of that need. Once you have selected a category all of the specific needs that are associated with the category will be available in the *Specific Needs* drop down box. The need categories are:

- Parenting Skills/Family Practices
- Substance Abuse/Medical Needs
- Financial Situation
- Living Situation
- Home Safety
- Transportation
- Emotional/Psychosocial Needs

To delete a need entered in error, click on the button with the red X to the right of that row.

Specific Need

For each need category there are several specific needs to choose from. After selecting the category choose the specific need from that category.

Need Status

For each specific need that you have selected enter the status of that need. Choose either *improved, needs improvement* or *resolved*.

Date Need Resolved

After a specific need has been resolved, change the need status to resolved and enter the date that the need was resolved.

Referral

For each specific need select the agency or service to which the client has been referred.

Referral Mode

For each referral enter how the referral was made. Select either *appointment made, brochure/information, escorted to referral site, or discussion/recommendation*.

Needs Comments

Enter comments about the specific need for the client.

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 Client Master, 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 are also fields for 'Alias ID', 'Add New Alias', and 'Delete Alias'. 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. The 'Number of Addresses' is 1, and the 'Address #' is 1. The 'Address Type' is 'Current Home' and the '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 the '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 has two rows: '121223333' with 'Social Security' type and '45673434K' with 'Medicaid' type. The 'Race' section has 'Asian' and 'White' options. The 'Ethnicity' is 'Other'. The 'Languages spoken' section has 'American Sign Language', 'Chinese', and 'English' options. There are also fields for 'Other language (specify)', 'Pig Latin', '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 Mqm'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.

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.

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 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.

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 'Marital Status' selected in the 'Risk Factor' field. The 'A Score Initial' dropdown menu is open, showing two options: '0' and '2'. The '0' 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.

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.

Select Client: Demo, lma 11310-0467 Adm ID 113100453

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 \geq 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 \geq 1 cm	Cervical dilation of the internal os of 1cm or more at 34 weeks gestation.	No =0 Yes =4
Uterine irritability \leq 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 \geq 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.	\geq 7lb =0 < 7lb =2
Weight loss	Any documented maternal weight loss.	< 5lb =0 \geq 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 'View' button to the first row of 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.

Select a Client:	Boyd, Melissa	114100154	Adm ID:	114100244
Master	History	Misc.	Assessment	Comments
Allergies? <input type="text"/> Specify allergies: <input type="text"/>				
Is client taking regular medications? <input type="text"/> What medications? <input type="text"/> <input type="button" value="X"/>				
Other meds (specify): <input type="text"/>				
Smoke cigarettes? <input type="text"/> How many? <input type="text"/>				
Drink alcohol? <input type="text"/> How often? <input type="text"/>				
Use drugs? <input type="text"/> What drugs? <input type="text"/> <input type="button" value="X"/>				
Other drug (specify): <input type="text"/>				
Tested for HIV/AIDS? <input type="text"/> Were results positive? <input type="text"/>				
Does client have STDs? <input type="text"/> What STDs? <input type="text"/> <input type="button" value="X"/>				
Other STDs (specify): <input type="text"/>				
Is client being treated for STDs? <input type="text"/> Partner treated for STDs? <input type="text"/>				
Is client a medical risk? <input type="text"/> a nutritional risk? <input type="text"/> a psychosocial risk? <input type="text"/>				

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.

Has client been tested for HIV/AIDS?

Indicate whether or not the client has been tested for HIV. If the client refuses to answer select *client declines*.

Were HIV test results positive?

If the client has been tested for HIV, indicate whether or not the test was positive. If the client refuses to answer select *client declines*.

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.

Specify other STD

If other was selected for STD, enter the name of that disease.

Is client being treated for STDs?

If the client has a sexually transmitted disease, indicate whether or not the client is currently being treated for that disease. If the client refuses to answer select *client declines*.

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*.

Is client a medical risk?

Indicate whether or not the client is a medical risk according to the Medicaid Risk Assessment.

Is client a nutritional risk?

Indicate whether or not the client is a nutritional risk according to the Medicaid Risk Assessment.

Is client a psychosocial risk?

Indicate whether or not the client is a psychosocial risk according to the Medicaid Risk Assessment.

Select a Client:	Demo, Ima G.	125100107	Adm ID:	125100119
Master	History	Misc.	Assessment	Comments
Comments:				
<div style="border: 1px solid black; padding: 5px;"> this is a comment </div>				
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 #:
Street Address:	<input type="text" value="123 Sesame"/>		Apt #:	<input type="text" value="123"/>
City:	<input type="text" value="Ames"/>	State:	<input type="text" value="Iowa"/>	Zip Code:
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. If a discharge record does not already exist for this client you will see a list of all admissions on the HISTORY tab of this form. Use the *Client ID* and *Admission Date* to find the admission record that you want to edit or enter information for and click on the **DISCHARGE** button.

If an admission record does not exist for this admission record, a pop up box will appear and prompt you as to whether or not you would like to create a discharge record at this time. Click on the **YES** button. The record will be created and you will be moved to the **Misc.** tab.

Begin entering the discharge information on the Misc. screen.

The screenshot shows a software interface for entering discharge information. At the top, there is a client selection dropdown menu showing 'Time, Justine' and a text box with the ID '125100108'. To the right, the 'Adm ID' is '125100120'. Below this is a navigation bar with tabs: 'Master', 'History', 'Misc.', 'Child Info', 'Health', 'Outcome', and 'Comments'. The 'Misc.' tab is active. The main form area contains several fields:

- Discharge Date:** A text input field.
- Were services terminated prior to delivery?:** A dropdown menu.
- If yes, reason:** A dropdown menu.
- Payment Source:** A dropdown menu with the instruction '(select all that apply)'. There is a small 'add' button with a plus sign and a 'cancel' button with an 'x'.
- Other reason (specify):** A text input field.
- Other payment source (specify):** A text input field.
- WIC certified?:** A dropdown menu.
- Did client attend childbirth education classes?:** A dropdown menu.
- Delivery date:** A text input field.
- Multiple birth?:** A dropdown menu.
- How many births?:** A dropdown menu with '0' selected.
- Complications with pregnancy?:** A dropdown menu.
- Comments:** A large text area.
- Is mother currently breastfeeding?:** A dropdown menu.
- Where delivered:** A dropdown menu.
- Other delivery place (specify):** A text input field.

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.

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

Maternal death- any death occurring while a woman is pregnant or within 6 months of delivery

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

Therapeutic abortion- the termination of a pregnancy with 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

Payment Source At Discharge

Choose all of the 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. To delete an option selected in error, click on the button with the red X to the right of that option.

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.

Attending Childbirth Education Classes

Indicate whether or not the client is attending childbirth education classes.

Attending Parenting Education Classes

Indicate whether or not the client is attending parenting education classes.

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.

Where Delivered

Select the type of delivery place from the list. If the correct response is not on the list, select *other* and enter that delivery place at the prompt *other delivery place (specify)*.

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.

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 software interface for a client record. At the top, it says 'Select a Client: Britt, Chantel' and 'Adm ID: 114100260'. Below this are tabs for 'Master', 'History', 'Misc.', 'Child Info', 'Health', 'Outcome', and 'Comments'. The main form area contains several sections of questions with dropdown menus and text input fields. The 'Smoke cigarettes?' section has 'no' selected for 'Smoke cigarettes?' and '10-20' for 'How many?'. The 'Drink alcohol?' section has 'yes' selected for 'Drink alcohol?' and 'never' for 'How often?'. The 'Use drugs?' section has 'no' selected for 'Use drugs?' and 'marijuana' entered in the 'What drugs?' field. The 'HIV/AIDS' section has 'yes' selected for 'Tested for HIV/AIDS?' and 'yes' for 'Were results positive?'. The 'STDs' section has 'no' selected for 'Does client have STDs?' and 'cytomegalovirus' and 'hepatitis' listed in the 'What STDs?' field. The 'Medical, Nutritional, and Psychosocial Risks' section has 'yes' selected for 'Is client being treated for STDs?', 'yes' for 'Partner treated for STDs?', 'yes' for 'Is client a medical risk?', 'no' for 'a nutritional risk?', and 'unknown' for 'a psychosocial risk?'.

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.

Has client been tested for HIV/AIDS?

Indicate whether or not the client has been tested for HIV. If the client refuses to answer select *client declines*.

Were HIV test results positive?

If the client has been tested for HIV, indicate whether or not the test was positive. If the client refuses to answer select *client declines*.

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.

Specify other STD

If other was selected for STD, enter the name of that disease.

Is client being treated for STDs?

If the client has a sexually transmitted disease, indicate whether or not the client is currently being treated for that disease. If the client refuses to answer select *client declines*.

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*.

Is client a medical risk?

Indicate whether or not the client is a medical risk according to the Medicaid Risk Assessment.

Is client a nutritional risk?

Indicate whether or not the client is a nutritional risk according to the Medicaid Risk Assessment.

Is client a psychosocial risk?

Indicate whether or not the client is a psychosocial risk according to the Medicaid Risk Assessment.

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

Master | History | Misc. | Child Info | Health | Outcome | Comments

Will client receive postpartum home care? Date of postpartum visit:

Attending parenting education classes?

Family planning arrangements: Other birth control (specify)


Number of prenatal contacts:

Number of nursing contacts:

Number of nutrition contacts:

Number of social work contacts:

Number of dental contacts:

Enhanced services provided: 

Will client receive postpartum home care?

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

Date of postpartum visit

Enter the date of the postpartum contact.

Primary Provider Name

Enter the name of the primary care provider.

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.

Number Of Prenatal Contacts

Enter the number of prenatal contacts for this pregnancy.

Number Of Nursing Contacts

Enter the number of nursing contacts for this pregnancy.

Number Of Nutrition Contacts

Enter the number of nutrition contacts for this pregnancy.

Number Of Dental Contacts

Enter the number of dental contacts for this pregnancy.

Number Of Social Work Contacts

Enter the number of social work contacts for this pregnancy.

Enhanced Services Provided

Select from the list the enhanced services that have been provided for this pregnancy. To delete an option selected in error, click on the button with the red X to the right of that option.

Select a Client: **Adm ID:**

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"/>

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 Dental Information Form

Information is entered into the Dental Information form once during service. When you open the dental form the first tab visible will be the Dental Info tab. This tab contains most of the dental questions asked.

The screenshot shows the 'Dental Info' tab of a software interface. It contains the following sections:

- Interview Questions:** Includes dropdowns for 'Does client have a dentist of record?' (Yes), 'Has client been to dentist within past year?' (Yes), 'What type of service did the client seek at their last dental encounter?' (Emergent), 'Where was the service received?' (Public Health), and 'What type of dental insurance does the client have?' (Private).
- Services Provided At Maternal Health Center:** Includes a dropdown for 'Was an oral screening/assessment provided?' (yes) and another for 'If so, who provided the screening/assessment?' (RDH/DDS).
- Assessment/Screening Findings:** Includes dropdowns for 'Was gingival inflammation present?' (yes), 'Were restored teeth present?' (yes), 'Were bleeding gums present?' (yes), and 'Was suspicious decay present?' (yes).
- Services:** A list of services with checkboxes: Fluoride, Prophy, and Oral Hygiene Instruction.
- Xylitol Project:** A dropdown for 'Is the client participating in the xylitol project?' (no).

Enter for all clients the responses to the following questions. All responses are required. Once you begin to enter information for a client you will not be able to leave the record without completing all questions.

Does the client have a dentist of record?

Has client been to the dentist within the past year?

What type of service did the client seek at their last dental encounter?

Where was the service received?

What type of dental insurance does the client have?

Services Provided At Maternal Health Center

Was an oral screening/assessment provided? If dental services are not being provided by your agency enter no. If no is entered here, responses will not be required for the rest of the questions.

If so, who provided the screening/assessment?

Assessment/Screening Findings: Indicate whether or not the following conditions were present

Was gingival inflammation present?

Were bleeding gums present?

Were restored teeth present?

Was suspicious decay present?

Services: Choose from the list all of the services provided by your agency.

The screenshot shows the 'Xylitol Project' section of the form, which includes:

- A dropdown for 'Is the client participating in the xylitol project?' (yes).
- Dropdowns for 'Which xylitol product did the client receive?' and 'What stage of pregnancy did client begin receiving xylitol?'.
- A dropdown for 'At the time of followup, was the client compliant with the xylitol protocol?'.
- A text area for 'What barriers did the client experience in following the xylitol protocol?'.

Some agencies are taking part in a xylitol gum study. If the client is a part of this project, answer "yes" to the xylitol project question and then additional project related questions will appear. If the client is not a part of the study enter "no" or leave blank.

Master History Dental Info **Comments**

Comments:

etertghhhhhhhhhhhhhhh

Form completed by: Date completed:

Data entered by: Date entered:

QA inspection by: Date of inspection:

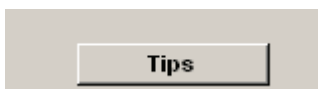
The comments tab is available for additional information or to track the name of the person completing the form.

Master History Dental Info **Comments**

Below is a list of all the the times that a client has received services. You will see the Admission ID, the admission date, the subcontractor that provided the service and the program. 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.

	Admission ID	Admission Date	Discharge Date	Subcontractor	Program	
View	122101005	1/1/2008		Test Clinic	Postpartum Visit Only	Print
View	122101004	1/1/2007		Test Clinic	Women's Health	Print
View	122100464	2/11/2003	6/26/2003	Test Clinic	Maternal Health	Print

If you want to enter or view information from a previous admission (if the client has been served more than once) go to the history tab and click on the view button to the left of that admission.



Help for common tasks is available by clicking on the Tips button.

The Time Input Form

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

History

Below is a list of all participations for this client. To view information for a participation click on the "View" button to the left of that record. All of the contact records for the participation selected will appear on the form at the bottom of this tab.

	Admission ID	Date Assigned	Subcontractor Assigned
View	122101005	1/1/2008	Test Clinic
View	122101004	1/1/2007	Test Clinic
View	122100464	2/11/2003	Test Clinic

Below is a list of all contacts for this client. To view more information for the contact click on the "View" button to the left of that record.

	Admission ID	Contact Date	Contact #	Service Provider	
View	122101005	2/1/2008	1		Add A New Contact Date
View	122101005	2/1/2008	2	sfsdf	Print All Contact Info
View	122101005	3/1/2008	3		Print Contact Info For Service Date
View	122101005		4		Print Contact Info For Service Date

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

You may print all of the contact information for an admission by clicking on the *Print All Contact Info* 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.

When you open the Time Input form you will see the History Tab. The top section of this tab lists all of the admissions for the client. The most recent admission is the default. The bottom half of the tab will display contacts for this admission. If you want to view contacts from an earlier admission, click on the view button to the left of that admission.

The bottom section lists all contact days for an admission. You may either view an existing contact or add a new one.

To add a new contact click on the *Add a New Contact Date* button. A new contact record will be created and you will go to the Contact Info tab. Enter the service date and county of service. The Primary Payment Source will carry over from the intake form. Changing the payment source on this form will also change it on the intake form.

Service and time information is entered in the bottom section of this tab.

History Contact Info Comments

Service Date: County of service:

Primary Payment Source: CHAMPUS Secondary Payment Sources: county funds Emergency Medicaid grant funds

Other insurance (specify):

Service Category: Not Indicated Service:

Interaction type: Time in: Time out: Time spent:

When entering service and time information first select a **Service Category**. Depending on which category is selected a different list of services will be available. Select the **Service** provided. If more than one service is provided in a day go to the next line and add that additional service.

If you are entering services for a different day, go back to the History tab and add a new contact date.

Enter the Interaction Type by choosing an option from the list.

When entering **Time In** or **Time Out** enter the time in hour and minutes. Use the space bar to move between hours and minutes. Make sure to enter *am* or *pm* after the time. AM will be the default. Time spent will be calculated from the Time In and Time Out entries.

You cannot delete a service line. You may however remove the time information and change the service category to not indicated if the record was entered in error. You can delete an entire day by going to the System Maintenance/Delete Records form.

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.

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.

Reports And Descriptions

Active Caseload Counts

Count reports showing number of inservice, new admissions, re-admission and discharges in the date range selected. This report summarizes the counts for all agencies.

Age At Admission

This report shows the age status at admission for clients admitted in the date range selected. It also shows the age at admission for clients in service in the date range selected and those discharged in the date range.

All Clients Missing Outcome Info 60 Days Past Due Date

Listing of all participants where the due date is past 60 days and a discharge date is missing. Listing includes name, address, phone, admission date, discharge date and due date. Report breaks and totals by subcontractor.

Birthweight By Dental Screening Results

Report shows the total number of unduplicated clients by birthweight at delivery and the response to dental screening. Dental screening results are shown in columns and birthweights are shown in rows. Clients are selected based on discharges in the date range selected.

Birthweight Ranges

This report shows the birthweights for infants born to mothers discharged in the date range selected.

Birthweight Ranges For Children Of Smokers

This report shows the birthweights for infants born to mothers who indicated they smoked and were discharged in the date range selected.

Breastfeeding At Delivery

This report shows the breastfeeding status at discharge for clients discharged in date range selected.

Check Admissions - Counts By Agency

Counts of all participants admitted date range selected. Report breaks by agency.

Check Admissions - Counts By Subcontractor By Month

Counts of all participants admitted in the date range selected. Report breaks by agency and subcontractor.

Childbirth Education Status At Discharge

The report shows the number of women reporting that they attended childbirth education classes from the discharge form.

Childbirth Education Status For Clients Inservice

The report shows the number of women inservice reporting that they attended childbirth education classes on the intake form.

Childbirth Statistics For Clients Discharged In Range

Columns on report include total unduplicated clients, live births under 2500 grams, live births greater than or equal to 2500 grams, number of fetal deaths, neonatal deaths, spontaneous abortions and therapeutic abortions. The categories include total clients, and break out detail by age, any combination of high risk factors, education level, ethnicity, marital status, medical risk, nutritional risk, parity, payment source, prenatal visits, psychosocial risk, race, trimester entered care and type of birth. It should be noted that clients could indicate more than one type for payment source and race. The total of all records in these categories may not equal the total number of unduplicated clients. The report can be generated for one specific agency or all agencies.

Client Time Audit

Report shows a detail list of services received in the date range selected with client name, time in, time out and minutes of service.

Clients Admitted In Date Range By Subcontractor - Detail

Listing of all participants admitted in the date range selected. Listing includes name, address, phone, admission date, discharge date and due date. Report breaks by subcontractor and includes counts.

Clients Discharged In Date Range By Subcontractor - Detail

Listing of all participants discharged in the date range selected. Listing includes name, address, phone, admission date, discharge date and due date. Report breaks by subcontractor and includes counts.

Clients In Service (Labels)

Labels for all participants in service in the date range selected. Report is in a standard format for mailing labels 3 across.

Clients In Service In Date Range - Detail

Listing of all participants in service in the date range selected. Report breaks by agency and subcontractor and includes counts.

Clients In Service In Date Range By Payor - Detail

Listing of all participants in service at some time in the date range selected. Listing includes name, address, phone, admission date, discharge date and due date. Report breaks by primary payor and includes counts of participants for each payor.

Clients In Service In Date Range By Subcontractor - Detail

Listing of all participants in service at some time in the date range selected. Listing includes name, address, phone, admission date, discharge date and due date. Report breaks by subcontractor and includes counts.

Clients In Service With Depression Issues - Counts

Counts of all participants in service at some time in the date range experiencing a depression issue. Depression issues include:
Indicated participant was screened for depression on intake or discharge
Indicated "mental health" as a need on Needs Assessment form
Indicated "postpartum depression" as a need on Needs Assessment form
Indicated taking antidepressants on Intake or Tracking form. Report shows counts for several combinations of language status and age. If a participant has any of the depression issues listed above they are included in the "At Least One Depression Issue" column. The "Total Clients" column shows counts of all participants in service in the age/language status group whether or not they have a depression issue.

Clients In Service With Depression Issues - Detail

Listing of all participants in service at some time in the date range experiencing a depression issue. Depression issues include:
Indicated participant was screened for depression on intake or discharge
Indicated "mental health" as a need on Needs Assessment form
Indicated "postpartum depression" as a need on Needs Assessment form
Indicated taking antidepressants on Intake or Tracking form

Clients In Service With Due Dates - Detail

Listing of all inservice participants with due dates within the date range selected. Listing includes name, address, phone, admission date, discharge date and due date. Report breaks by subcontractor and includes counts.

Clients Referred In Date Range But Not Served - Detail

Listing of all participants referred in the date range selected but for whom "Will Services Be Provided" is no. Listing includes name, reason not served and referral date.

Clients Referred Within Date Range

Listing of all referrals in the date range selected. Listing includes name, address, phone, contact date and admission status.

Clients Transferred To State In Date Range - Counts

Counts of all participants transferred to state in the date range selected. The report looks at 4 tables for records transferred, the client table, the referral table, the admission table and the discharge table. Report breaks by agency and subcontractor.

Clients Transferred To State In Date Range - Detail

Listing of all participants transferred to state in the date range selected. The report looks at 4 tables for records transferred, the client table, the referral table, the admission table and the discharge table. Report breaks by agency and subcontractor and includes counts.

Contacts - Outcome Summary

This report shows counts of prenatal contacts, nursing contacts, nutrition contacts, social work contacts and dental contacts for participants discharged in date range indicated.

Country Of Origin For Hispanic Clients

This report shows the country of origin of Hispanic participants in service in the date range selected.

County of Residence At Discharge By Primary Race

Report shows the number of clients at discharge (based on the date range selected) by primary race by county of residence. Counties are listed in row and race categories are listed in columns. This report can be generated for one specific agency or all agencies, with each agency on a separate page.

Dental Insurance Status For Clients Discharged In Range

Reports shows the total number of clients discharged in date range and dental insurance types. The report shows the unduplicated counts and percents of dental insurance types.

Dental Services Accessed At Maternal Health Center

Reports shows the total number of clients discharged in date range who received dental services. The report shows the unduplicated counts and percents of clients receiving each service.

Dental Services Received At Last Dental Visit

Reports shows the total number of clients discharged in date range and the type of dental service accessed at the last dental visit. The report shows the unduplicated counts and percents of clients receiving each service.

Dental Services Where Received At Last Dental Visit

Reports shows the total number of clients discharged in date range and where the dental service was accessed at the last dental visit. The report shows the unduplicated counts and percents of clients receiving service at each location.

Education Level

This report shows the education status at admission for clients admitted in the date range selected. It also shows the education status at admission for clients in service in the date range selected and those discharged in the date range.

Enhanced Services All Agencies - Discharged In Range

Reports shows the total number of clients discharged in date range who received enhanced services (as indicated on the Outcome Summary). The report shows the unduplicated counts and percents for all agencies combined. The report will only show enhanced services that were provided. Duplicate clients have been eliminated on this report.

Enhanced Services By Agency - Discharged In Range

Reports shows the total number of clients discharged in date range who received enhanced services (as indicated on the Outcome Summary). The report also shows the percent of the total unduplicated clients receiving each service. The report will only show enhanced services that were provided. Duplicate clients have been eliminated on this report.

Ethnicity Status

This report shows the ethnicity status of participants in service in the date range selected.

First Care Received - By Payment Source

This report shows counts of when first care was received by primary payment source at intake. Counts are shown for participants admitted in date range, discharged in date range and in service in date range.

First Care Received For Clients Admitted In Range - Detail

Listing of all participants admitted in the date range grouped by trimester that first care was received.

First Care Received Status

This report shows counts of when first care was received. Counts are shown for participants admitted in date range, discharged in date range and in service in date range.

Followups In Date Range- Detail By Client

Report shows a detail list of clients with followup dates in the date range indicated. Report groups clients by followup date Report includes service notes.

High Risk Pregnancies

This report shows the unduplicated count of clients scoring 10 or above on the Medicaid Risk Assessment. It looks at either the combined scores of A+B1 or A+B2. If a client scores 10 or above on either subtotal they are included in the high risk count. Report shows percent age of total clients in service.

Language Status

This report shows the language status of participants in service in the date range selected. Counts may be greater than the number of participants in service as multiple languages per participant are allowed.

Language Status Of "Other" Languages

This report shows the language status of participants in service in the date range selected who indicated "other" as language spoken. The language comes from the "Specify other language" field. All languages spelled exactly the same way will be group and counted. The percent field shows the percent of all indicating "other" as a response.

Marital Status

This report shows the marital status at admission for clients admitted in the date range selected. It also shows the marital status at admission for clients in service in the date range selected and those discharged in the date range.

Medical Home Status

This report shows the medical home status at discharge for clients discharged in date range selected.

Need Status

This report shows the need status of participants in service in the date range selected.

Need Status - Detail Listing

This report shows a detailed listing of needs identified, status, referral, referral mode and comments for all participants in service in the date range selected.

Outcome Statistics & Services For Discharged In Range

Reports show the break out of total number of Title XIX clients (as indicated on the payment source on the Outcome Summary) to total number of unduplicated clients. Numerous services and statistical information is available in summary format. It should be noted that each client may select more than one payment source. The total of the counts may not equal the number of clients discharged in the period selected. This report can be generated for one specific agency or all agencies, with each agency on a separate page.

Payment Source At Admission For All In Service

This report shows the total number of unduplicated clients by primary payment source indicated on the Intake Form. Clients are selected based being in service in the date range selected. Total and percent of total clients is shown for each primary payment source type.

Payment Source At Delivery By Agency

This report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary. Clients are selected based on discharges in the date range selected. Total and percent of total clients is shown for each payment source type. This report can be generated for one specific agency or all agencies, with each agency on a separate page.

Payment Source At Delivery For All Discharges

This report shows the total number of unduplicated clients by primary payment source indicated on the Outcome summary. Clients are selected based on discharges in the date range selected. Total and percent of total clients is shown for each payment source type.

Payment Source At Discharge By Delivery Place

Report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary form by Delivery Place. Delivery Place is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected.

Payment Source At Discharge By Delivery Place By Agency

Report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary form by Delivery Place. Delivery Place is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected. This report can be generated for one specific agency or all agencies, with each agency on a separate page.

Payment Source At Discharge By Dental Provider Frequency

Report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary form by clients response to "Has client been to the dentist in the past year?" Dental Provider Frequency is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected.

Payment Source At Discharge By Dental Provider Status

Report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary form by Dental Provider Status. Dental Provider Status is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected.

Payment Source At Discharge By Ethnicity By Agency

Report shows the total number of unduplicated clients by payment source indicated on the Outcome Summary form by Ethnicity. Ethnicity is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected. This report can be generated for one specific agency or all agencies, with each agency on a separate page.

Payment Source At Discharge By Hispanic/Non Hispanic

Report shows the total number of unduplicated clients by payment source indicated on the Outcome Summary form by Hispanic or Non Hispanic ethnicity. Ethnicity is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected.

Payment Source At Discharge By Postpartum Visits

This report shows counts of participants receiving postpartum home care by primary payment source. Counts are shown for participants discharged in date range.

Payment Source At Discharge By Primary Race All Agencies

Report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary form by primary Race. Race is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected. Report sorts and totals by agency.

Payment Source At Discharge By Primary Race By Agency

Report shows the total number of unduplicated clients by primary payment source indicated on the Outcome Summary form by primary Race. Race is shown in columns and payment sources are shown in rows. Clients are selected based on discharges in the date range selected. Report sorts and totals by agency.

Payment Source At First Visit By Agency

This report shows the total number of unduplicated clients by primary payment source indicated in the initial visits. Clients are selected based on discharges in the date range selected. Total and percent of total clients is shown for each payment source type. This report can be generated for one specific agency or all agencies, with each agency on a separate page.

Prenatal Care Status - By Payment Source

This report shows counts of clients receiving prenatal care by primary payment source at intake. Counts are shown for participants admitted in date range, discharged in date range and in service in date range.

Race Status - General

This report shows the general race status of participants in service in the date range selected. Counts may be greater than the number of participants in service as multiple races per participant are allowed.

Race Status - Primary

This report shows the primary race status of participants in service in the date range selected.

Race Status - Primary By Agency

This report shows the primary race status of participants in service in the date range selected. The report groups and totals by Agency Assigned.

Reason Terminated Prior to Delivery

This report shows counts of the reasons terminated for all participants who's service was terminated prior to delivery. The report includes only those terminated prior to delivery with a discharge date in the range indicated.

Reasons For Early Termination

This report shows the breakdown of discharges that were terminated prior to delivery based on reason indicated on Outcome Summary. This report summarizes the counts for all agencies.

Referral Status

This report shows the referrals made for participants in service in the date range selected.

Report Listing

This is a print out of all reports in the system along with their description.

Services Received In Date Range

Report shows counts of all services provided in date range, counts of participants receiving service (a participant may receive a service more than once) and the total time for the service. Report totals by service category.

Services Received In Date Range- Detail By Client

Report shows a detail list of clients receiving services in the date range selected. Report includes time and service notes.

Services Received In Date Range- Detail By Payor

Report shows a detail list of clients receiving services in the date range selected. Report includes time and service notes and groups and totals by payor at admission.

Smoking, Drugs & Alcohol Status

This report shows counts of participants reporting use of alcohol, drugs and tobacco. Counts are shown for participants admitted in date range, discharged in date range and in service in date range.

Translator Needed Status

This report shows counts of the number of participants needing a translator for those in service in the date range selected.

Translator Needed Status By County

This report shows counts of the number of participants needing a translator for those in service in the date range selected. Report breaks and totals by county.

Type of Delivery

This report shows counts of the delivery types for all live births for participants with a discharge date in the range indicated.

Validation Detail

Report shows a detail list of all of the clients stored in the database who's records are not completed sufficiently for submission to the state's Maternal and Child Health database. The report will display all of the fields that need to be completed for each client that is missing required data. Only those records that have been filled out completely will be sent to the state database. The records that are missing data required by the state will not be exported.

Validation Summary

Report shows the names of all of the clients stored in the database who's records are not completed sufficiently for submission to the state's Maternal and Child Health database. Only those records that have been filled out completely will be sent to the state database. The records that are missing data required by the state will not be exported. To see a list of the fields that are missing for each of the clients on this list run the Validation Detail report.

Weeks Pregnant at Admission

This report shows the number of weeks pregnant at admission for clients admitted in the date range selected. It also shows the number of weeks pregnant at admission for clients in service in the date range selected and those discharged in the date range.

WHIS- Risk Status

This report shows the counts for each risk indicated for participants in service in the WHIS program in the date range selected.

WHIS- Screening Status

This report shows the counts for each screening completed for participants in service in the WHIS program in the date range selected.

ADMISSION REPORTS

This category contains reports for clients admitted in date range

DATA CHECKING REPORTS

This category contains reports for checking data in a date range.

DENTAL REPORTS

This category contains reports for information from the Dental Intake form. All dental reports are for clients discharged in the date range unless otherwise indicated.

DISCHARGE REPORTS

This category contains reports for clients discharged in date range

GENERAL REPORTS

This category contains general reports not fitting into any of the other categories. The date range used in generating the report does not refer to admissions, discharges or inservice participants.

INSERVICE REPORTS

This category contains reports for clients in service in date range. 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 of the range. They must have been in service for at least one day during the date range selected to be included in these reports.

MULTI - LEVEL DATE RANGE REPORTS

This category contains reports that show statistics separately for admissions, discharges and inservice clients. All three groups are included on all reports in this category.

TIME REPORTS

This category contains reports for information from the Time Input form. All time reports are for clients in service in the date range unless otherwise indicated.

WOMEN'S HEALTH ONLY REPORTS

This category contains reports applicable to the Women's Health program only.

System Maintenance

All procedures other than data input and reporting are accessed from the System Maintenance menu. Depending on the privileges (set up on the password form) that have been assigned to a specific user, different buttons will appear on this menu. Each of the procedures available on the System Maintenance menu will be discussed on the following pages.

The screenshot shows a web-based interface titled "System Maintenance". It features a grid of buttons for various administrative tasks. The buttons are arranged in two columns. The left column contains buttons for "Delete Or Reactivate Records", "Subcontractor Functions" (with sub-buttons for "Import/Export For Subcontractor" and "Setup Subcontractor's Security"), and "Contractor Functions" (with sub-buttons for "Import/Export For Contractor", "Export Records To The State", and "Setup Contractor's Security"). The right column contains buttons for "Control File Maintenance", "Maintain Subcontractor Table", "Transfer Subcontractor Assigned", "Transfer Agency Assigned", "Supplemental Table Maintenance", and "Import Contractors To State Database". Each button has a small square icon to its left.

System Maintenance	
<input type="checkbox"/> Delete Or Reactivate Records	<input type="checkbox"/> Control File Maintenance
Subcontractor Functions	<input type="checkbox"/> Maintain Subcontractor Table
<input type="checkbox"/> Import/Export For Subcontractor	<input type="checkbox"/> Transfer Subcontractor Assigned
<input type="checkbox"/> Setup Subcontractor's Security	<input type="checkbox"/> Transfer Agency Assigned
Contractor Functions	<input type="checkbox"/> Supplemental Table Maintenance
<input type="checkbox"/> Import/Export For Contractor	<input type="checkbox"/> Import Contractors To State Database
<input type="checkbox"/> Export Records To The State	
<input type="checkbox"/> Setup Contractor's Security	

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 System Maintenance 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
122100877			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 System Maintenance 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 System Maintenance 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 System Maintenance 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 System Maintenance 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 System Maintenance 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.

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.

Before beginning the import or export procedure make sure that you have followed the instructions in the installation section of this manual and have created the necessary INBOX and OUTBOX folders.

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.
- The subcontractor transfers the datafile in the OUTBOX folder to the contracting agency. The data can be transferred by e-mail, diskette or a data transfer utility such as PCAnywhere.
- After transferring the file, the subcontractor should move the file from the OUTBOX folder to the OUTBOX/BACKUP folder. This will allow the subcontractor to better monitor the data transfer. Following this procedure, if a file exists in the OUTBOX folder then the subcontractor will know that it has not be sent to the contracting agency.
- The contracting agency receives the data and places it in the subcontractor's folder located in their INBOX folder. 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. (see installation of software)
- The contracting agency imports the data from each subcontractor into their master database.
- The contractor then exports data to each subcontractor. This is necessary so that each subcontracting agency has a complete client list. This will prevent duplication of clients.
- The subcontractor receives the data and places it in their INBOX folder.
- The subcontractor runs the import procedure and imports the data from the contracting agency.
- The subcontractor does data input and then repeats the export process.

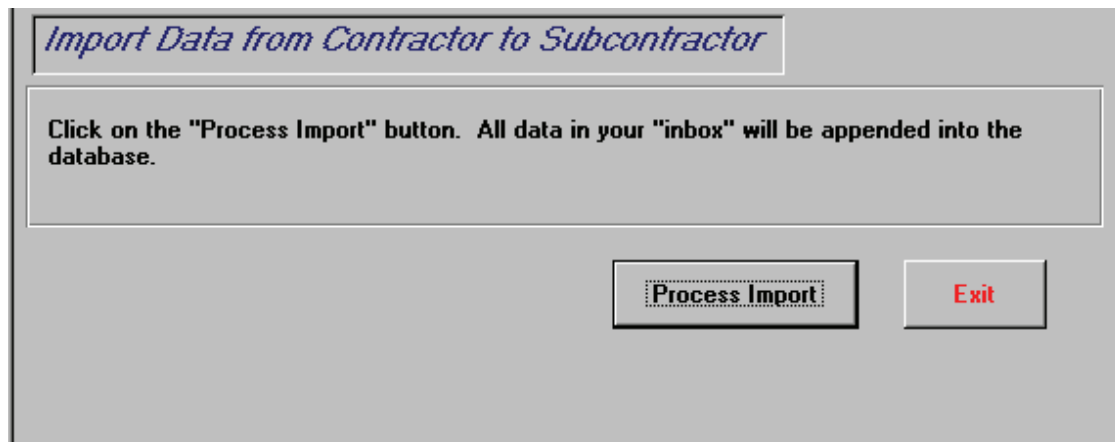
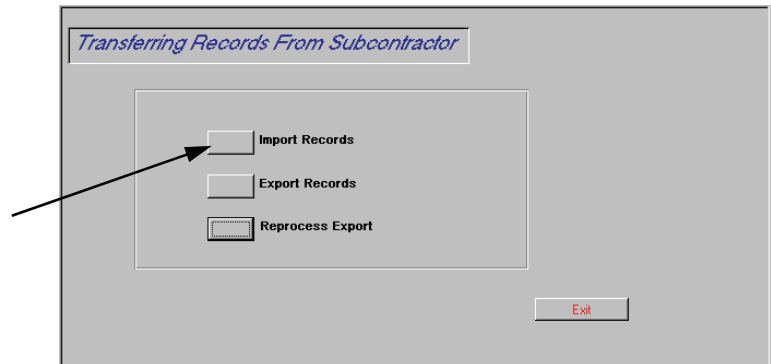
Once a month the data at the contracting agency is exported to the state database. This should be done after all of the data from the subcontracting agencies have been imported. This procedure is different from the import/export between contractors and subcontractors. There is no import of records from 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.

Import Procedure For The Subcontractor

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

- Take the data file that has been exported and transferred from the main database and put it in the C:/DPH/INBOX folder.
- Click on the *System Maintenance* button on the Main Menu
- Click on the *Import/Export From Subcontractor* button on the System Maintenance menu



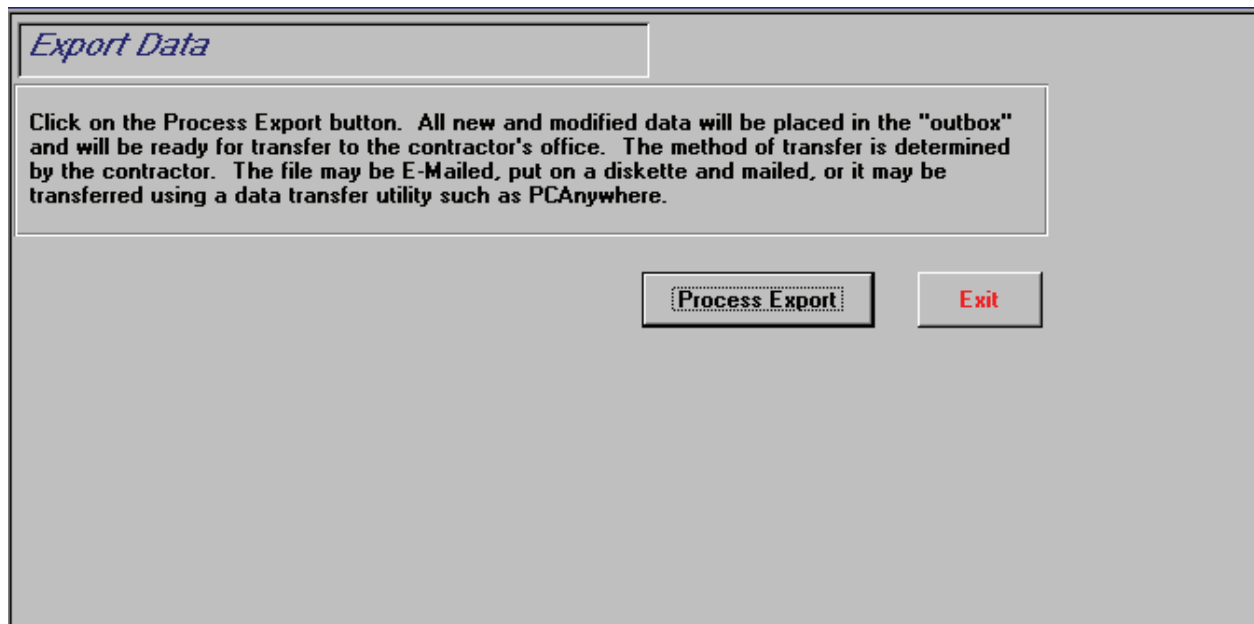
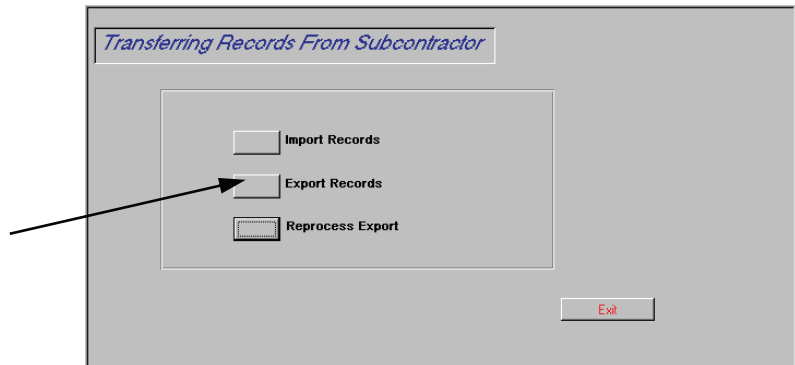
All of the records in the data file transferred will be imported into the subcontractor's database. If changes were made to a record at both the contractor's and subcontractor's sites since the last import, the record that was most recently modified will remain. Any other record will be overwritten. Any deletions made at the contractor's site will be deleted from the subcontractor's database.

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

Export Procedure For The Subcontractor

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

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



Click on the PROCESS EXPORT button.

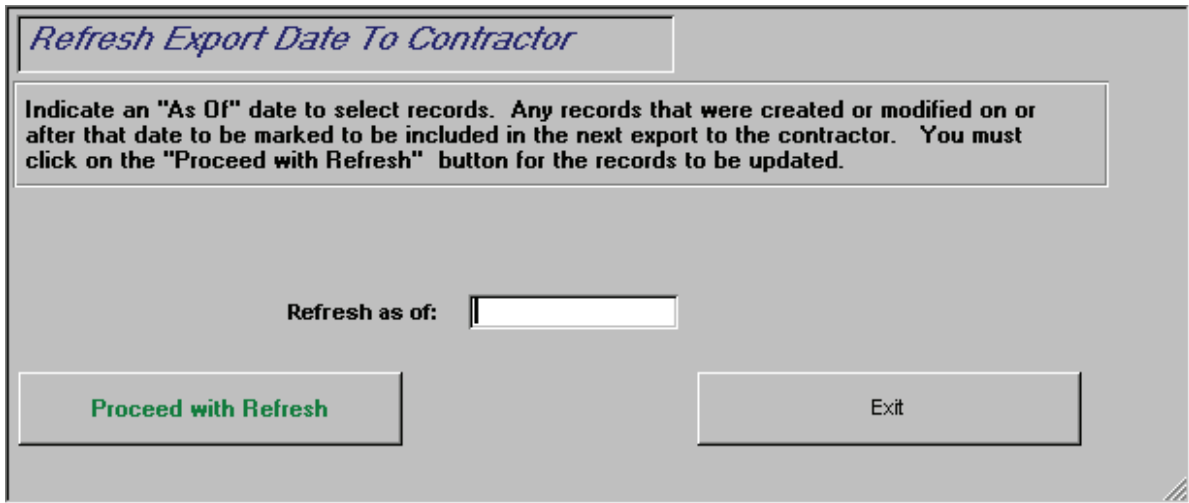
All records entered or changed since the last export procedure will be exported to a file in the C:/DPH/OUTBOX folder. This file must then be transferred to the contractor for import at their site. The method of transfer is up to the discretion of the contracting agency. You may move the file to a diskette, use E-Mail or a file transfer utility such as pcAnywhere.

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

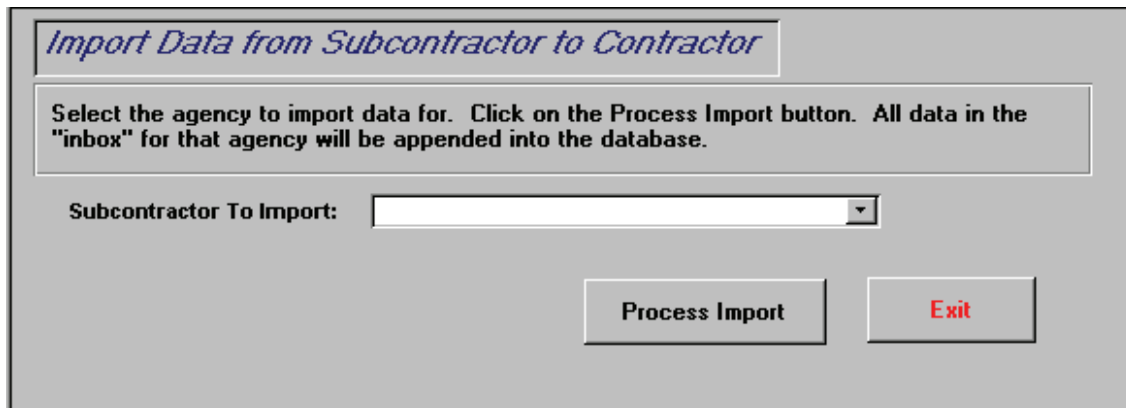


If for any reason you need to re-export records that have already been exported you may do that by clicking on the REPROCESS button on the *Import/Export From Subcontractor* form.

Enter the earliest date for which you want to re-export records. For example; if you exported on 4/1/2000 and also on 4/15/2000 and you want to re-export all of the records from both of these export procedure, enter 4/1/2000 at the **Refresh As Of** prompt.

Import Procedure For The Contracting Agency:

- Take the data file that has been exported and transferred from the subcontractor and put it in the C:/DPH/INBOX/Loc_?? folder. 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 *System Maintenance* button on the Main Menu
- Click on the *Import/Export For Contractor* button on the System Maintenance menu
- Click on the *Import Records* button.

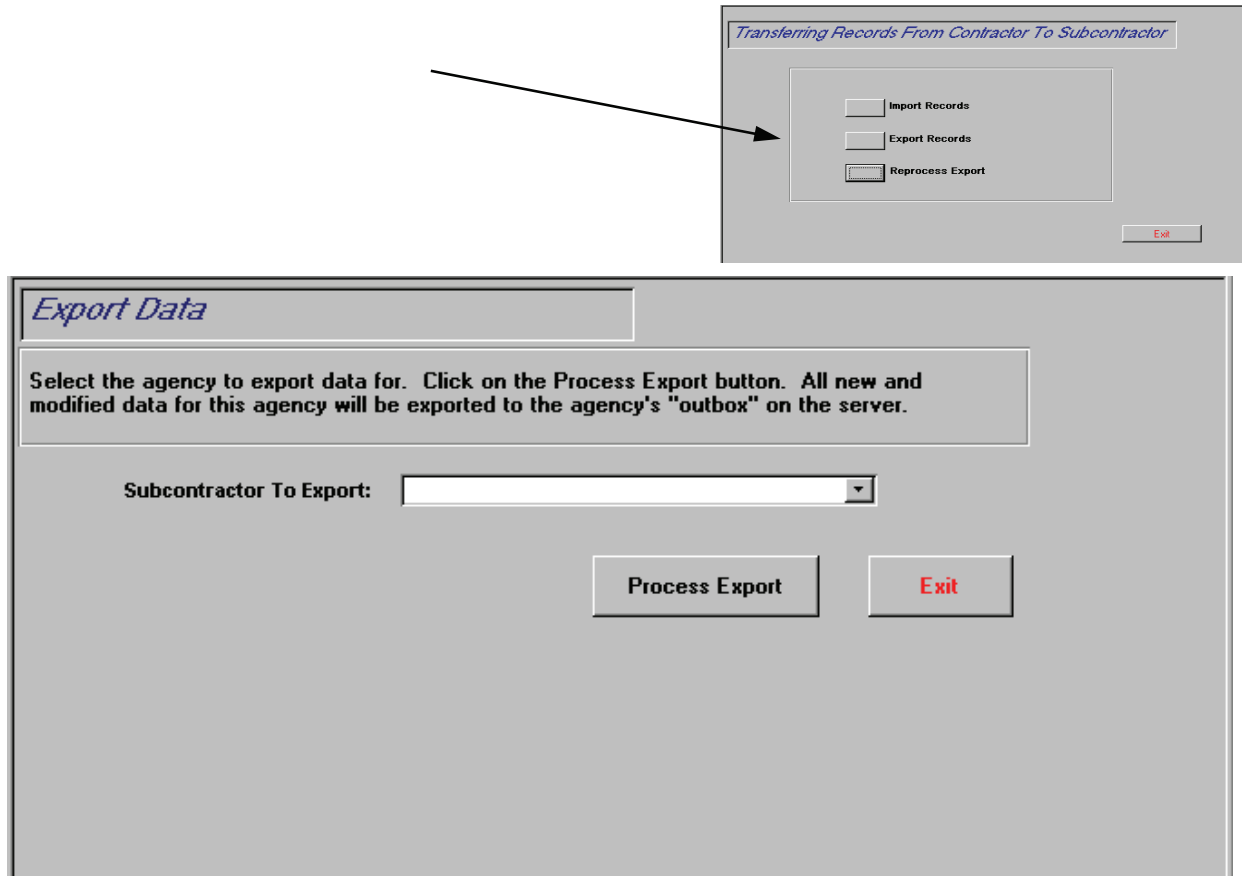


Select from the list the subcontractor that you want to import data for. Click on the PROCESS IMPORT button. All of the records in the file located in the subcontractor selected INBOX folder will be imported into the your database. If changes were made to a record at both the contractor's and subcontractor's 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:

- Click on the *System Maintenance* button on the Main Menu
- Click on the *Import/Export For Contractor* button on the System Maintenance menu
- Click on the *Export Records* button.



Select from the list the subcontractor that you want to export data for. Click on the PROCESS EXPORT button. All of the records applicable to the subcontractor selected will be exported to that subcontractor's folder located in the OUTBOX folder in the directory in which the software resides (Loc_??).

This procedure will export all of the client master information and any of the other information that has been added or modified since the last export to the subcontractor. Even if the subcontractor's data is not modified at the contractor's site, it is necessary to do regular exports in order for each subcontractor to receive a complete client list. This will help prevent duplication of clients.

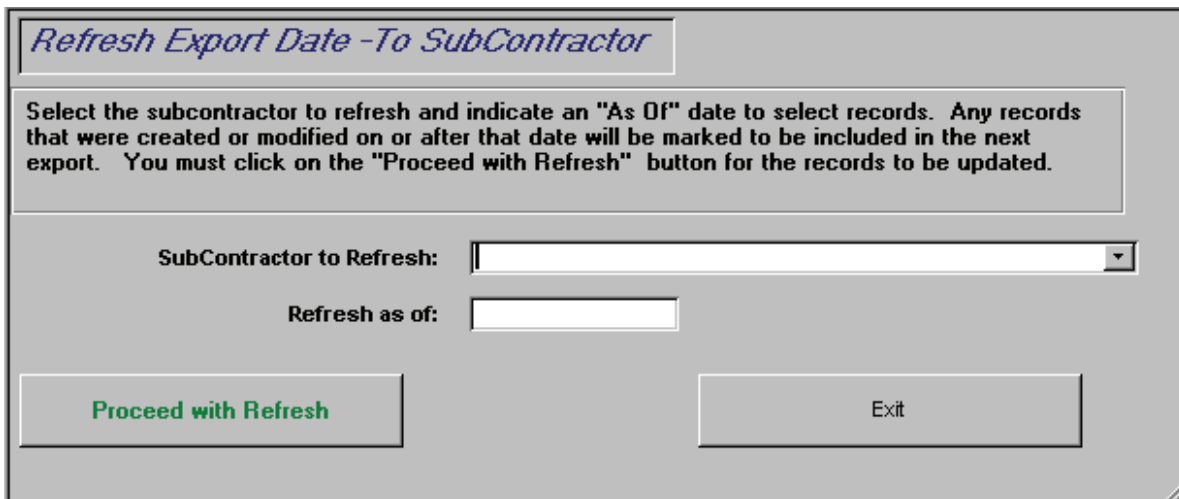
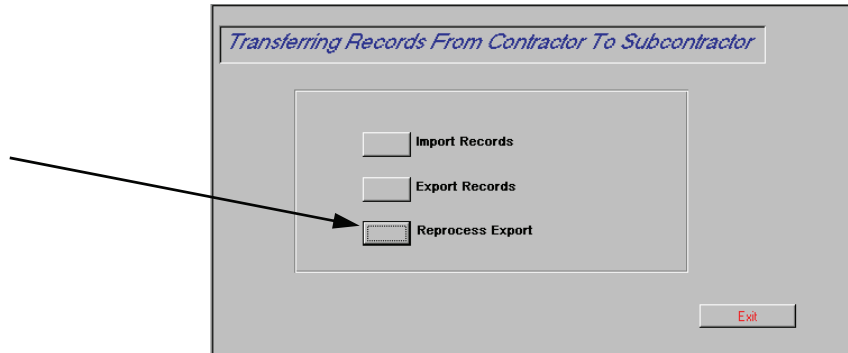
This file must then be transported to the subcontractor's location. The method of transfer is up to the discretion of the contracting agency. You may move the file to a diskette, use E-Mail or a file transfer utility such as pcAnywhere.

Once the file has been transferred, move it from the OUTBOX/Loc?? folder to the OUTBOX/Loc??/BACKUP folder. This is done to protect the export file in case it is lost during the physical transfer. Data files should be cleaned out of this backup folder on a periodic basis. This is done by deleting the oldest files in the folder. A new export can not be run if the file has not been moved to backup.

Reprocess Export For The Contractor

To reprocess an export for the contractor's site:

- Click on the *System Maintenance* button on the Main Menu
- Click on the *Import/Export For Contractor* button on the System Maintenance menu
- Click on the *Reprocess Export* button.



Refresh Export Date -To SubContractor

Select the subcontractor to refresh and indicate an "As Of" date to select records. Any records that were created or modified on or after that date will be marked to be included in the next export. You must click on the "Proceed with Refresh" button for the records to be updated.

SubContractor to Refresh:

Refresh as of:

Proceed with Refresh Exit

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.

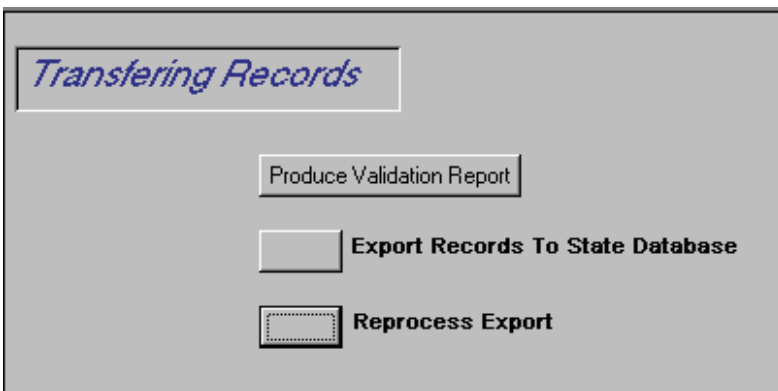
Enter the earliest date for which you want to re-export records. For example; if you exported on 4/1/2000 and also on 4/15/2000 and you want to re-export all of the records from both of these export procedure, enter 4/1/2000 at the **Refresh As Of** prompt.

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.

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 System Maintenance Menu and click on the *Export Records To State*.

You must have System privilege (set up on the password form) in order to have access to this function.



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 System Maintenance menu. You must have System privilege (set up on the password 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 C:/DPH/Outbox_State folder.

Move the file located in the OUTBOX_State folder to that Department of Public Health's state office. The method of transfer is up to the discretion of the state. You may move the file to a diskette, use E-Mail or a file transfer utility such as pcAnywhere.

Once the file has been transferred, move it from the OUTBOX_State folder to the OUTBOX_State/BACKUP folder. This is done to protect the export file in case it is lost during the physical transfer. Data files should be cleaned out of this backup folder on a periodic basis. This is done by deleting the oldest files in the folder.

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 4/1/2000 and also on 4/15/2000 and you want to re-export all of the records from both of these export procedure, enter 4/1/2000 at the **Refresh As Of** prompt.

Setting Up Passwords Subcontracting Agencies

To access, click on **Setup Subcontractor's 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 two types of workgroups that you may choose from, *Administrator* and *Data Entry*. Users that are set up with the workgroup, *Data Entry*, will not have access to all of the functions on the System Maintenance menu.

At least one person at each site must be set up with the workgroup Administrator. This person will be able to change password and import/export records. Two sample users are currently in the table. For security purposes you may want to change or delete these users.

Maintain Passwords

Enter the user's name and password. Assign the user to a workgroup. The Administrator workgroup has access to many of the system maintenance functions. Most users should be assigned to the Therapist workgroup. The Employee ID field is for agency use only.

	User Name	Password	Workgroup	Employee ID
▶	Administrator	admin	Administrator ▼	0
	Data Entry	User	Data Entry ▼	0
*			▼	0

Setting Up Passwords Contracting Agencies

To access, click on **Setup Contractor's 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 all of the functions on the System Maintenance menu. At the contracting agency there is no reason to set up a user with the workgroup *Administrator*. This workgroup is for use at the subcontracting agencies. This workgroup has more privileges than the *Data Entry* workgroup, but less than the *System*.

At least one person at each site must be set up with the workgroup *System*. This person will have access to all of the functions on the System Maintenance menu, including changing passwords, import/export and processing the export for the state database. Three sample users are currently in the table. For security purposes you may want to change or delete these users.

Maintain Passwords

Enter the user's name and password. Assign the user to a workgroup. The Administrator workgroup has access to many of the system maintenance functions. Most users should be assigned to the Therapist workgroup. The Employee ID field is for agency use only.

	User Name	Password	Workgroup	Employee ID
▶	System	chief	Systems	10
	Administrator	admin	Administrator	0
	Data Entry	User	Data Entry	0
*				0

Control File Maintenance

Subcontracting Agencies

Setting up the control file correctly is essential. If the control file is not set up correctly it is possible that duplicate IDs will be assigned and records could be lost during the import/export procedure.

The screenshot shows a web form titled "Control File Maintenance" in a blue box. Below the title is a grey box containing instructions: "Complete the information before starting any input into the applications. If you are a contractor and your name is not found in the contractor list, call the State DPH before proceeding. If you are a subcontractor and your agency is not in the subcontractor list, contact the contractor before proceeding to obtain your subcontractor control number. PLEASE verify all information before proceeding with control file setup!!!!". Below this is a question: "Is this location a Contractor or Sub-Contractor agency?" with a dropdown menu set to "Subcontractor". There are two sets of input fields: one for "Contractor:" with a dropdown and two text boxes, and one for "Your agencies name:" with a dropdown and two text boxes. At the bottom is a button labeled "Proceed with Control File Setup".

If your agency is a subcontracting agency, select *Subcontractor* at the first prompt.

Contractor: Select the contracting agency that your agency reports to. Review your response to make sure that you choose the correct response from the list.

Your Agency's name: Select the name of your agency from the list. Review your response to make sure that you choose the correct response from the list.

Proceed with Control File Setup: Click on this button to setup the control file with the responses that you selected. **Make sure that you review all of your responses before clicking on this button.**

You will not be able to change the control file once you have clicked on this button.

If your agency's name is not on the list follow this procedure:

- Select not on list from the drop down list
- Call your contracting agency to get the number assigned to your agency. The contracting agency must also set this number up in their subcontractor table.
- Type the number assigned by the contractor in the smaller box on the left of the last prompt line. This is a five digit number. The first three digits of this number **must** be the number assigned to your contracting agency. You will see this number in the box after **CONTRACTOR** on this form. The last two digits must be between 11 and 99.
- Type the name of your agency in the larger box on the right of the last prompt line.
- Click on the **PROCEED WITH CONTROL FILE SETUP** button at the bottom of the form.

Control File Maintenance Contracting Agencies

Setting up the control file correctly is essential. If the control file is not set up correctly it is possible that duplicate IDs will be assigned and records could be lost during the import/export procedure.

The screenshot shows a web-based form titled "Control File Maintenance". At the top, there is a header box with the title. Below it is a large text box containing instructions: "Complete the information before starting any input into the applications. If you are a contractor and your name is not found in the contractor list, call the State DPH before proceeding. If you are a subcontractor and your agency is not in the subcontractor list, contact the contractor before proceeding to obtain your subcontractor control number." Below this is a warning: "PLEASE verify all information before proceeding with control file setup!!!!". The main form area has a question: "Is this location a Contractor or Sub-Contractor agency?" with a dropdown menu currently set to "Contractor". Below this is a section labeled "Contractor:" with a dropdown menu and two empty input fields. At the bottom of the form is a button labeled "Proceed with Control File Setup".

If your agency is a contracting agency, select *Contractor* at the first prompt.

Contractor: Select the name of your contracting agency. Review your response to make sure that you choose the correct response from the list.

Proceed with Control File Setup: Click on this button to setup the control file with the responses that you selected. **Make sure that you review all of your responses before clicking on this button. You will not be able to change the control file once you have clicked on this button.**

If your agency's name is not on the list contact the state Department of Health. The contracting agencies must be assigned at the state.

Maintain Subcontractor Table (Contracting Agencies Only)

All subcontracting agencies that report to your agency must have a number assigned in this table. The first number in this table is assigned to the contracting agency. The first three digits of this number is the ID assigned to the contracting agency and the last two digits are "10".

All other subcontracting agencies must have a five digit number assigned. The first three digits of this number must be the contractor's three digit ID number. The last two digits must be between 11 and 99. If a new subcontractor is added to your agency, they must have a new number assigned. The contractor should assign and enter the number in the SUBCONTRACTOR MAINTENANCE table prior to sending the new software to the subcontractor for installation. The subcontractor will need to use the number assigned by the contracting agency in order to set up their control file.

Care must be taken that the same number assigned in this table is used when the subcontractor sets up their control file. If the subcontractor uses a number that has been assigned to another agency, duplicate Client IDs will be assigned and records will be lost during the import/export process.

Records may not be deleted from this table. If a subcontractor is entered in error, or is no longer associated with your agency, change the **STATUS** to *inactive*.

Subcontractor Table Maintenance					
ID	Sort Order	Subcontractor (Full Name)	Subcontractor (Short Name)	Status	
▶ 12510		Marshalltown Medical & Surgical Center, Mc	Marshalltown Medical & Si	active	▲
12520		Subcontractor 20	Subcontractor 20	active	▼
12530		Subcontractor 30	Subcontractor 30	active	▼

Record: ◀▶ 1 ▶▶▶* of 5

Exit

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 Exit

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.

Transfer Agency Assigned (State Only)

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

Upon creation an admission record is assigned to a specific subcontractor and agency. If sometime during the service period that agency should change, this form gives the state the ability to transfer the client to the new agency. An audit table is created to monitor all agency transfers. This table is CTS_tblParticipationTransfer and can be found in the DHSDAT.MDB database.

Transfer Agency Assigned

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

Select a Client:

Select Admission:

Transfer To Agency:

Comments:

Apply Transfer Exit

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 Agency: Select the agency 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 agency assigned for this client.

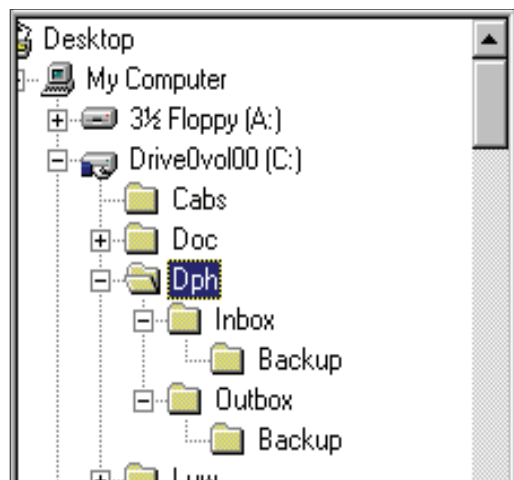
Installation Procedure (Subcontracting Agencies)

For Subcontractors:

Before installing the software check to see if the computer that you are installing on has Access 97 loaded on it. There are two different distributions. One is a runtime version and one is a non-runtime version. If the computer has Access 97 installed, load the software from the non runtime distribution.

Install the software in a directory named "DPH" on the C drive if possible. To install, insert the CD, from the start menu choose **Run**. Click on the **Browse** button and locate **SETUP.EXE** on your CD drive. Click on the **OK** button. Follow the prompts, installing in the default directory where possible.

After installing the software, create the following folders in the directory in which the software was installed: **Inbox** and **Outbox**. Under both the Inbox and the Outbox folders create a folder called **Backup**.



Open the software and allow the attachment manager to attach all of the tables.

Login as "Admin"

Enter the password "Admin"

Enter the control file information

Click on the **Control File Maintenance** button. Enter the information for this agency. (See the Control File Maintenance section of this manual)

Set up user security

Go the **System Maintenance** menu.

Click on **Set-up User Security**.

Enter names and passwords for all users at the site. Make sure that at least one person has administrative privileges. This is done by setting the workgroup for at least one person to *Administration*. (See the Setup Password section of this manual)

Installation Procedure (Contracting Agencies)

For Contractors:

Before installing the software check to see if the computer that you are installing on has Access 97 loaded on it. There are two different distributions. One is a runtime version and one is a non-runtime version. If the computer has Access 97 installed, load the software from the non runtime distribution.

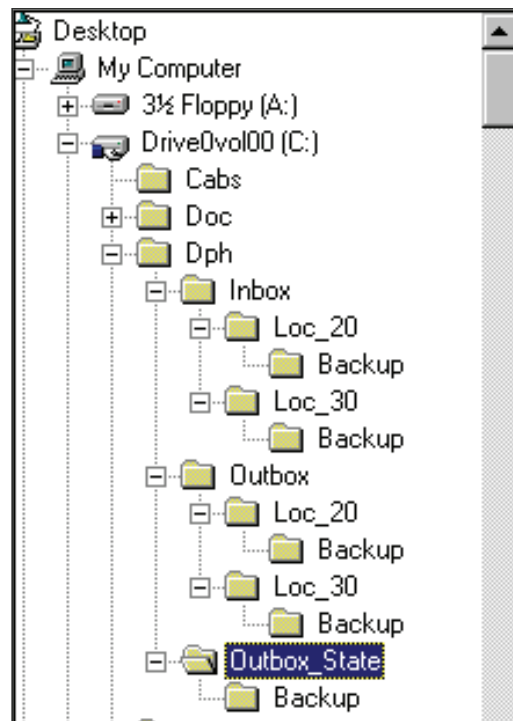
Install the software in a directory named "DPH" on the C drive if possible.

After installing the software, create the following folders in the directory in which the software was installed: **Inbox** and **Outbox**. Under both the Inbox and the Outbox folders create a folder for each subcontractor assigned to your agency.

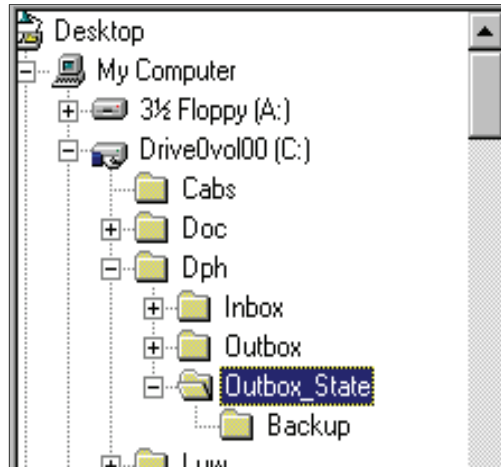
Each subcontractor must have a two digit ID. This ID must be a number between 11 and 99. Assign each of your subcontractors an ID and make a note of this ID.

Create directories for each subcontractor named Loc_?? where the ?? are replaced by the subcontractor's ID. Under each Loc_?? folder create a folder called **Backup**.

Create a folder called **Outbox_State**. Under this folder create a folder called **Backup**.



You also need to create a directory called Outbox_State in C:/DPH. In this folder create a folder called Backup.



Open the software and allow the attachment manager to attach all of the tables.

Login as "System"

Enter the password "Chief"

Enter the control file information

Click on the **Control File Maintenance** button. Enter the information for this agency. (See the Control File Maintenance section of this manual)

Set up user security

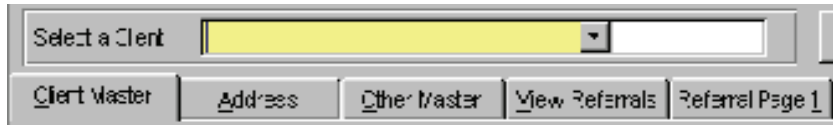
Go the **System Maintenance** menu.

Click on **Set-up User Security**.

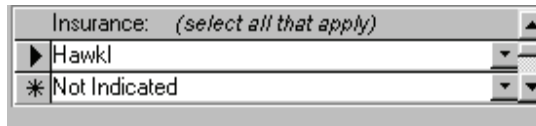
Enter names and passwords for all users at the site. Make sure that at least one person has system privileges. This is done by setting the workgroup for at least one person to *System*. (See the Setup Password section of this manual)

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.

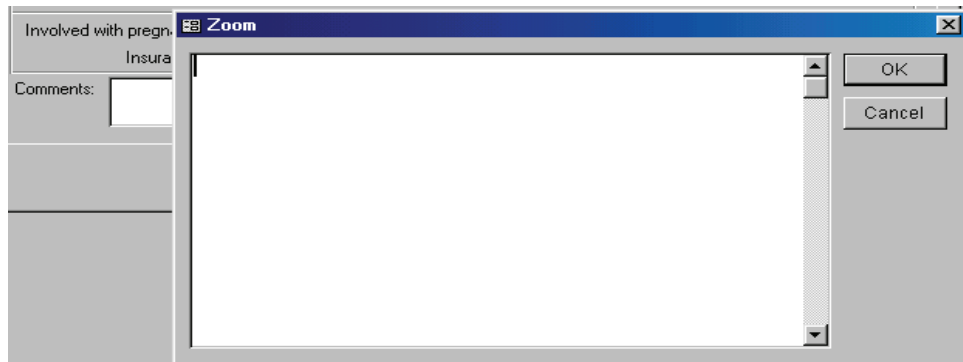


Moving out of a option box using the keyboard: When doing data entry most people use either the **Tab** or **Enter** keys to move to the next prompt. Once you are in a option box where you may choose more than one response to a question, the **Tab** and **Enter** keys will not work. To move to the next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

