

Home Visits – Child



User's Manual

Home Visits – Child

Health District Information System
HDIS (Windows Ver. 5.3)

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Introduction

This program is designed to assist you in organizing a systematic approach to entering your High Risk Child visits and provides accurate up-to-date records within your health district.

Please review the manual carefully to obtain the maximum benefits. Little or no prior computer experience is necessary to operate this program.

About This Manual

HDIS is simple to use. ***The maximum benefit with the least time spent will be obtained if you start at the first page of this manual and follow the directions exactly as you enter the first record in your computer.***

Square boxes in this manual surround the key that you are to press on your keyboard. As an example, when you read

ENTER

, press the **enter** key on your keyboard.

The word

TYPE is followed by bracketed [] instructions of what to type into a field.

Note: For Technical Support, email: helpdesk@hdis.org



Navigation

Whenever you see one  click the left side of your mouse once.

Whenever you see two  click the left side of your mouse twice.

Navigation Keys For Entering Information

Tab or **ENTER** to move to next field

| **Shift** **Tab** or **Up** to go back one field

Editing Keys

Backspace deletes one character left of cursor

Delete deletes one character

Insert inserting & overwriting modes

When you see a pull-down field, click the arrow to the right to view all your choices.



Starting HDIS

Start

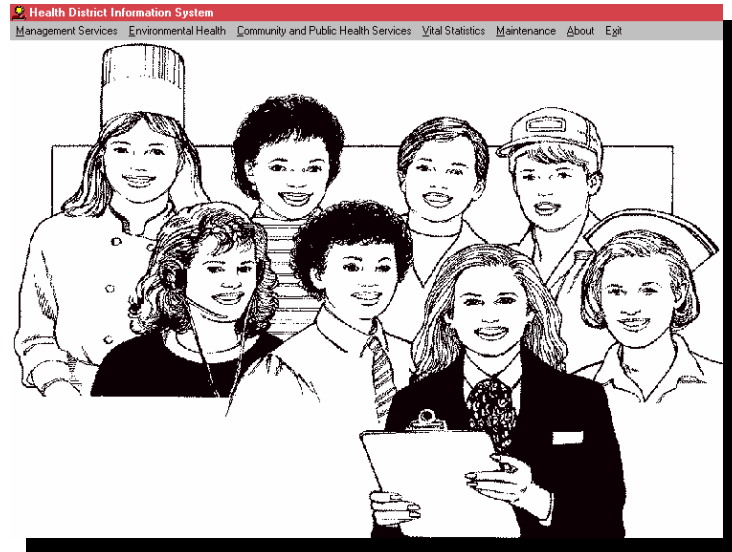
Programs

Health District Info Systems

HDIS

Health District Information System Menu Bar

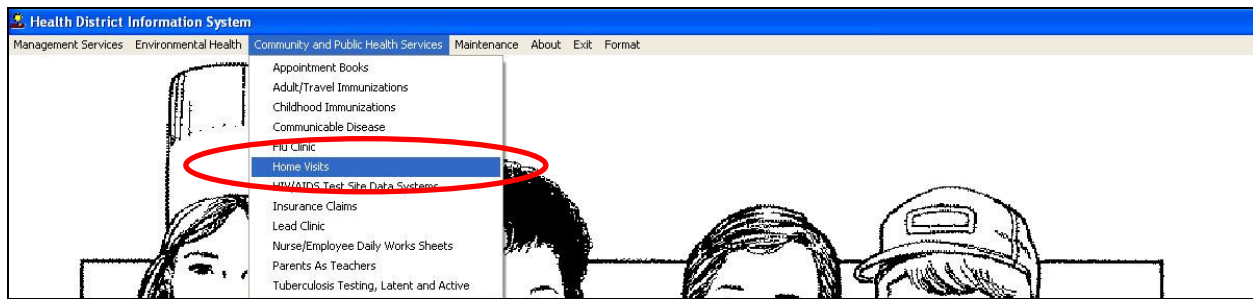
HDIS (Health District Information System) has several different modules designed to assist your health district in its day-to-day operations. The **Home Visits module** is a great addition to these modules and simplifies your record keeping, billing and information management needs.



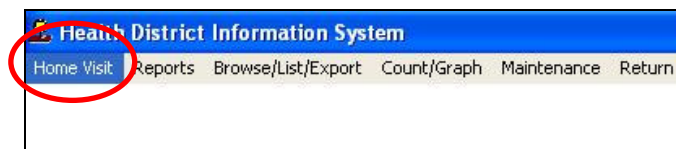
Community and Public Health Services



Home Visits



Home Visit



Entering a Child Record

The screenshot shows a software window titled "Household Information". It features a "Find" section with radio buttons for "By Name", "By DOB", "By Address", "By Street Name", and "M.R.#". Below this are input fields for "Street #", "Street", "Apt. #", "P.O. Box", "City", "State", "Zip Code", "Phone", "Date of Entry", and "Political Subdivision". There are also text areas for "Address Directions" and "Contact Instructions". A section for "Household size" and "Gross Income" includes checkboxes for "Week", "Month", and "Year", and a "Calc By Week" button. To the right are fields for "Verified", "Revised", and "Sliding Fee" with a "Calc Sliding Fee" button. A table with columns "Last", "First", "Middle", "Suffix", "DOB", "Sex", "Relationship", "SSN", and "Race" contains two rows of data. On the right side of the table are buttons for "Client Details", "Add Client*", and "Comments". At the bottom, there are "Adult" and "Child" buttons, with the "Child" button circled in red. A "Close" button is located at the bottom right.

Last	First	Middle	Suffix	DOB	Sex	Relationship	SSN	Race
SMITH	JANE			10/04/1980	F			WHITE
SMITH	JOHN			01/01/2006	M			WHITE

When you are ready to enter the Child portion of the Home Visit module, click the on the client in the grid you wish to enter data for, and then click the **Child** button.

**** All fields labeled in RED are MANDATORY.**

Encounters

Right-click the **Add Encounter*** button. **Once, you have clicked the Add button, you do not have to click it again to add the information.**

Field/Button	Description
Re-Sort Dates*	Right-click to put the dates in chronological order.
Delete Encounter*	Right-click to delete the encounter row.
Add Encounter*	Right-click to add an encounter.
Zoom	Click to open the zoom screen.
Print	Click to open the print window.
Modify/Add	Click to modify/add a record.
Close	Click to close the Child Home Visit windows.

The screenshot shows the 'Encounter Zoom' window with the following fields and controls:

- Date of Entry:** 07/22/2009
- Date of Service:** //
- Nurse / Outreach Worker:** (dropdown menu)
- Program:** (dropdown menu)
- Setting / Activity:** (dropdown menu)
- Billable Time:** (text input)
- ICD9:** (dropdown menu)
- CPT Code:** (dropdown menu)
- Non-Billable Time:** (text input)
- Location of PHHV Face to Face Visit:** (dropdown menu)
- Travel Time:** (text input)
- Vehicle:** (text input)
- Mileage:** (text input)
- Total Time:** 0
- Return Visit:** //
- Buttons:** Previous Encounter, Next Encounter, Add to Dailys *, Close

When the Add Encounter button is clicked, the above Zoom screen appears for you to enter the encounter.

Field/Button	Description
--------------	-------------

Date of Entry	Automatically filled out by the computer.
Date of Service	Enter the date of service.
Nurse/Outreach Worker	Choose the nurse/outreach worker.
Program	Choose the program.
Setting/Activity	Choose the setting/activity.
Billable Time	Enter your billable time.
ICD9	Choose the ICD9 code.
CPT Code	Choose the CPT code.
Non-Billable Time	Enter your non-billable time.
Loc. of PHHV Face to Face Visit	Choose the location of the face to face visit with the client (mandatory field).
Travel Time	Enter your travel time.
Vehicle	Enter your vehicle number.
Mileage	Enter your mileage traveled.
Total Time	Automatically filled out by the computer.
Return Visit	Enter the return visit date (optional)
Previous Encounter	Click to view the previous encounter.
Next Encounter	Click to view the next encounter.
Add to Dailies*	Right click to add the encounter to your daily worksheets.
Close	Click to close the zoom screen.

HRIO - Intake



HRPIO - Intake

Child - - - - - Medical Record #: 1812

Encounters | **HRIO-Intake** | HRIO-Outcome | LSP | Care Plan | S.O.A.I.P. | Assessment Tools | Progress Notes(narrative) | Progress Notes(checklist)

Intake Date: / / Completed By: County/Reservation: ☐ Infant of a PHHV Client Case #:

Mother seen in PHV during pregnancy?
☐ Yes ☐ No

Birth Wt. Lb. Oz. Grams
 Convert to Grams

Gestational Age

APGAR
 1 Min. 5 Min.

Breastfed
☐ Breastfed ☐ Bottle Fed ☐ Both

Primary Health Care Provider Identified?
☐ Yes ☐ No

Parent(s) have children in DPHHS custody?
☐ Yes ☐ No

Homeless or substandard housing?
☐ Yes ☐ No

Risk Factors
☐ Child <12 months of age who was born to a woman who received PHHV and/or TCM services as a high risk pregnant woman. and/or
☐ Child or youth is diagnosed with a special health care need as designated by an ICD9 CM code.

☐ In Utero Exposure to Alcohol
☐ Child or youth has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions as evidenced by:
 • Low or very low birth weight
 • Documented child abuse or neglect
 • Foster care replacement
 • Exposure to alcohol/substance use or abuse prenatally, in home or place of residence and/or second hand smoke.
 • Regular use of medication prescribed by a doctor (excluding vitamins)
 • Documented need for:
 ☐ Therapeutic services, i.e. physical, speech, audiology, occupational, mental health, nutrition, home health, or home nursing services needed
 ☐ Family support services, i.e. family counseling and education, special instruction, case management, care coordination, respite care needed
 ☐ Equipment and supplies, i.e. durable medical equipment and assistive technology devices and services needed
 ☐ Early intervention, special education, special transportation adaptation, or social services needed

• Has an established condition with a high probability of resulting developmental delay (even if the delay does not currently exist), such as:
☐ Genetic disorders Memo
☐ Inborn errors of metabolism Memo
☐ Infectious disease Memo
☐ Neurological disorders Memo
☐ Congenital syndromes Memo
☐ Visual/auditory impairments Memo
☐ Severe attachment disorders Memo

Archive

Previous Intake/Outcome Next Intake/Outcome Delete Intake/Outcome **Add Intake/Outcome *** Print Modify/Add

To add a HRIO – Intake form, right-click the Add Intake/Outcome* button.

Child - - - - - Medical Record #: 1812

Encounters | HRIO-Intake | HRIO-Outcome | LSP | Care Plan | S.O.A.I.P. | Assessment Tools | Progress Notes(narrative) | Progress Notes(checklist)

Intake Date: / / Completed By: County/Reservation: Infant of a PHHV Client: Case #:

Mother seen in PHV during pregnancy?
☐ Yes ☐ No

Birth Wt. Lb. Oz. **Grams**

Gestational Age

APGAR
 1 Min. 5 Min.

Breastfed
☐ Breastfed ☐ Bottle Fed ☐ Both

Primary Health Care Provider Identified?
☐ Yes ☐ No

Parent(s) have children in DPHHS custody?
☐ Yes ☐ No

Homeless or substandard housing?
☐ Yes ☐ No

Risk Factors
☐ Child <12 months of age who was born to a woman who received PHHV and/or TCM services as a high risk pregnant woman, and/or
☐ Child or youth is diagnosed with a special health care need as designated by an ICD9 CM code.

In Utero Exposure to Alcohol
☐ Child or youth has or is at increased risk for chronic physical, developmental, behavioral, or emotional conditions as evidenced by:
 • Low or very low birth weight
 • Documented child abuse or neglect
 • Foster care replacement
 • Exposure to alcohol/substance use or abuse prenatally, in home or place of residence and/or second hand smoke.
 • Regular use of medication prescribed by a doctor (excluding vitamins)
 • Documented need for:
☐ Therapeutic services, i.e. physical, speech audiology, occupational, mental health, nutrition, home health, or home nursing services needed
☐ Family support services, i.e. family counseling and education, special instruction, case management, care coordination, respite care needed
☐ Equipment and supplies, i.e. durable medical equipment and assistive technology devices and services needed
☐ Early intervention, special education, special transportation adaptation, or social services needed

• Has an established condition with a high probability of resulting developmental delay (even if the delay does not currently exist), such as:
☐ Genetic disorders
☐ Inborn errors of metabolism
☐ Infectious disease
☐ Neurological disorders
☐ Congenital syndromes
☐ Visual/auditory impairments
☐ Severe attachment disorders

Enter the information for the intake form.

**** All fields labeled in RED are MANDATORY.**

HRIIO - Outcome



HRPIO - Intake

Child - - - - - Medical Record #: 1812

Encounters | HRIIO-Intake | **HRIIO-Outcome** | LSP | Care Plan | S.O.A.I.P. | Assessment Tools | Progress Notes(narrative) | Progress Notes(checklist)

Date of Client Discharge: / / Completed By: [Dropdown]

<p>Weight for length <5 percentile or >95% <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify: Memo</p> <p>Developmental milestones WNL <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: Memo</p> <p>Immunizations current <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Total # of PHHV visits [] Total # of Face to Face visits []</p> <p>Length of time breastfed []</p> <p>Three or More Residences or Homeless <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Infant's Primary Caregiver Screened with DV ACOG Tool during first year of life <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Parent's changes since intake in: SMOKING HABITS: <input type="checkbox"/> No Change <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> UNK</p> <p>SUBSTANCE ABUSE <input type="checkbox"/> No Change <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> UNK</p> <p>ALCOHOL USE <input type="checkbox"/> No Change <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> UNK</p>	<p>Number of emergency room visits []</p> <p>Number of ear infections []</p> <p>Number of calls/reports made by PHHV for suspected child abuse and neglect []</p> <p>Depression Screen Score []</p> <p>Diagnosed with a special health care need, congenital anomalies, medical risk factors ICD9 DX []</p> <p>Referrals to child protective services Specify: Memo</p> <p>Primary health care provider identified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Medicaid <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Eligible <input type="checkbox"/> Unknown</p> <p>WIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Eligible <input type="checkbox"/> Unknown</p> <p>Early Intervention <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Specialty Clinic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>Exited PHHV project: <input type="checkbox"/> Lost to care <input type="checkbox"/> Child in out of home placement <input type="checkbox"/> Child deceased Memo <input type="checkbox"/> Moved <input type="checkbox"/> Refused <input type="checkbox"/> Transferred <input type="checkbox"/> Reclassified as child (>12 months) <input type="checkbox"/> Other Memo</p> <p>Referrals Made by PHHV to Community Service <input type="checkbox"/> MTUPP Quitline <input type="checkbox"/> Other Tobacco Cessation Resources <input type="checkbox"/> Substance Abuse Cessation Resources <input type="checkbox"/> Domestic Violence Resources <input type="checkbox"/> Mental Health or Support Services <input type="checkbox"/> Resources to Obtain Housing <input type="checkbox"/> Food Resources Other than WIC <input type="checkbox"/> WIC <input type="checkbox"/> Medicaid <input type="checkbox"/> No Referrals Made <input type="checkbox"/> Other Memo</p>
--	---	--

Print Modify / Add

Enter the information for the Outcome form.

**** All fields labeled in RED are MANDATORY.**



LSP

LSP (Optional)

The LSP tab is for entering your Life Skills Progression form for your client. To enter the scores, click the Zoom button.

Field/Button	Description
Previous LSP	Click to navigate to the previous LSP.
Next LSP	Click to navigate to the next LSP.
Delete LSP*	Right-click to delete the LSP form.
Add LSP*	Right-click to add a LSP form.
Zoom	Click to open the Zoom screen.

Print	Click to open the Print window.
Modify/Add	Click to modify/add a LSP record.

The screenshot shows a software window titled "The Life Skills Progression - Number 36". At the top, there is a navigation bar with tabs: Encounters, HRIIO-Intake, HRIIO-Outcome, LSP (selected), Care Plan, S.O.A.I.P., Assessment Tools, Progress Notes(narrative), and Progress Notes(checklist). Below the tabs, there are fields for "Child's Last Name", "Child's First Name", "Date of Birth" (with a // placeholder), "Individual Number" (1037), and "Family Record Number" (587). The main content area displays a scale for "Communication*" ranging from 0 to 5. Each score has a corresponding description: 0 (BELOW AA/CA AND EARLY INTERVENTION CRITERIA; REFERRED TO EI; NOT ENROLLED OR ATTENDING.), 1.5 (DELAYS MEET EI CRITERIA; REFERRED; ENROLLED; SOMETIMES ATTENDS.), 2.5 (DELAYS MEET EI CRITERIA; REFERRED; ENROLLED; ATTENDS REGULARLY.), 3.5 (NO DELAYS. AVERAGE DEVELOPMENT FOR AA OR CA.), and 4.5 (ABOVE AVERAGE DEVELOPMENT FOR AA OR CA.). Below the scale, there are fields for "Score" (0.0) and "Comments". At the bottom of the window, there are buttons for "Previous", "Next", and "Close". A separate bar at the very bottom contains buttons for "Re-Sort Dates*", "Previous LSP", "Next LSP", "Delete LSP *", "Add LSP *", "Zoom", "Print", and "Modify / Add".

The Zoom screen allows you to navigate through each question of the Life Skills Progression form. To enter the score, simply click on one of the black numbers. You may also enter your own comments for each question. Click the Previous or Next buttons to go to advance through the question.

Care Plan (Optional)



Care Plan

To enter a Care Plan, right-click the **Add Master Care Plan*** button. HDIS has preloaded care plans already in the system but you can also create your own care plans under the Maintenance Menu.

Field/Button	Description
Delete Care Plan*	Right-click to delete the care plan.
Add Care Plan Row*	Right-click to add a single care plan row.
Add Master Care Plan*	Right click to open the care plan window.
Zoom	Click to open the care plan zoom window.
Print	Click to open the Print window.
Modify/Add	Click to modify or add a care plan record.

Add	Diagnosis	Intervention
<input type="checkbox"/>	Nutrition	Link with info re: feeding methods, and positioning, appropriate amounts, and/or
<input type="checkbox"/>	Nutrition	Refer nutrition programs.
<input type="checkbox"/>	Nutrition	Refer and assist to access dietician.
<input type="checkbox"/>	Nutrition	Monitor height/weight.
<input type="checkbox"/>	Nutrition	Refer to food resources.
<input type="checkbox"/>	Nutrition	Link with info re: infant stimulation
<input type="checkbox"/>	Nutrition	Link with info re: feeding cues/feeding interaction
<input type="checkbox"/>	Nutrition	Link with info to modify feeding to adapt to special health care needs.
<input type="checkbox"/>	Nutrition	Link with info re: risks associated with sleeping with bottle.
<input type="checkbox"/>	Nutrition	Link with info re: weaning infant from bottle.
<input type="checkbox"/>	Elimination	Refer and assist to access medical evaluation
<input type="checkbox"/>	Elimination	Link with info re: changes in normal functioning.
<input type="checkbox"/>	Elimination	Link with info re: toilet training/expectations.
<input type="checkbox"/>	Elimination	Link with info re: special needs adaptations.
<input type="checkbox"/>	Sleep/Rest	Monitor sleep patterns.
<input type="checkbox"/>	Sleep/Rest	Assist to develop sleep routine, bed time, and link with info re: benefits of sleep routin
<input type="checkbox"/>	Sleep/Rest	Assist to develop plan to develop optimal sleep environment.
<input type="checkbox"/>	Sleep/Rest	Link with info re: sleep position.
<input type="checkbox"/>	Sleep/Rest	Assist to develop and implement plan to adapt to special health care needs
<input type="checkbox"/>	Sleep/Rest	Link with info re: daytime sleep.
<input type="checkbox"/>	Sleep/Rest	Assist with developing plan to address night waking.
<input type="checkbox"/>	Sleep/Rest	Link info re: benefits of sleep routines, constant bed time.
<input type="checkbox"/>	Sleep/Rest	Assist to develop sleep routine.
<input type="checkbox"/>	Activity/Exercise	Link with info re: low and no cost play materials.
<input type="checkbox"/>	Activity/Exercise	Link with info re: importance of appropriate play materials/activities and physical activ
<input type="checkbox"/>	Activity/Exercise	Link with info re: interpreting infant cues.
<input type="checkbox"/>	Activity/Exercise	HOME evaluation.
<input type="checkbox"/>	Activity/Exercise	NCAST Teaching assessment.
<input type="checkbox"/>	Activity/Exercise	Medical referral.

The Select Care Plan window allows you to select which care plans that you would like to add to the grid. Put a checkmark in the Add column for which of the care plans you would like to add, when finished click Add Care Plans & Close.

Adult - SMITH, JANE - 01/01/1976 - 33 - Medical Record #: 2

Encounters | HRPIO-Intake | HRPIO-Outcome | LSP | Care Plan | S.O.A.I.P | Assessment Tools | Progress Notes(narrative) | Progress Notes(Checklist)

Care Plan

Date: 02/05/2009

Diagnosis: Elimination Prenatal

Related To (Max 254 characters):

Intervention: Link with info re: when to access medical assistance.

Outcome:

F2 = Resolved F3 = Closed F4 = Intervention Ongoing
 F5 = Intervention Completed F6 = Barriers to Completion F7 = Client Refusal

Previous Next Close

Delete Plan Row* Add Care Plan Row* Add Master Care Plan* Zoom Print Modify / Add

After you have added the care plans, click **Zoom** to navigate through each care plan to enter the client's information.

S.O.A.I.P. (Optional)



S.O.A.I.P.

Date	Staff	Subjective	Objective	Assessment	Intervention	Plan

The S.O.A.I.P. tab is for entering your S.O.A.I.P. notes for your client. To add a row, right-click the Add S.O.A.I.P. Row* button.

Field/Button	Description
Re-Sort Dates*	Right-click to put the dates in chronological order.
Delete Blank S.O.A.I.P. Row*	Right-click to delete any blank rows in the grid.
Add S.O.A.I.P.Row*	Right-click to add a S.O.A.I.P. note.
Zoom	Click to open the S.O.A.I.P. zoom window.
Print	Click to open the print window.
Modify/Add	Click to modify or add a S.O.A.I.P. record.

The image shows a software window titled "S.O.A.I.P." with a blue border. Inside, there are several input fields and buttons. At the top left, there is a "Intake Date" field with a date picker icon. Below it is a "Staff" field with a dropdown arrow. The main body of the window is divided into six horizontal sections, each with a label on the left and a large text area on the right: "Subjective", "Objective", "Assessment", "Intervention", and "Plan". Each text area has a vertical scrollbar on its right side. At the bottom of the window, there are four buttons: "Previous S.O.A.P.I.", "Next S.O.A.P.I.", "Spell Check", and "Close".

Enter your S.O.A.I.P. notes and click the close button. To navigate through your notes, use the **Previous** and **Next** buttons. You also have to ability to perform a spell check on your notes with the **Spell Check** button.

Assessment Tools



Assessment Tools

Child: [Name] Medical Record #: 1037

Encounters | HR/O-Intake | HR/O-Outcome | LSP | Care Plan | S.O.A.I.P. | **Assessment Tools** | Progress Notes(narrative) | Progress Notes(checklist)

Age & Stages Questionnaire

Date	Age	Communication	Cutoff	Gross Motor	Cutoff	Fine Motor	Cutoff	Problem Solving	Cutoff	Personal	Cutoff

Delete ASQ Information* Add ASQ Information *

ASQSE

Date	Age	Score	Cutoff

Delete ASQSE Information* Add ASQSE Information *

Tools

Date	Type	Normal	Abnormal	Questionable	Untestable

Delete Tool* Add Tool*

Print Modify / Add

The Assessment Tools tab contains three different tools that you can enter information for. They are the Ages and Stages Questionnaire, ASQSE, and Tools.

Field/Button	Description
Delete ASQ Information*	Right-click to delete a row.
Add ASQ Information*	Right-click to open the Select Age form.
Delete ASQ Information*	Right-click to delete a row.
Add ASQ Information*	Right-click to open the Select Age form.
Delete ASQ Information*	Right-click to delete a row.
Add ASQ Information*	Right click to add a tool.
Print	Click to open the print window.
Modify/Add	Click to modify or add an assessment tool record.

The screenshot displays the ASQ software interface. At the top, a menu bar includes 'Child', 'Medical Record #', and 'Encounters'. Below this is a tabbed interface with tabs for 'HRIIO-Intake', 'HRIIO-Outcome', 'LSP', 'Care Plan', 'S.O.A.I.P.', 'Assessment Tools', 'Progress Notes(narrative)', and 'Progress Notes(checklist)'. The main area is titled 'Age & Stages Questionnaire' and contains a large table with columns for 'Date', 'Age', 'Communication', 'Cutoff', 'Gross Motor', 'Cutoff', 'Fine Motor', 'Cutoff', 'Problem Solving', 'Cutoff', 'Personal', and 'Cutoff'. A modal dialog box titled 'Select Age for Proper ASQ Form' is open in the center. It contains a text field for 'Today's age in months' and a list of radio button options for ages from 4 to 60 months. The dialog also has 'Add ASQ *' and 'Close' buttons. Below the dialog, there is another table titled 'ASQSE' with columns for 'Date', 'Age', 'Score', and 'Cutoff'. At the bottom of the window, there are buttons for 'Delete ASQSE Information *', 'Add ASQSE Information *', 'Delete Tool*', and 'Add Tool*'. The bottom right corner has 'Print' and 'Modify / Add' buttons.

When the **Add ASQ Information*** or the **Add ASQSE Information*** buttons are clicked, the above select Age form will appear for you to select the proper Age for the client.

Progress Notes (Narrative) (Optional)



Progress Notes (Narrative)

To enter your narrative progress notes on the client, right-click the **Add Progress Note*** button.

Field/Button	Description
Re-Sort Dates*	Right-click to put the dates in chronological order.
Delete Blank Progress Note*	Right click to delete any blank progress notes.
Add Progress Note*	Right-click to add a progress note.
Zoom	Click to open the progress note zoom window.
Print	Click to open the print window.
Modify/Add	Click to modify a progress note record.

Child Medical Record #: 1037

Encounters | HRIIO-Intake | HRIIO-Outcome | LSP | Care Plan | S.O.A.I.P. | Assessment Tools | Progress Notes(narrative) | Progress Notes(checklist)

Date	Staff	Notes

Progress Notes

Date:

Staff:

Progress Note

Previous Progress Note | Next Progress Note

Spell Check | Close

Re-Sort Dates* | Delete Blank Progress Note* | Add Progress Note*

Zoom | Print | Modify / Add

Click the **Zoom** button to navigate and enter your progress notes.

Progress Notes (Checklist) (Optional)



Progress Notes (Checklist)

The screenshot shows a software window titled "Child - Medical Record #: 1037". It has a menu bar with options: Encounters, HRIIO-Intake, HRIIO-Outcome, LSP, Care Plan, S.O.A.I.P., Assessment Tools, Progress Notes(narrative), and Progress Notes(checklist). The "Progress Notes(checklist)" tab is active. Below the menu bar, there is a "Screening Date" field with a date picker showing "/ /". To the right of the date field are five buttons: "F2 = ASSESS", "F3 = PLAN", "F4 = MONITOR", "F5 = REFER", and "F6 = EDUCATION". Below these buttons is a table with five columns: "Date of Visit", "Issue", "Focus Area", "Intervention", and "Notes". The table has 15 empty rows. At the bottom of the window, there are buttons: "Re-Sort Dates*", "Add Form", "Delete Empty Rows*", "Zoom", "Print", and "Modify / Add".

The **Progress Notes (Checklist)** allows you to enter pre-created forms for the clients. To add on of these forms, enter the screening date and click the **Add Form** button.

This screenshot is similar to the previous one, but the "Screening Date" field now contains the date "02/10/2009". A modal dialog box titled "Gallatin County - Select Screening Form" is open in the center of the screen. The dialog box contains a list of radio button options: "Newborn Nutrition Progress Notes (checklist)", "Pediatric Progress Notes (0 - 6 Months)", "Pediatric Progress Notes (6 months - 1 year)", "Pediatric Progress Notes (1 year - 4 years)", "Postpartum/Newborn Assessment", and "Social Worker Progress Notes (checklist)". The "Newborn Nutrition Progress Notes (checklist)" option is selected. At the bottom of the dialog box are two buttons: "Add & Close" and "Close".

Select the form that you wish to add to the grid and click the **Add & Close** button.

Child Medical Record #: 1037

Encounters | HRIIO-Intake | HRIIO-Outcome | LSP | Care Plan | S.O.A.I.P. | Assessment Tools | Progress Notes(narrative) | Progress Notes(checklist)

Progress Note(checklist)

Date of Visit: 02/10/2009 Home Visitor: [dropdown]

F2 = ASSESS F3 = PLAN F4 = MONITOR F5 = REFER F6 = EDUCATION

Issue: 1) NUTRITI Focus Area: MOTHER'S DIET Intervention: [text box]

Notes: [text area]

Choices: [list area]

Buttons: Spell Check, Add to Notes, Next, Previous, Close

Footer: Re-Sort Dates* Add Form Delete Empty Rows* Zoom Print Modify / Add

After the selected form has been added to the grid, you can scroll through each issue by using the **Zoom** button.

Print Button



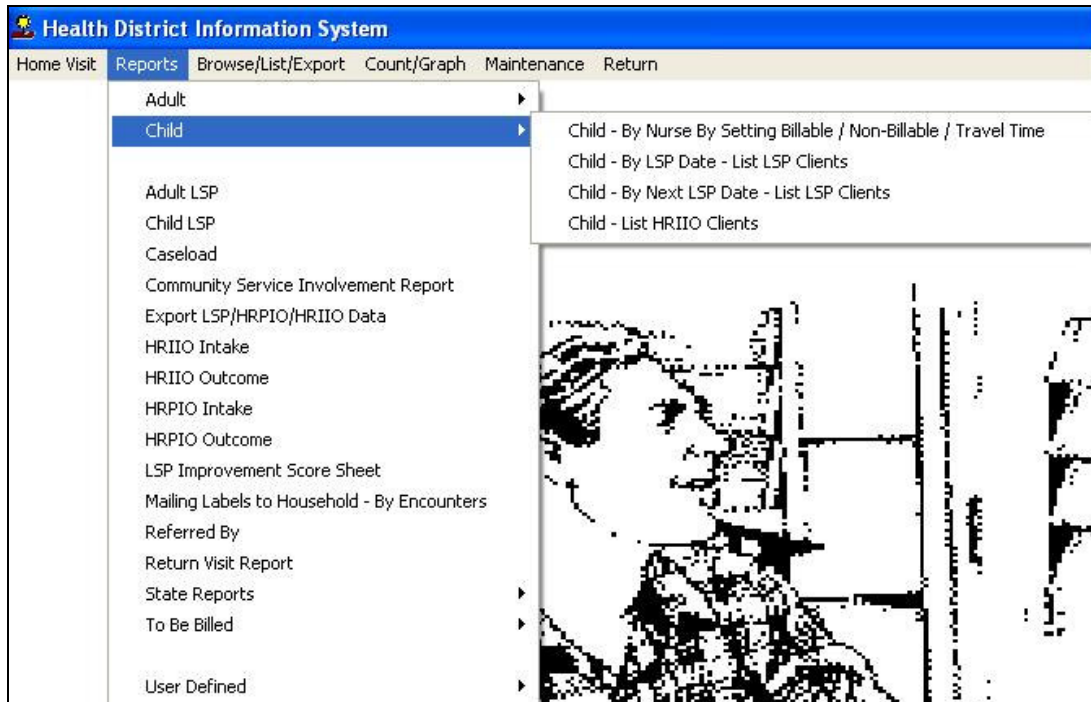
Print

Field/Button	Description
Ages & Stages Questionnaire	Prints the Ages & Stages Questionnaire.
Ages & Stages – Social Emotional Questionnaire	Prints the Ages & Stages – Social Emotional Questionnaire.
Care Plan	Prints the care plan.
Intake Form	Prints the intake form.
Outcome Form	Prints the outcome form.
LSP Form	Prints the LSP form.
LSP Cumulative Scores	Prints the cumulative scores LSP form.
Progress Notes	Prints the progress notes.
Specific Progress Notes	Prints only the Progress Note you have positioned to
Specific Staff Progress Notes	Prints only the Progress Notes for the staff member for the Note you have positioned to
S.O.A.I.P.	Prints the S.O.A.I.P. notes.
Specific S.O.A.I.P.	Prints a specific S.O.A.I.P. note.
Tools	Prints a list of assessment tool tests and scores for the client.
Encounters	Prints a list of encounters for the dates specified.
Preview	Previews the printout.
Print	Prints the form.
OK	Prints/previews the form.
Close	Closes the print menu.

Reports



Reports



The **Home Visits program** has a set of pre-defined reports to choose from. Each reported will ask for **From date** and **To date**.

The screenshot shows the 'HRIIO Intake Report Options' dialog box. It has a title bar with a close button. The main area contains two date input fields: 'From HRIIO Intake Date' and 'To HRIIO Intake Date', each with a placeholder '||'. Below these is an 'Employee' dropdown menu. At the bottom, there are three buttons: 'Preview' (with a magnifying glass icon), 'Printer' (with a printer icon), and 'Filters'. On the right side, there are three buttons: 'OK', 'Close', and 'Filters'.

You may also preview the report before printing. Also, you have the ability to use filters to build a query.

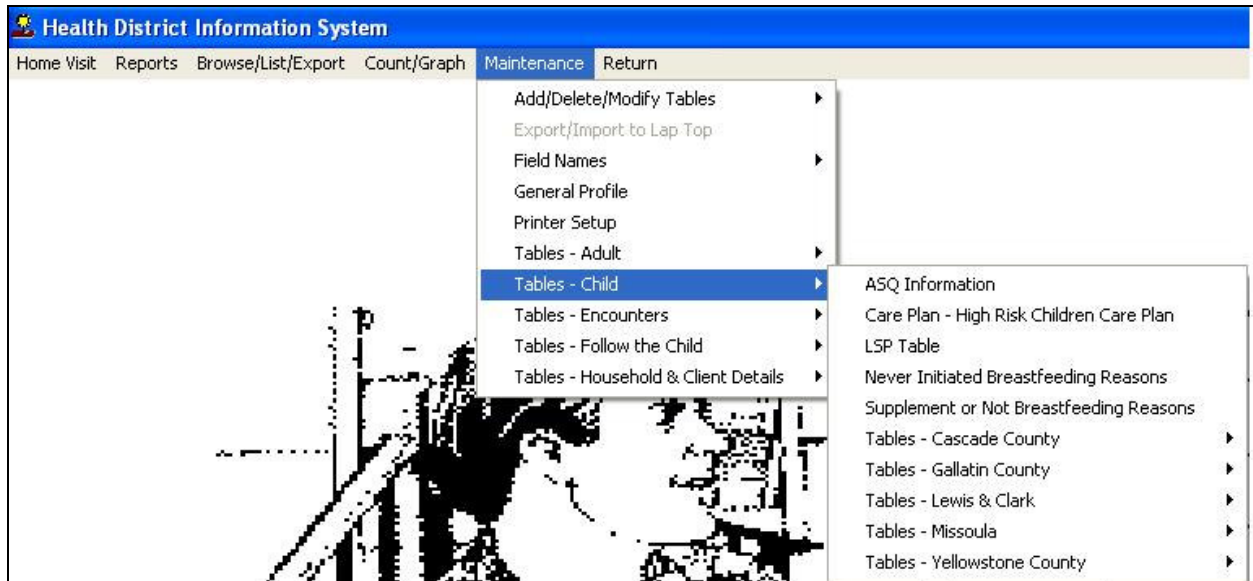
Reports

Report	Description
Child – By Nurse By Setting Billable/Non-Billable/Travel Time	Generates a List of Clients and their Billable/Non-Billable/Travel times.
Child – List HRPIO Clients	Generates a list of HRPIO clients.
Child – By LSP Date – List LSP Clients	Generates a list of HRPIO clients by date of LSP.
Child – By Next LSP Date – List LSP Clients	Generates List of LSP Clients by Next LSP due date
HRPIO – Outcome Vs. Intake	Measures outcomes for HRPIO risk factors
Caseload	Generates a caseload of clients by employee and program.
Community Service Involvement	Counts Community Service being used
Export LSP/HRPIO/HRPIO Data	Used by Gallatin County for research purposes
HRPIO Intake	Generates your HRPIO Intake forms in bulk.
HRPIO Outcome	Generates your HRPIO Outcome forms in bulk.
LSP Improvement Score Sheet	Generates the LSP Improvement Score Sheet.
Mailing Labels to Household – By Encounters	Generates mailing labels by encounters.
Referred By	Generates a count report of referrals.
Return Visit Reports	Generates a return visit report for your clients.
State Reports – MCH Block Grant 2006	Generates the 2006 MCH Block Grant reports.
State Reports – MCH Block Grant 2007	Generates the 2007 MCH Block Grant reports.
Public Health Home Visit Quarterly Report	Generates your Quarterly report for Public Health Home Visits.
To Be Billed – Child – By Date of Entry	Generates a “to be billed” report for your Child clients by date of entry.
To Be Billed – Child – By Date of Service	Generates “a to be billed” report for your Child clients by date of entry.

Maintenance - Add/Delete/Modify Tables



Maintenance



The maintenance menu contains a list of the tables that you can modify for your program. For Child tables, select “Tables – Child” under the Maintenance Menu where you can add or modify your dropdown selections.

The screenshot shows a software window titled "Add/Delete/Modify". It contains a list box with a "Name" header. The list includes the following entries: DFS, EMILIE CENTER, FOOD STAMPS, HELPING HANDS, HMHB, JOB AND FAMILY SERVICES, LIFEWAY, MEDICAID, MENTAL HEALTH SERVICES, OPPORTUNITY INCORPORATED, OTHER, PLANNED PARENTHOOD, SALVATION ARMY, ST. VINCENT'S, TANF, and WIC. Below the list are four buttons: "Close", "Add", "Delete", and "Print".

Name
DFS
EMILIE CENTER
FOOD STAMPS
HELPING HANDS
HMHB
JOB AND FAMILY SERVICES
LIFEWAY
MEDICAID
MENTAL HEALTH SERVICES
OPPORTUNITY INCORPORATED
OTHER
PLANNED PARENTHOOD
SALVATION ARMY
ST. VINCENT'S
TANF
WIC

The above is an example of what the Maintenance tables will look like.

Field/Button	Description
Name	Enter the name.
Close	Closes the table.
Add	Adds a row to the table.
Delete	Deletes the row.
Print	Prints the table.

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