

First Nations and Inuit Home and Community Care Program:

e-SDRT User Guide





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About the e-SDRT User Guide

What's New!

- The e-SDRT User Guide update is intended to guide and support users of the e-SDRT spreadsheet in their program data capture. It provides a step by step process on how to access, navigate, enter, and upload information in the application. Tips and Notes sections are included where appropriate to provide additional assistance to the user.
- The e-SDRT User Guide is divided into seven (7) sections:
 - 1. Introduction
 - 2. Getting Started
 - 3. e-SDRT Spreadsheet
 - 4. Client Information Worksheet
 - 5. Home Care Services Worksheet
 - 6. HCC Application
 - 7. Appendices
- All e-SDRT fields are now mandatory and have been established to provide the essential information for community, ministerial and departmental reporting, Performance Measurement and Evaluation for Grants and Contributions and Program Plan requirements (the <u>only field which is not mandatory and is an</u> <u>exception, is the Community Space field)</u>. Data entered in the columns with red headings are required for successful uploading failure to complete these sections fully and in the correct format will result in the system application generating validation errors. Data entered in the columns with black headings are required for overall comprehensive data quality that provides the most accurate picture of your Home Care Program. The e-SDRT User Guide update is intended to promote data capture in a standardized format according to system capabilities and to facilitate program data analysis.
- According to the update of the Performance Measurement on Grants and Contributions (May 2013), all fields are subject to program monitoring and random data quality audits by regional and national offices.
- Client Information, Home Care Services Coding Definitions and Appendices were reviewed by national, regional and partner representatives and updated to capture relevant information and all services. These updates include clarifying instructions for each section of the guide and expanding and updating the code definitions such as:
 - $\circ~$ W code in Primary Reason for Home Care is no longer valid. It can no longer be used.
 - \circ $\;$ Most Z codes are no longer in use. Exceptions are:
 - In the Home Care Services Worksheet Under Personal Care:
 - Z "Other" can be used for TRANSLATION
 - In the Home Care Services Worksheet Under Professional Therapies :

- Z "Other Professional Serivces" still in use. Please note that "Traditional Healer" has been added under this code.
- Primary Reason for Care and Services definitions are expanded to capture additional details and examples for each code.
- **All charting** is to be captured under the code "Charting" and is no longer to be captured as part of a service.
- **IMPORTANT INFORMATION** e-SDRT users need to refer to this current guide (*Appendix C Lists of Codes and Definitions*) to input proper coding.
- e-SDRT services are captured under appropriate category of service regardless of role or function
- e-SDRT services captured are those performed or supervised by the HCC program.
- No further updates are planned to this guide to maintain data integrity and consistency.

For technical support, or for any questions beyond the scope of this user manual, please contact your Regional Home and Community Care Office (refer to Appendix A – Education/Training/Contact Information).

Introduction

OVERVIEW

Welcome to e-SDRT! (electronic-Service Delivery Reporting Template)

The e-SDRT application was developed on Excel, a spreadsheet software application that the majority of communities have access to, and that could be supported by the multitude of computer environments in operation today. It is supported by the HCC application which was developed to accept monthly uploads. These applications form the e-SDRT system. They were developed to assist communities in collecting and providing all their essential and supportive services Home and Community Care Program data to Health Canada's First Nations Health Branch Regional Offices, in accordance with Program and Contribution Agreement requirements.

The First Nations and Inuit Home and Community Care Program provides basic Home and Community Care services that are comprehensive, culturally sensitive, accessible, effective. These services are equitable to those available to other Canadians and respond to the unique health and social needs of First Nations and Inuit. It is intended to be a coordinated system of home and community based health related services which enable people of any age, with disabilities, chronic or acute illnesses and the elderly to receive the care based on assessed need in their home communities.

Each Home and Community Care Program is unique, and based on the needs and

characteristics of the community it serves. It is **a mandatory program** which requires, regardless of funding arrangements, that the Essential Service Elements of this program are provided.

e-SDRT is designed to capture the program's Essential Service Elements such as:

- Program Management and Supervision
- Managed Care: Case Management and Referrals and Linkages
- Client Assessment
- Home Care Nursing
- Home Support Services: Personal Care and Home Management
- In-Home Respite Services
- Access to Medical Supplies and Equipment
- Information and Data Collection

and the program's Supportive Service Elements, such as:

- rehabilitation and therapy services (physical, speech, dietary, respiratory and others);
- adult day program;
- home-based services for long term psychiatric clients and clients experiencing mental or emotional illness. These services might include traditional counseling and healing services, medication monitoring;
- support services to maintain independent living which may include assistance with special transportation needs, grocery shopping, accessing specialized services, interpretative services, and therapeutic bath;
- home-based palliative care services;
- social services directly related to continuing care issues; and
- specialized health promotion, wellness and fitness.

The Service Delivery Plan document is a written and official description of how the Home and Community Care Program will be implemented in the community. The plan should be complete, and describe how each of the Essential Service elements will be implemented, and how the needs identified by the community will be met.

The e-SDRT application captures the data that relates to the type and frequency of service provided to the HCCP Client as described in the Service Delivery Plan document, and outlined in the Care Plan developed by the Home Care Nurse and designed to address the Client's identified needs. In other words, e-SDRT is used to capture and describe how the Community's Home Care Clients are accessing/receiving the Essential and Supportive Service Elements.

Data should be recorded on a daily basis where possible, through utilization of a tracking sheet for example, when Clients receive services. This data should ideally be recorded in the e-SDRT spreadsheet as soon as possible as well in order to preserve accuracy and quality. In accordance with best practices, this recorded data in the e-SDRT spreadsheet should be uploaded to the HCC Application database on a <u>monthly</u> basis.

This <u>monthly</u> upload enables communities to review reports generated, ensure accuracy of data quality and allow communities/Tribal Councils to carry out utilization trending analysis and forecasting. It also meets the data collection requirements set out in Contribution

Agreements and Home and Community Care Program Plan.

Communities and/or Tribal Councils that receive funding for the Home and Community Care Program and deliver Home Care service are **required** to collect service delivery information and upload their spreadsheets every month using the HCC Application.

Important Note: e-SDRT and HCC applications were designed for <u>monthly</u> uploads to promote a sustainable system capacity and avoid system overload and failure. Monthly uploads are subject to monitoring and random IT quality audits. Uploading several months at once can cause system failure.

SYSTEM REQUIREMENTS

Hardware Requirements

To work with the e-SDRT you will need a personal computer, equipped with a CD-ROM or USB memory stick drive, a minimum 5-GB hard drive, and 128 MB of RAM. If you require assistance, or if you encounter problems, contact your Regional Home and Community Care Office (refer to Appendix A – Education/Training/Contact Information).

Software Requirements

The e-SDRT uses a specific encoded Excel Spreadsheet (e-SDRT Spreadsheet) designed to function with Microsoft Excel 2000 but has been tested and shown to perform properly using other versions of Microsoft Excel, including 97, 98, 2000, 2002, 2003, 2007 and 2010. You must also have an Internet browser such as Internet Explorer 5.5 or higher and/or Mozilla Firefox installed on your computer. If you encounter performance problems, please contact your Regional Home and Community Care Office (*refer to Appendix A – Education/Training/Contact Information*).

e-SDRT Spreadsheet

You should use the spreadsheet containing the e-SDRT only template (2 tabs).

IMPORTANT - Please contact your Regional Home and Community Care Office (refer to Appendix A – Education/Training/Contact Information) to make sure you are using the right version of the e-SDRT Spreadsheet.

e-SDRT HCC Data Collection Requirement and Frequency of Data Capture

The recording of data on services delivered is completed daily using community tracking tools. Each user should collect and record their own data. Data entry on the e-SDRT spreadsheet can be performed on a daily basis to ensure quality of data interpretation and entry.

The e-SDRT template works with the HCC application which allows communities to upload community service delivery data on a <u>monthly</u> basis. Data quality audits are performed randomly to ensure accurate data capture. Once the e-SDRT data has been entered, the spreadsheet is uploaded via the HCC Application to generate national, regional and community-based reports. Of note, only communities can generate community-specific reports.

All e-SDRT fields are now mandatory and essential to meet community, departmental and ministerial reporting requirements, Performance Measurement and Evaluation for Grants and Contributions, and Program Plan requirements. *(The <u>only field which is not mandatory</u> <u>and is an exception, is the Community Space field)</u>.</u> Data entered in the columns with red headings are required for successful uploading - failure to complete these sections fully and in the correct format will result in the system application generating a validation error. Data entered in the columns with black headings are required for overall comprehensive data quality that provides the most accurate picture of your Home Care Program.*

According to the update of the Performance Measurement on Grants and Contributions (May 2013), all fields are subject to program monitoring and random data quality audits by regional and national offices.

The standardized data input and <u>monthly</u> upload enables communities to review reports generated, ensure accuracy of data quality and allow communities/Tribal Councils to carry out utilization trending analysis and forecasting. It also responds to the recommendation set out in the 2008-2012 FNIHCC Evaluation Report for data collection and quality improvements and responds to the data collection requirements set out in Contribution Agreements and Home and Community Care Program Plans.

Important Note: The e-SDRT system was designed for monthly uploads to promote a sustainable system capacity and avoid system overload and failure. Monthly uploads are subject to monitoring and random IT quality audits. Uploading several months at once can cause system failure.

Getting Started

RETRIEVING, OPENING AND SAVING THE e-SDRT SPREADSHEET

REMINDER - use the spreadsheet containing the e-SDRT template only (2 TABS). **To open the spreadsheet :** Double click on the file name OR right-click on the file name and click "Open" and the e-SDRT Excel Spreadsheet will open.

Immediately "Enable Macros" when you open the -SDRT Excel Spreadsheet file. (*Please refer to Appendix B – Excel Basics for help in enabling macros in different Excel versions*) Save the file with a new name by selecting **File Save As** from the Excel menu. The new name must contain your Community or Tribal Council name and the month and year for which you are reporting activity.

ENABLING MACROS

Depending on which version of Microsoft Excel is in use, you will see either of the following messages :

Microsoft Excel 2010 version

When you open the e-SDRT spreadsheet, a Security Warning message box will appear above a blank worksheet with the following message above it:

! Security Warning Macros have been disabled.

Enable Content

Click on the Enable Content box to activate macros.

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7	Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason for Discharge
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Microsoft Excel 2010

Microsoft Excel 1998, 2003, 2007



Note: For earlier versions of Microsoft Excel, if you do not get the message box below that prompts you to enable or disable the macros, you may need to Tools/Macro/Security to change the security level. Under the Security Level tab, select Medium.

(For additional information on Enabling Macros, refer to Appendix B – Excel Basics)

Tip: <u>Reasons for enabling macros at all times:</u>

- If the Community Name, Staff Name and Year/Month (yyyy/mm) fields are not entered while macros are enabled, the spreadsheet will not upload
- Enabling macros will reduce the chance of coding errors;
- Enabling macros will ensure all codes are entered in a valid format (and avoid validation errors)
- Function buttons will not work if macros are not enabled.

RECOMMENDED FILE NAMING CONVENTION

It is recommended that you rename the e-SDRT spreadsheet file to reflect the name of your community and the reporting month. The file name format is Community Name_Year-Month Example: Ottawa_2013-04.

Note:

Community Name: This entry should match the name found in the approved list of community names (e.g. Enter community name only). To obtain a copy of the approved list of community names in your region, please contact your Regional Home and Community Care Office (refer to Appendix A – Education/Training/Contact Information).

Year: 4-digit numerical entry (e.g., 2013)

Month: This is a 2-digit numerical number for each of the 12 months of the year (e.g., 01 for January, 02 for February, etc.)

Example: Ottawa_2013-04

Tip: Communities that have several different staff members preparing the e-SDRT monthly spreadsheet will need to add a fourth element to the file name in order to distinguish them. This can be achieved by adding the staff name to each file (e.g., Ottawa_ 2013-04_**Jean)**. Staff name should be different for each separate

document. Each person can upload his/her own file, or one person can log on and upload files for others.

DATA BACKUP

Even though your data is being uploaded for reporting purposes, you must retain a copy of your monthly e-SDRT spreadsheet for your records. All your e-SDRT data should be copied to an easily-accessible storage device such as a CD or USB memory stick and this device stored in a manner which follows your established standards for privacy and security of client data. Consult with your regional help desk to determine the best method and location to back up and store your files. *Communities are required to keep original copies of data for seven (7) years.*

e-SDRT Spreadsheet

IMPORTANT - You should use the spreadsheet containing the <u>e-SDRT only template</u> (2 Tabs). Please contact your Regional Home and Community Care Office (*refer to Appendix A – Education/Training/Contact Information*) to make sure you are using the right version of the e-SDRT Spreadsheet.

The e-SDRT Spreadsheet contains two (2) worksheets that capture data, the Client Information worksheet and the Home Care Services worksheet:

Client Information – This worksheet allows you to collect the basic client and Home Care Program information. The client record (the client's unique Client Identifier) should appear only once on this worksheet (only one row). **Exception**: The client record can appear twice on this worksheet if a client is discharged and admitted again with a new Primary Reason and/or Client Type OR if the client is a Readmission which means the client was discharged than "readmitted" for the same Primary Reason within the same calendar month.

Home Care Services – This worksheet allows you to capture the services provided by home care staff. Since every row in the worksheet represents a type of service within a category of service when the home care service was provided, the client identifier appears as many times as necessary (multiple rows), and must be repeated on every row for each type of service provided to the client during the visit.

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5 3 0 1 2 3	Client Identifier	Date of Service (yyyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Visits/Events	Number of Attempted Home Visits	Reason	Hours	Space

USING THE e-SDRT SPREADSHEET

Although Microsoft Excel is the software used to produce the e-SDRT spreadsheet, only basic Microsoft Excel functions are employed. It is, therefore, not necessary that you take an Excel training program if you follow the basic steps of this manual.

To begin entering your data in the e-SDRT worksheets, you must first become familiar with the system functions. Similarly, to understand the terminology used in this user manual, it is very important to review and understand the textual references used. The e-SDRT Excel spreadsheet has several elements:

- the Excel top menu bar
- the e-SDRT/HCC worksheet name or title on the top left hand side under the Excel top menu bar
- the custom spreadsheet has five (5) function buttons
- the two (2) e-SDRT worksheets (Client Information and Home Care Services) in which you enter data
- the Excel spreadsheet columns, rows, and cells

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Note: The screen capture above is from an earlier version of the e-SDRT template and is to be used as reference only.

Client Information Worksheet

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7	Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason for Discharge
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Home Care Services Worksheet

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FUNCTION BUTTONS

The function buttons provide five (5) key functions that you may require when using the e-SDRT spreadsheet. The function buttons are in the grey boxes at the top of the spreadsheet and in blue font. The function buttons will only work if macros are enabled. (If the function buttons do not work, refer to Appendix B - Excel Basics to enable macros.)

Insert Row(s) / Inserer rangée(s)

e-SDRT/HCC Applica	ation	Communi	ty or Tribal Council N
Client Information W	orksheet		Staff N
Note: Mandatory column	s are marked in red.	Insert Row(s) / Inserer rangée(s)	Year/Month (yyyy)
English / Français	Sort / Trier	Delete Row(s) / Supprimer rangée(s)	Help / Aide

This button allows you to insert a new row by clicking on the row number where you want the row inserted, and then clicking on the **Insert Row(s)/Insérer rangée(s)** button.

English / Français

This button will change the language of the spreadsheet's headings, field labels and column headers, but will not change the data that you entered.

Sort / Trier

You may sort the data entered on a worksheet so that you can more easily verify that client data has been entered. The data is sorted in ascending order (from a to z, from 1 to 10). On the **Client Information** worksheet, the data is sorted by Client Identifier. On the **Home Care Services** worksheet, the data is sorted first by Client Identifier and then by Date of Service.

```
Delete Row(s) / Supprimer rangée(s)
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You may delete an entire row by clicking on the row number rather than just the data contained in the row.

Highlight the row(s) that you wish to delete by clicking on the row number at the left of the worksheet, then click **Delete Row(s)/Supprimer rangée(s).** Click **OK** on the pop-up message to confirm the row deletion.

6		Client	Inform	ation		A	Imission/Discha	rge	Refe	erral	
7	Client Idertifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason for Discharge
8	Α	B	С	D	E	F	G	H	1	J	S
9								· · · · · · · · · · · · · · · · · · ·		2	11
10											
11											
12 13	To delete a ro	w, click the	e row nu	ımber.							
14				NAKAKAKATINA KAKAKAKAKA							

Help / Aide

The Help function provides information related to the data to be entered in each column. Simply place the cursor in the appropriate cell or field and click the **Help/Aide** button. Two (2) types of help are provided, depending on the type of information required. If you are in a cell or field that requires:

1. a text entry (such as a Staff Name, Community or Tribal Council Name or Client Identifier), an explanatory Help message will appear.

Help	×
Enter the Client Identifier. The client identifier may have any combination of letters and/or numbers. It must be unique and should not be changed. Spec characters such as slashes, dashes and colons are not valid.	ial:
ОК	

 a code entry (such as Gender, Source of Referral or Client Type), a list of available codes will appear in an Options pop-up window.



Click the down arrow to display the dropdown list of available codes

Click the down arrow to display the drop-down list of available codes, then scroll down to the code of your choice and select the appropriate code using the left mouse button or the **<Enter**> key. The corresponding letter will appear in the cell.

- **Tip:** You can also type the letter directly in the cell if you know the correct code.
- Note: If macros are not enabled and letters are typed in in lower case, upload validation error messages will occur.

When the **Options** window is open, you may click the Help icon *to view the explanatory Help message about the options available.*

NAVIGATION

Once the spreadsheet is open, you can use your keyboard arrow keys to move from cell to cell in the worksheet, or use your mouse to click in the cell where you wish to enter information.

Navigation keys are:

• Arrow keys on your keyboard (\leftarrow , \uparrow , \rightarrow , \downarrow) that move your cursor in the direction they

indicate (i.e., up arrow for up one cell, down arrow for down one cell, etc.).

- The **Home key** always brings you back to the first cell in the row; **Ctrl+Home** brings you back to the first cell in the worksheet.
- **Tip:** In Excel, you can use the **[Tab]** key to move from one cell to the next cell, and from the end of one row to the beginning of the next row. To learn more about shortcuts, open Microsoft Excel **Help** from the top menu bar, select **Index**, then enter "shortcuts" in the search area. A long list of choices will be displayed. Click on any topic to read more about it.

DATA ENTRY

Select a Worksheet

To select a worksheet, click on the appropriate worksheet label tab located at the bottom of left-hand corner of the e-SDRT template.

Enter Data

You can enter information in three (3) ways:

- Type the information into a cell.
- Select from the list of available codes.
- Copy (Ctrl+C) the data from one cell and paste (Ctrl+V) it into another cell.

FREQUENCY OF DATA CAPTURE

Each user collects and records daily their own data using community tracking tools. e-SDRT is designed to capture essential service delivery information per client on a daily basis. For example, services provided to a client can be entered into the e-SDRT spreadsheet on the day the services were delivered.

MANDATORY FIELDS

All fields in the Client Information and Home Care Services Worksheets are now

mandatory. Data entered in the columns with red headings are required for successful uploading - failure to complete these sections fully and in the correct format will result in a validation error. Data entered in the columns with black headings are required for overall comprehensive data quality that provides the most accurate picture of your Home Care Program. However, the fields under section heading: Services Not Provided, field headings: Attempted Home Visits, Reason and Hours should be completed only when applicable.

Tip: If you have entered data incorrectly in the columns with red headings, you will receive validation errors during upload. Print the validation error messages you receive as they provide the location where the information must be corrected on your worksheets. It will be easier for you to work from a paper copy to your worksheets on screen to locate and identify the errors.

WORKSHEETS

Worksheets allow you to report the basic client and home care service delivery information. The worksheet label tabs are located at the bottom left of the e-SDRT template.



Basic Information

Enter the basic information in the upper right side of the worksheet, which identifies the community name, the staff member who is completing the worksheet, and the year and month to which the data relates.

Tip: Before adding this information, ensure that the macros have been enabled so that what is entered on the Client Information Worksheet will show up on the Home Care Services Worksheet.

Community or Tribal Council Name	
Staff Name	
Year/Month (yyyy/mm)	

Note: When several spreadsheets are uploaded by the same community for the same month, the HCC Application uses these three (3) mandatory informatics fields (Community or Tribal Council Name, Staff Name and Year/Month) to determine if the current spreadsheet has data that must be added to the existing data or if the current spreadsheet must replace any previously uploaded spreadsheets. If all three fields in the second spreadsheet are identical to the first spreadsheet, then the information in the second spreadsheet <u>overwrites</u> the first. If the second spreadsheet has a different Staff Name, then that information is <u>added</u> to the existing information for that community.

Community or Tribal Council Name

The Community or Tribal Council Name must be a valid name as provided on a previously successful upload of the e-SDRT spreadsheet. If any other name is used, the spreadsheet will not be accepted at the time of the upload.

Note: The staff person uploading the spreadsheet must have uploading authorization for e-SDRT. Authorization is given by Regional eHealth department or Regional Administrator after they've received notification that the staff person assigned to upload has completed the Protecting Personal Information training (*refer to Appendix A – Education/Training/Contact Information*).

Staff Name

The Staff Name <u>does not require a specific format but cannot be left blank</u>. It is recommended that you enter a name that allows you to identify the health care worker who entered the data. Some communities may have all staff activities entered by one person, in which case that community will upload a single spreadsheet. Other communities may choose to have each health care worker prepare and upload his/her own spreadsheet. Either approach is acceptable, as long as the file names are distinct, as described in the section entitled Recommended File Naming Convention.

Year/Month

The year and month must be entered in the format yyyy/mm. For example, June 2013 would be entered as 2013/06.

CLIENT INFORMATION WORKSHEET

The Client Information worksheet has three (3) main sections:

- 1. Client Information (Columns A,B,C,D,E)
- 2. Admission/Discharge (Columns F,G,H)
- 3. Referral (Columns I, J, S)

Each section comprises several columns in which data must be captured. Each section and its corresponding columns are described below.

The Client Information section contains five (5) columns.

	Client	Inform	ation	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services
Α	B	С	D	E

Client Identifier (Column A)

The <u>Client Identifier is entered only once on **this** worksheet (only one row) unless the client has been discharged and admitted again and/or readmitted within the same calendar month.</u>

Client Information					A	Admission/Discharge			Referral	
Client Identif	er (yyyy) or (yyyy/mm/do	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/cd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason for Discharge
A	B	С	D	E	F	G	Н	1	J	S
1	1927/01/04	I F	A	A-3	2004/12/07	2004/12/07	2004/12/21	A	A	
1	1927/01/04	F	В	A-3	2004/12/07	2004/12/28		A	A	



The client identifier could be any combination of letters and numbers (A to Z, a to z, and 0 to 9). There is no minimum and no maximum amount of characters to be used, nor are there any mandatory components. <u>Special characters such as slashes, dashes and colons are not valid</u>. If invalid characters are entered, an error message will appear and the field will be cleared automatically. It must be unique within a community and, <u>after it has been created, it should</u> not be changed for the entire life of a client nor given to any other client.

Note: The Client Identifier used in this tool should be client-specific but not identifiable outside of the program in the community. It is recommended that each community keeps a master list of Client Identifiers (ID number), comprised of the Identifier associated with the client name. It is recommended that this master list of client identifiers be provided to the Health Director and stored in a second location that is central and secure.

<u>The client identifier is case sensitive</u>. For example, ZA004 is counted as one client and za004 is counted as a second client.

Tip: When starting a new client ID list, start with 001 rather than 1, otherwise the ID numbers will not sort in numerical order: 1, 1,11, 12 etc.

Birth Date (Column B)



The date of birth may be entered in yyyy format (just the year of birth) or in yyyy/mm/dd format, depending on the policies for your community. For example, September 30, 1957 would be entered either as 1957 or as 1957/09/30. If an invalid format is used, an error message will appear and the field will be cleared automatically. It is recommended that the complete birth date be used to avoid confusion.

Date of birth information can only be entered at the time of the creation of the file. Users will not be able to modify this information.

It is important to verify that a client's date of birth (i.e., the year of birth) is correct. it is not, notify Health Canada's National Help Desk *(refer to Appendix A – Education/Training/Contact Information).*

Gender (Column C)

Gender
С

Enter the letter "M" if the client is male and the letter "F" if the client is female. If invalid characters are entered, an error message will appear and the field will be cleared automatically.

Gender information can only be entered at the time of the creation of the file. <u>Users will not be able to modify this information</u>. Please note if you have previously entered the client as a female and in error someone entered it at a later date as a male, the data base will give you a warning and then change the gender to the last updated entry. It is important to verify that a client's gender is correct. If it is not, notify Health Canada's National Help Desk (refer to Appendix A – Education/Training/Contact Information).

Admission/Readmission (Column D)

|--|

This field indicates whether the client has begun to receive services from the Home Care program, whether the client was discharged then readmitted to the program within the current month for the same primary reason (see note below), or whether services are ongoing.

Click the **Help/Aide** button to display the drop-down list of three available choices.

Most frequently used codes are A for Admission and C for Services Continued. Code A – Admission is used when you first register/admit the client into the home care program. This

code will only apply to the first month of services the client receives. If the client continues to receive services the following month/months, the code <u>must be changed to C</u>.

Note: To change a Primary Reason for Home Care Services:

You would discharge the client and enter the client ID under Code A - Admission with the Admission Date one day after the Discharge Date.

To change a Client Type only:

You would discharge the client and enter the client ID under Code B – Readmission with the new Admission Date one day after the Discharge Date.

IMPORTANT INFORMATION: Code B – Readmission <u>should only appear for readmissions</u> within the same calendar month for the same Primary Reason for Home Care Services.

Primary Reason for Home Care Services (Column E)

Primary
Reason for
Home Care
Services
E

There are approximately twenty-five (25) choices in the Primary Reason for Home Care Services list of codes. Click the **Help/Aide** button to display the list of available choices. Select the code that best describes the primary reason for the client's inclusion in the HCC program (e.g., Diabetes, Hepatic, Biliary and Pancreatic, Conditions of the Endocrine, etc.).

IMPORTANT INFORMATION: <u>Code W is no longer applicable – do not use.</u>

If you are a non–nurse completing this section and are unsure about what the primary reasons is, please validate this choice with a health professional.

If the client's Primary Reason for Home Care Services changes, **you have to discharge** the client, and **Admit** the client with the new Primary Reason for Home Care Services. The date for Admission will be the date following the Discharge Date – you will receive validation error if the Discharge and Admission dates are the same.

Note: Client type may also change with the new Primary Reason for Home Care Services.

This field is used by communities to obtain a clearer understanding of the emerging trends and/or changes within their HCC program. This is important information for the community's overall health plan. It is also used by regional and national offices to make evidence-based informed decisions.

The Admission/Discharge section contains three (3) columns.

Admission/Discharge								
Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)						
F	G	Н						

Referral Date (Column F)



The Referral Date must be entered in yyyy/mm/dd format. For example, September 30, 2013 would be entered as 2013/09/30. If an invalid format is used, an error message will appear, and the field will be cleared automatically.

Admission Date (Column G)



The Admission Date must be entered in yyyy/mm/dd format. For example, September 30, 2013 would be entered as 2013/09/30. If an invalid format is used, an error message will appear, and the field will be cleared automatically.

Discharge Date (Column H)



The Discharge Date must be entered in yyyy/mm/dd format. For example, September 30, 2013 would be entered as 2013/09/30. If an invalid format is used, an error message will appear, and the field will be cleared automatically.

When the client has been discharged, the "Discharge Date" and "Reason for Discharge" must be completed

The following are some examples of when to discharge. You must discharge a client when:

- the HCC program determines they no longer require services;
- the HCC Client Type changes, you must discharge and then do another admission for the new applicable client type; and
- the HCC client has not received services for a consecutive and maximum period of six (6) months. *exceptional circumstance only*

Reminder: If you have filled in a Discharge Date, you <u>must</u> also fill in the Reason for Discharge, or you will receive an error when you upload your worksheet.

All fields are subject to periodic review and data quality audits.

The Referral section contains two columns.

Referral							
Source of Referral	Client Type						
I	J						

Source of Referral (Column I)



Click the **Help/Aide** button to display the list of available choices. Select the code that best describes the person or organization that referred the client to the HCC program (e.g., Client, Family Member, Neighbor, etc.)

Client Type (Column J)



Click the Help/Aide button to display the list of available choices. Select the code that best describes the type of condition that justifies this client's inclusion in the Home Care program (e.g., Acute, End of Life, Rehabilitation, etc.).

<u>If the Client Type changes</u>, **you have to discharge** the client and (A) **Admit** <u>with the new</u> <u>Client Type code</u>. The date of Admission will be the date following the Discharge Date. (See Section on Admission/Readmission)

Note: <u>If Client's Primary Reason for Home Care Services changes</u> then **this will be also be considered an Admission**, <u>not a Readmission</u>.

Reason for Discharge (Column S)



Click the Help/Aide button to display the list of available choices. Select the code that best describes why the client was discharged.

Note: If a client is active in the HCC case load but doesn't receive services in a month, the client should remain in the client information sheet (no entries will be necessary in the Home Care Services sheet for that client that month).

If a Reason for Discharge is entered, the Discharge Date must be entered.

HOME CARE SERVICES WORKSHEET

The **Home Care Services** worksheet captures information related to the services performed by health care professionals and related staff.

Note: Every row in the worksheet represents a type of service within a category of service.

First Nations a	and Inuit H	ome and Com	munity Care F	Program			-		
e-SDRT/HCC Application Community or Tribal Council Name									
Home Care Services Worksheet Staff Name									
Note: Mandatory columns are marked in red.			Insert Row(s) / Inserer rangée(s) Year/N	lonth (yyyy/mm)			
English / Français Sort / Trier			Delete Row(s)	Delete Row(s) / Supprimer rangée(s) Help / Aide					
		ŀ	lome Care Servi	me Care Services			Services Not Provided		
	Date of Serv (yyy/mm/do			Hours of Service	Number of	Number of			Com.
Client Identifier	OR - Day of Service (do	Service	Service	Provided	Home Visits/Events	Attempted Home Visits	Reason	Hours	Space

The Home Care Services worksheet has three sections:

- 1. Home Care Services
- 2. Services Not Provided
- 3. Community Space

Each section and its corresponding columns are described below.

The Home Care Services section contains six (6) columns.

	Home Care Services								
Client Identifier	Date of Service (yyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events				
A K		L	Μ	Ν	0				

Client Identifier (Column A)



The Client Identifier in the Client Information Worksheet assigned to the client is repeated here for each of the services that have been provided to that particular client.

Note: The **Client Identifier** used in this tool should be client-specific, but not identifiable outside of the program in the community.

The **Client Identifier** entered in the Home Care Services worksheet must be already entered in the **Client Information** worksheet. If there is no corresponding entry, the spreadsheet will be rejected when you try to upload.

Date of Service (Column K)



The **Date of Service** can be entered in full yyy/mm/dd format, or in the shorter dd format, provided that the Year/Month yyyy/mm field is filled in at the top of the worksheet. The date must be within the reporting month. It is recommended that the complete date be used to avoid confusion and possible errors.

Category of Service (Column L)



Click the **Help/Aide** button to display the list of available choices. Select the code that best describes the category of services being provided to the client (e.g., Assisted Living, Nursing Services, etc.). If an invalid code is used, an error message will appear and the field will be cleared automatically.

Note: Services delivered by a nurse or delegated by a nurse are reported under Nursing Services. Nurses providing care services other than those listed under Nursing Services should report them under appropriate category and service.

Service (Column M)



Click the **Help/Aide** button to display the list of available choices. The options displayed are based on the **Category of Service** that you have selected (e.g., for the **Assisted Living** category of services, a series of choices including Home Making/Home Management, Meal Services, etc. will be offered).

Note: You must first select the Category of Service before choosing the Service.

Category of Service code "F" (In Home respite), does not require corresponding service type information, and therefore no choices will be offered in a drop-down menu. The cell may be left blank without causing upload issues.

Hours of Service Provided (Column N)



Enter the number of hours of service that were provided to the client. For example, if a client receives one hour of services, 1.0 should be entered in the **Hours of Service Provided** column. Enter zero (0) in this column when a client <u>did not</u> receive services as scheduled or planned and complete the **Services Not Provided** section.

Note: When a client is not scheduled to receive one or more services in a calendar month, <u>do not</u> list this client in the **Home Care Services Worksheet**. You may leave the client information pertaining to the client in the **Client Information Worksheet** only.

Recording Time

Two fields in the Home Care Services worksheet require that you enter hours of service.

		Ho	me Care Servi	ces		Ser			
Client Identifier	Date of Service (yyyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events	Number of Attempted Home Visits	Reason	Hours	Com. Space
Α	K	L	M	N	0	Р	Q	R	Т

Record time in 15-minute increments only and use decimals to indicate partial hours. The decimal symbol (i.e., decimal period [0.25] or comma [0,25]) will depend on your system settings.)

15 minutes	=	0.25
30 minutes	=	0.50
45 minutes	=	0.75
1 hour	=	1.00

		Ho	me Care Servi	Services Not Provided					
Client Identifier	Date of Service (yyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events	Number of Attempted Home Visits	Reason	Hours	Com. Space
Α	K	L	М	N	0	Р	Q	R	Т
3110000002	2013/09/05	A	A	0.00	0	1	Н	0.50	
3110000002	2013/09/05	E	E	0.25	0				

Number of Home Visits/Events (Column 0)



Indicate the number of visits/events for client where home care services were provided.

Note: If multiple services are provided in one visit by one health care provider only record one visit for the 1st entry.

EXAMPLES

Single Entry:

	-	Но	me Care Servi	Ser					
Client Identifier	Date of Service (yyyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events	Number of Attempted Home Visits	Reason	Hours	Com. Space
Α	K	L	М	N	0	Р	Q	R	Т
3110000002	2013/09/01	В	G	1.00	1				
3110000002	2013/09/01	E	Е	0.25	0				

Home Care Services						
Date of Service (yyyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events		
K	L	Μ	Ν	0		
2013/09/01	В	G	1.00	1		
2013/09/01	В	F	0.50	0		
2013/09/01	В	В	0.25	0		
2013/09/01	С	А	0.50	0		
2013/09/01	А	В	0.50	0		
2013/09/01	E	E	0.25	0		
	(yyyy/mm/dd) - OR - Day of Service (dd) 2013/09/01 2013/09/01 2013/09/01 2013/09/01 2013/09/01	Date of Service (yyy/mm/dd) - OR - Day of Service (dd) Category of Service K L 2013/09/01 B 2013/09/01 B 2013/09/01 Category of Service 2013/09/01 Category of Service 2013/09/01 A	Date of Service (yyy/mm/dd) - OR - Day of Service (dd) Category of Service Service K L M 2013/09/01 B G 2013/09/01 B F 2013/09/01 B B 2013/09/01 C A 2013/09/01 A B	Date of Service (yyy/mm/dd) - OR - Day of Service (dd)Category of ServiceService ProvidedHours of Service ProvidedKLMN2013/09/01BG1.002013/09/01BF0.502013/09/01BB0.252013/09/01CA0.50		

Multiple Entries:

Cumulative Services:

	Home Care Services					
Client Identifier	Date of Service (yyyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events	
Α	K	L	Μ	N	0	
311000002	2013/09/30	С	А	20.00	20	
311000002	2013/09/30	E	E	5.00	0	

The Services Not Provided section contains three (3) columns.

Services Not Provided							
Number of Attempted Home Visits	Reason	Hours					
P Q R							

Number of Attempted Home Visits (Column P)



Indicate the number of times that staff visited the client's home, but no services were provided because the client was not home or for other reasons, such as refusing services.

Note: This should also be recorded in the client's paper record, along with the reason why services were not provided.

Tip: When a client does receive services, the trip to that client's home should be entered in the **Number of Home Visits** column of the **Home Care Services** section.

Reason (Column Q)



The **Reason** column allows you to explain why services were not provided.

Click the **Help/Aide** button to display the list of available choices. Select the code that best describes the reason why services were not provided to the client (e.g., Insufficient Funds, Understaffing, etc.).

Note: The reason why services were not provided should also be recorded in the client's paper record, along with the number of attempted home visits.

Hours (Column R)



Enter the number of hours of service that were not provided to the client, but should have been provided according to the client's care plan. For example, if a client is scheduled to receive 45 minutes of personal hygiene services but these services were not delivered, 0.75 should be entered in the **Hours** column.

Note: When recording time, use decimals to indicate partial hours.

15 minutes	=	0.25
30 minutes	=	0.50
45 minutes	=	0.75
1 hour	=	1.00

For example, 3 hours and 45 minutes = 3.75 Decimal numbers can be separated with periods or commas ("." or ",").

		Но	me Care Servio	Services Not Provided					
Client Identifier	Date of Service (yyy/mm/dd) - OR - Day of Service (dd)	Category of Service	Service	Hours of Service Provided	Number of Home Visits/Events	Number of Attempted Home Visits	Reason	Hours	Com. Space
Α	K	L	М	N	0	Р	Q	R	Т
3110000002	2013/09/05	A	A	0.00	0	1	Н	0.50	
311000002	2013/09/05	E	E	0.25	0				

Community Space (Column T)*

*This is the <u>only</u> field that is not mandatory.



The Community Space column allows you to track information specific to your community using one of 26 optional alphabetic codes (for example, to track the number of Assisted Living hours that were funded by AANDC).

The specific information to be tracked is identified by the community and regionally defined; however, a master list of codes must be maintained by the regional office to ensure codes have the same value throughout the region. For example, if code 'Y' is used to identify the number of Assisted Living hours that were funded by AANDC, 'Y' must be used by all the communities in the region that wish to track this information.

If your community wishes to track specific items, please contact your Regional Home and Community Care Office (*refer to Appendix A – Education/Training/Contact Information*) to explore possibilities of assigning a code to these items.

This completes the review of the e-SDRT Excel Spreadsheet.

Tip: Remember to save your spreadsheet each time you enter data.

After inputting and saving your data for the month, you will be ready to upload this information to the HCC application.

Note: The HCC application will upload files created with MS Excel 97, 98, 2000, 2002, 2003 and 2007 and 2010. Communities should not use Excel 95, as it does not support the functions required to display messages and lists of codes. Users should contact their Regional Help Desk (*refer to Appendix A – Education/Training/Contact Information*) for an upgrade and then convert the file into one of the above formats.

Tip: If communities use Excel 2007 and 2010 to fill in report files, they must save the document as Excel 1997-2003 workbook (.xls) as .xlsx documents will not upload.

HCC Application

UPLOADING THE e-SDRT SPREADSHEET AND DOWNLOADING COMMUNITY REPORTS

For new users, you will need to complete the Protecting Personal Information online training before getting access to the HCC application used to upload and download data. You will need a 20-digit authorization number to register and complete the training. Your Regional Help Desk should assist you in this matter (*refer to Appendix A* – *Education/Training/Contact Information*).

Once you have completed this training, a user account ID and password will be sent to you via email by your regional e-Health system administrator. Once you receive this information, you will be ready to upload your e-SDRT spreadsheet and download your community reports.

Uploading monthly e-SDRT files and downloading community reports are done using the HCC application.

You can access the HCC application at:

http://www.fnihis.org/hcc-eng.html

Tip: Add the internet address above to your list of Favorites for ease of upload and download.

Saving and Uploading the e-SDRT Spreadsheet to the HCC Application.

Once you have entered all your data for the month, and saved your spreadsheet *(see Recommended File Naming Convention)*, you are ready to "upload" or transmit this information to the HCC program office. You have two (2) options, depending on whether or not you have access to the HCC Application.

OPTION 1

STEPS TO UPLOAD YOUR SAVED MONTHLY SPREADSHEET TO THE HCC APPLICATION:

In order to transfer this information to the HCC program office, you must have access to the internet and you must have been authorized by Regional Help Desk and Regional Home and Community Care Office to upload your data.

(Access passwords will be provided by regional Help Desk–see Appendix A– Education/Training/Contact Information).

- 1. Log on to the HCC Application at <u>http://www.fnihis.org/hcc-eng.html</u>.
- 2. In the top menu bar, choose Administration.

3. In the Administration menu at the left of the screen, **click e-SDRT Excel Spreadsheet Upload**. The **Excel Spreadsheet Upload** screen will be displayed.

	Home Client Search Reports Administration Help Français Log Out
	HCC Reports 2
Administration Menu	Excel Spreadsheet Upload
Change Password e-SDRT/HCC Excel Spreadsheet Upload	* Indicates Mandatory
	Please specify the File Name of the Excel spreadsheet by clicking on the Browse button.
	Region Ontario File Name * Browse
	Please note that only files saved in Microsoft Excel 2002, 2000, 98 and 97 format can be uploaded. Other formats must be converted before submitting the file.
	Click on the Upload button to start uploading the file into the regional database
Session Status	Please note that it may take up to 10 minutes to upload the file (500 kb file with 28.8 kbps modern).

4. Click the **Browse** button. In the pop-up screen that appears, navigate to the file that you wish to upload, and double click on the file name. The system will display your file name in the **File Name** field.

	Home Reports Administration Help Français Log Out
- V	HCC Reports
Administration Menu	Excel Spreadsheet Upload
Change Password e-SDRT/HCC Excel Spreadsheet Upload	* Indicates Mandatory
e-HRTT Excel Spreadsheet Upload	Please specify the File Name of the Excel spreadsheet by clicking on the Browse button. Region Ontario File Name L:\Home and Community Care\E-SDRT & E-H Please note that only files saved in Microsoft Excel 2002, 2000, 98 and 97 format can be uploaded. Other formats must be converted before submitting the file.
Session Status User Name: Annie Fleurant Logged on since: 23-JUN-2011 16:14 EDT Region: Ontario	Click on the Upload button to start uploading the file into the regional database Upload Please note that it may take up to 10 minutes to upload the file (500 kb file with 28.8 kbps modem).

5. Click the **Upload** button. The system will transfer your file to the database and following message if the transfer is successful:

All data has been successfully uploaded. # of rows processed in Client Sheet. # of rows processed in Service Sheet.

6. If your community has more than one file, repeat the process as many times as necessary to transfer all your files.

Note: The HCC application will upload files created with MS Excel 97, 98, 2000, 2002, 2003, 2007 and 2010. Communities should not use Excel 95, as it does not support the functions required to display messages and lists of codes. Users should contact their Regional Help Desk (*refer to Appendix A – Education/Training/Contact Information*) for an upgrade and then convert the file into one of the above formats.

Tip: If communities use Excel 2007 and 2010 to fill in report files, they must save the document as Excel 1997-2003 workbook (.xls) as .xlsx document will not upload.

Note: When several spreadsheets are submitted by the same community for the same month, the HCC Upload program checks three fields (Community or Tribal Council Name, Staff Name, Year/Month) to determine if the contents must be added to the existing .data or replace it. <u>If all three (3) fields in both files are identical, then the information in the second and subsequent files overwrites the contents of the first.</u> If each file has a different Staff Name, then that information is added to the existing information for that community.

OPTION 2

Save the e-SDRT spreadsheet on a CD or USB memory stick and please contact your Regional Home and Community Care Office (*refer to Appendix A – Education/Training/Contact Information*).

ERROR MESSAGES

If you attempt to upload a file that contains incomplete mandatory fields or logic errors, such as a discharge date that precedes the admission date, the system will display a validation error along with a comprehensive table listing the errors and suggestions to correct them. As you can see in the screen image provided below, to facilitate the correction process, details

Change Pas e-SDRT/HC Excel Sprea		Validation Error			
	cel Spreadsheet Upload			ving error(s) before proceeding:	
		Work Sheet	Row	Error	
		CLIENT	10	Admission Date must be within Year/Month for a Readmission or Admission.	
		CLIENT	11	Client Type is mandatory.	
		CLIENT	11	Admission Date is mandatory	
		CLIENT	13	Client Type is mandatory.	
		CLIENT	17	Admission Date for a continuing client must be earlier than Year/Month	
		CLIENT	19	Admission Date for a continuing client must be earlier than Year/Month	
	ssion Status	SERVICE	25	Date of Service does not fall between an Admission Date and Discharge Date	
Jser Name:	Annie Fleurant	SERVICE	25	Date of Service less than Admission Date.	
	23-JUN-2011 18:14 EDT Ontario	SERVICE	26	Date of Service does not fall between an Admission Date and Discharge Date	
Region:	Ultarit	SERVICE	28	Date of Service less than Admission Date.	
		SERVICE	27	Date of Service does not fall between an Admission Date and Discharge Date	
		SERVICE	27	Date of Service less than Admission Date.	
		SERVICE	28	Date of Service does not fall between an Admission Date and Discharge Date	1
		SERVICE	28	Date of Service less than Admission Date.	
		SERVICE	32	Date of Service does not fall between an Admission Date and Discharge Date	
		SERVICE	32	Date of Service less than Admission Date.	1
		SERVICE	33	Date of Service does not fall between an Admission Date and Discharge Date	
		SERVICE	33	Date of Service less than Admission Date.	
		SERVICE	34	Date of Service does not fall between an Admission Date and Discharge Date	
		SERVICE	34	Date of Service less than Admission Date.	
		SERVICE	47	Date of Service does not fall between an Admission Date and Discharge Date	

include the worksheet name (Client or Service), the specific row, and a description of the error.

Make the corrections to your spreadsheet, save it, and repeat the upload process described above. When your file is accepted, the system will display the following message: "All data has been successfully uploaded." We recommend making a copy or printing this page for your files.

A	Home	1	Reports Administration Help Français Log Out
- VV	HCC Reports		
Administration Menu	Excel Spreadshee	et Uplo:	oad
Change Password e-SDRT/HCC Excel Spreadsheet Upload	Validation Error You must correct the		ing error(s) before proceeding:
	Work Sheet	t Row	Error
	CLIENT	9	Admission Date must be within Year/Month for a Re-admission or Admission.
	CLIENT	10	Admission Date must be within Year/Month for a Re-admission or Admission.
	CLIENT	11	Admission Date must be within Year/Month for a Re-admission or Admission.
	CLIENT	12	Admission Date must be within Year/Month for a Re-admission or Admission.
	CLIENT	13	Admission Date must be within Year/Month for a Re-admission or Admission.
	CLIENT	14	Admission Date must be within Year/Month for a Re-admission or Admission.
	SERVICE	9	Date of Service is not within the Year/Month of this file
Session Status	SERVICE	10	Date of Service is not within the Year/Month of this file
User Name: User 1	SERVICE	11	Date of Service is not within the Year/Month of this file
Logged on since: 08-MAR-2005 12:45 EST	SERVICE	12	Date of Service is not within the Year/Month of this file
Region: Ontario	SERVICE	13	Date of Service is not within the Year/Month of this file
	SERVICE	14	Date of Service is not within the Year/Month of this file
	SERVICE	15	Date of Service is not within the Year/Month of this file

DOWNLOADING e-SDRT REPORTS

e-SDRT REPORT TYPES

Once the e-SDRT spreadsheet has been uploaded and processed, the e-SDRT reports become available online via the HCC application. The following reports are available in both French and English, and are available in monthly and annual formats:

- Community Cumulative Report
- Community Total Services Report
- Tribal Council/Health Authority Total Services Report
- Regional Total Services Report
- National Total Services Report

Note: Not all authorized individuals have access to these reports.

More information about each of these reports is provided below.

Note:

• The Cumulative Reports (CRs) contain confidential patient information whereas the Total Services Reports (TSRs) do not. CRs are available only to the authorized individuals that have upload capability. • The regional and national Total Services Reports (TSRs) do not contain confidential data.

Community Cumulative Report (CR) – Monthly

- The monthly format is the same as before.
- Available to authorized individuals that **DO** have upload capability. One line per admission cycle (admission to discharge).
- Nursing Services and Case Management Services are broken out; hence, the length of the report will vary according to the quantity of these services provided.

Community Cumulative Report (CR) – Annual

- The <u>annual</u> format is now available.
- Available to authorized individuals that **DO** have upload capability.
- One line per client.
- The length of the report varies according to the number of clients reported on. (Approximately 20 clients per page.)
- Provides the sum of hours and the number of home visits.

Community Total Services Report (TSR)

- The monthly and annual reports are available.
- Available to authorized individuals that **DO** have upload capability.
- Computations in the monthly report have been improved.
- Approximately 11 pages for all report types (monthly, annual).

Tribal Council/Health Authority Total Services Report (TSR)

- This is a report available in <u>monthly</u> and <u>annual</u> report formats.
- Available to authorized individuals that have access to report downloads for a specific community.
- 11-15 pages depending on the length of the appendix.
- Includes an appendix (may be as short as one page) listing the communities (associated with the Tribal Council or health authority) that did not report.
- The appendix for the monthly report lists the communities that did not report in that month.

• The appendix for the annual report lists the communities that did not report in each month of the reporting period. The report shows the months included in the report and has an X to indicate that the community did not report in a particular month.

Regional Total Services Report (TSR)

- Regions **<u>DO NOT</u>** have upload capability.
- Two reports: mandatory and non-mandatory data.
 - Mandatory
 - This is a report available in <u>monthly</u> and <u>annual</u> report formats.
 - Approximately 5 pages long.
 - Contains the minimum mandatory reporting information to meet
accountability requirements.

- Non-mandatory
 - This is a report available in monthly and annual report formats.
 - Data is amalgamated from all communities, Tribal Councils and health authorities in the region.
 - Approximately 11 pages long.
 - Includes an appendix (may be a few pages) listing all communities, Tribal Councils and health authorities (with upload capability) in the region that did not report.

The appendix for the monthly report lists the communities that did not report in that month.

The appendix for the annual report lists the communities that did not report each month of the reporting period. The report shows the months included in the report and has an X to indicate that the community did not report in a particular month.

National Total Services Report (TSR)

- This is a report available in monthly and annual report formats.
- National **DOES NOT** have upload capability.
- All diabetes data is collapsed into a single line item under Primary Reason for Services Provided.
- Approximately 11 pages of data, plus the appendix.
- Includes an appendix (may be several pages; will vary in length) listing all communities (nationally) that did not report. The appendix for the monthly report lists the communities that did not report in that month.

The appendix for the annual report lists the communities that did not report each month of the reporting period. The report shows the months included in the report and has an X to indicate that the community did not report in a particular month.

Once your monthly spreadsheets have been processed, reports will be available to you by the same means that you used to send your data in (i.e., HCC Application, e-mail, Canada Post).

Once your files have been uploaded and processed, the **Cumulative Reports** and the **Total Services Reports** will become available online through the HCC Application. These reports are available in the following formats: monthly and annually.

STEPS TO DOWNLOAD e-SDRT REPORTS FOR YOUR COMMUNITY FROM THE HCC APPLICATION:

To download the **Cumulative Reports** or **Total Services Reports** for your community:

1. Log on to the HCC Application (access passwords will be provided by your Regional Help Desk (refer to Appendix A – Education/Training/Contact Information).

2. On the top menu bar, choose **Reports**,

3. On the Reports menu at the left of the screen, click on **Home and Community Care Reports**, click on **Service Delivery Reports**. The **Service Delivery Reports** screen is displayed.

	Home Client Search Reports Administration Help Français Log Out
	HCC Reports
Reports Menu	Service Delivery Reports
 Home and Community Care Reports Service Delivery Reports 	*Indicates Mandatory
	Please enter the search criteria, then click the Get the List of Reports button to display the list of reports.
	Report Type * Community Service Community *
	Year * Period *
	Language *
Session Status	Get the List of Reports Clear

4. Select **Community** from the **Report Type** drop-down list, and then select the **Service Community**, the **Year**, the **Period** and the **Language**.

5. Click the **Get the List of Reports** button. The List of Reports panel appears at the bottom of the screen, displaying the appropriate **Total Services** and **Cumulative Reports** for the selected fiscal year.

Note: The reports that are available for download appear as a hyperlink. If a report is not listed, this means that it has not yet been generated. If you are unable to view or download reports for your community, you may not have the appropriate security permissions and should contact your Regional Help Desk *(refer to Appendix A – Education/Training/Contact Information)*.

User Name: Logged on since: Region:	User 17-FEB-2005 15:49 EST Ontario	List of Reports	
		Report Type	Community
		Service Community	Wahgoshig
		Year	2004
		Period	Monthly
		Language	English
		Cumulative Reports	Total Services Reports
		01-Apr-2004 - 30-Apr-2004	01-Apr-2004 - 30-Apr-2004
		01-May-2004 - 31-May-2004	01-May-2004 - 31-May-2004
		01Jun-2004 - 30Jun-2004	01Jun-2004 - 30Jun-2004
		01Jul-2004 - 31Jul-2004	01Jul-2004 - 31Jul-2004
		01-Aug-2004 - 31-Aug-2004	01-Aug-2004 - 31-Aug-2004
		01Sep-2004 - 30Sep-2004	01Sep-2004 - 30Sep-2004
		01Oct-2004 - 31Oct-2004	01Oct-2004 - 31Oct-2004
		01Nov-2004 - 30Nov-2004	01Nov-2004 - 30Nov-2004
		01Dec-2004 - 31Dec-2004	01Dec-2004 - 31Dec-2004
		01Jan-2005 - 31Jan-2005	01Jan-2005 - 31Jan-2005
		01-Feb-2005 - 28-Feb-2005	01-Feb-2005 - 28-Feb-2005
		01Mar-2005 - 31Mar-2005	01Mar-2005 - 31Mar-2005
			ouse pointer on the link and press the left mouse button. se pointer on the link and press the right mouse button.
			to view and print report files. If it is not installed on your computer, you can ease click <u>here</u> to go to the Adobe web site.

This is a fictional example using fictional data.

Note: Difference between **.pdf** and **.txt** : **.pdf** provides easy to read tables. **.txt** is for creating charts and graphs and also requires additional skills (see Appendix I – Importing Your Reports into Excel for User Customizing)

- 6. Left click on a hyperlinked report name to view the report, or right click to download it (select **Save Target As** from the drop-down menu).
 - Click on PDF, open the file
 - Click on PDF, download the file
- **Tip:** When you right click and select **Save Target As**, the report file will be highlighted in a **Save As** popup window listing its default file name. If you wish to change this name, overwrite the highlighted File Name. To save this file to your computer, click the down arrow in the **Save** in field, select your preferred location (e.g., My Documents), then click the **Save** button. The **Download Complete** dialogue box appears. Click the **Close** button. You can now retrieve the file from your selected location.

Rename your downloaded files clearly:

For example, "CommunityName_year_month".xls is: Ottawa_2013-04.xls

If you have several people uploading then you can add the person's name. For example. "CommunityName_Year-Month_Staff Name". xls is: **Ottawa_2013-04_Jean**.

Sample Reports

The next two pages display a sample of the Cumulative Report and the Total Services

Report.

Note: To interpret the Cumulative Report, you will need to convert the alphabetical codes (e.g., Referral, Client Type, Nursing Services Codes). The list of codes and their meaning is available in the table below.

Sample - Cumulative Report

Idan: Information Administion/Educatory Defaures Defaures Bone Visible (4) Assume of the state of the sta		Fra	it Nation:			t Hor Prog		d C	ann.	rty					CC nc de	MML	E REI JNITY Delive (c SE	ery R	271 U 2010-02-02	ng			Loma Regim Report	0.02010	TAE		Onle	igesnig altr -2005			
1 1 2			lien:	lutz		:icn	6		79		icn/Eisc	'aarche	De	facta	1 Dor	ne Vial	tu (4)						Applie	aŭ Li=:	13				8	PLLY	.dati
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4 32 800 94 7 7. 1 03 JW 46 12 JUN 66 17 C C N 2 L.G N 3 1 C 2.G 4.G															3		3						4			2			G.		
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											18 378	CE 13			,						1.6	- 3	3	~	a			2.6	4.6		

First Nations and Inut Home and Co Care Program	ommuni	Ŋ		TOTAL SERVICES REPORT COMMUNITY Electronic Service Delivery Reporting Template (e-SDRT)									Community: Region: Reporting Period: Month - Apr-2010									
						N	lusber	of Gee	urrences	by Ge	nder pe	r Age	Group									
		Total		0 -	2. Alm	6 -	10 yrs	11 -	16 yrs	17 -	25 yrs	26 -	45 yrs	46 -	55 yrs	56	- 64	утя	65 -	74 YER	75 1	YES +
E	ж	7	Total	н	p.	м	7	н	7	ж	9	M	ÿ	ж	¥	м	10	,	м	P	н	7
Sumber of Clients	6	4	10	0	0	0	0	0	0	0	0	0	0	0	0	.4		0	2	0	0	4
PRIMARY REAGON FOR HOME CARE																						
Habetes - Diagnosed Over One	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	0	0
onditions of the Endocrine	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	3
iabetes - Disgnosed in Past	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0
ear iabetes - Early Signs of or xisting Cardiovascular Disease	12	0	12	0	0	ø	٥	0	0	0	0	σ	٥	0	0	12		D	0	•	0	0
Viabetes - Early Signs of or Nisting Cardiovascular and enal Disease	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	3	0	0	0	0	0
iabetes - Pregnant Diabetic	0	0	0	D	0	0	0	0	0	0	0	Ø	0	0	0	0	1	0	0	0	0	0
epatic, Biliary, and Pancreatic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	÷.	0	0	0	0	0
ardiovascular Disease/Heart, Circulatory	0	a	٥	0	۵	٥	٥	0	٥	0	0	٥	0	٥	٥	۵	4	9	e	0	٥	0
lastrointestinal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Difficulty Feeding (Tube Feeds, Dysphagia, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0

Sample – Total Service Report

EDUCATION / TRAINING & CONTACT INFORMATION - APPENDIX A

EDUCATION/TRAINING

 Prior to becoming an HCC user you must complete the online training course on Protecting Person Information – basics of privacy. You can access this online training at:

http://www.fnihis.org/education-formation-eng.html

- Please contact your Regional Coordinator and/or e-SDRT Trainer for:
 - copies of the latest updated e-SDRT User Guide and e-SDRT template

http://www.fnihis.org/bulletin-communique-eng.html

• For technical issues when uploading or downloading from the HCC application, please contact your Regional Help Desk at:

CONTACT INFORMATION

Help Desk – Contact Information

Pacific Region

Help Desk (877) 666-3211 Toll Free Fax (604) 666-7363 e-Health Solutions Unit FNIHB-Health Canada Pacific Regional Office #540-757 West Hastings St. Vancouver BC V6C 3E6

Alberta Region

Help Desk (877) 495-5334 Toll Free Fax (780) 495-2687 Health Canada 9700 Jasper Ave., Suite 730 Edmonton AB T5J 4C3

Saskatchewan Region

Help Desk (877) 772-7715 Toll Free Fax (306) 780-7137 Health Canada 2045 Broad Street, 5th Floor Regina SK S4P 3T7

Manitoba Region

Help Desk (800) 846-6428 Toll Free Fax (204) 984-1940 e-Health Solutions Unit Manitoba Regional Office First Nations and Inuit Health Branch 300 - 391 York Ave Winnipeg MB R3C 4W1

EDUCATION / TRAINING & CONTACT INFORMATION - APPENDIX A

Ontario Region

Help Desk (800) 241-2751 Toll Free Fax (613) 952-0177 Health Canada 1547 Merivale Road, 3rd Floor Ottawa ON K1A 0L3

Quebec Region

Help Desk (877) 543-5353 Toll Free Fax (514) 283-6567 Health Canada 200 René-Lévesque Blvd. West East Tower, 2nd Floor, Room 202-145 Montréal QC H2Z 1X4

Alberta Region Home and Community Care Health Canada, FNIHB Suite 730 Canada Place 9700 Jasper Avenue, Edmonton, AB T5J 4C3 (780) 495-2314

Atlantic Region

Help Desk (877) 426-4515 Toll Free Fax (902) 426-8675 Health Canada 1505 Barrington Street, Suite 1525 Halifax NS B3J 3Y6

National Help Desk

(613) 301-2276 Fax (613) 595-0395 Health Canada 340 Legget Drive, Room E107 AL: 2801C Ottawa ON K1A 0K9

EXCEL BASICS

The e-SDRT application was developed on Excel, a spreadsheet software application that the majority of communities have access to and that could be supported by the multitude of computer environments in operation today. The e-SDRT uses a specific encoded Excel Spreadsheet (e-SDRT Spreadsheet) designed to function with Microsoft Excel 2000 but has been tested and shown to perform properly using other versions of Microsoft Excel, including 97, 98, 2000, 2002, 2003, 2007 and 2010.

EXCEL TERMINOLOGY

Definition:

In database terminology, a <u>record</u> holds all the information or <u>data</u> about one specific object that has been entered into the database.

Each individual element of information in the record - such as a telephone number or hair color - is referred to as a <u>field</u>.

To ensure that data is entered in the same order for each record, headings are added to the database. These headings are referred to as *field names*.

In an Excel <u>database</u>, records are normally organized in <u>rows</u> with each <u>cell</u> or field in the row containing one item or element of information.

Field names are added to the cells at the top of each <u>column</u> in an Excel of the database.

Reference: <u>http://spreadsheets.about.com/od/f/g/2010-10-25-Excel-Field-Name-Definition.htm</u>

NAVIGATION

Once the spreadsheet is open, you can use your keyboard arrow keys to move from cell to cell in the worksheet, or use your mouse to click in the cell where you wish to enter information. Navigation keys are:

- Arrow keys on your keyboard (←, ↑, →, ↓) that move your cursor in the direction they indicate (i.e., up arrow for up one cell, down arrow for down one cell, etc.).
- The **Home key** always brings you back to the first cell in the row; **Ctrl+Home** brings you back to the first cell in the worksheet.
- **Tip:** In Excel, you can use the **[Tab]** key to move from one cell to the next and from the end of one row to the beginning of the next row. To learn more about shortcuts, open Microsoft Excel **Help** from the top menu bar, select **Index**, then enter "shortcuts" in the search area. A long list of choices will be displayed. Click

on any topic to read more about it.

RETRIEVING, OPENING AND SAVING THE e-SDRT SPREADSHEET

To retrieve the e-SDRT spreadsheet from your email, your hard drive, a CD or USB memory stick, go to the location where the file is stored. Highlight the file name and double-click on it to open the file. See "To open the e-SDRT Spreadsheet" section below.

Note: To work with the e-SDRT spreadsheet, you will need, as a minimum, a personal computer with a CD-ROM or USB memory stick, a 5-GB hard drive and 128 MB of RAM.

To open the e-SDRT Spreadsheet:

1. Double click on the file name. The e-SDRT spreadsheet will open. OR right-click on the file name and click "Open".

Tip: Remember that you must choose Enable Macros when you open the file.

- 2. Save the file with a new name by selecting **File Save As** from the Excel menu. The new name must contain your community or Tribal Council name and the month and year for which you are reporting activity, as described in the section File Naming Convention on page 4.
 - **Tip:** It is important that you keep a backup files on a CD-ROM or USB memory stick to avoid losing months of data.

An up-to-date version of the e-SDRT spreadsheet is available from your Regional Home and Community Care Office (refer to Appendix A – Education/Training/Contact Information).

EXCEL BASICS - APPENDIX B

ENABLING MACROS IN EXCEL 2007 AND 2010

Step 1 – File Menu

In Excel 2007	In Excel 2010
e-HRTT_practice spreadsheet.xls [Compatibility Home Insert Page Layout Formulas Data Review V Arial 10 - Paste Paste Clipbo 5 Font 5 Aria Font 5 Alignment 5 Number 5 Cell	Image: Second
Security Warning Macros have been disabled. Options H5 • (* fx	$\begin{array}{c c} \blacksquare & \blacksquare & \blacksquare \\ \hline Paste \\ \bullet & \checkmark \end{array} \qquad \begin{array}{c c} \blacksquare & \blacksquare & \blacksquare \\ \blacksquare & I & \blacksquare & \bullet \\ \hline \bullet & \bullet & \blacksquare \end{array} \qquad \begin{array}{c c} \blacksquare & \blacksquare & \blacksquare \\ \blacksquare & \blacksquare & \blacksquare \\ \blacksquare & \blacksquare & \blacksquare \\ \hline \blacksquare & \blacksquare & \blacksquare \\ \blacksquare & \blacksquare & \blacksquare \\ \blacksquare & \blacksquare & \blacksquare \\ \blacksquare & \blacksquare &$
A B 1 First Nations and Inul Home and Community Care Program	Clipboard 😼 Font 🔤

Step 2 – Excel Option

Options..." will lead you to this pop-up window

A.C.		v View			@ - •
New	1 e-HRTT_practice spreadsheet.xls	Condition Format	onal Formatting *	G™Insert ▼ G™ Delete ▼	
Open	2 Reconciliation_TSR-Regional_MCCSReport_Oct	Cell Styl	es ~ Styles	Cells	2 * Filter * Sele Editing
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Print >		-	Inserer rangée(s		
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EXCEL BASICS - APPENDIX B

Step 3 - Trust Centre

ormulas	Help keep your documents safe and your computer secure and healthy.
Proofing	Protecting your privacy
ave dvanced	Microsoft cares about your privacy. For more information about how Microsoft Office Excel helps to protect your privacy, please see the privacy statements. <u>Show the Microsoft Office Excel privacy statement</u>
ustomize	Microsoft Office Online privacy statement
dd-Ins	Customer Experience Improvement Program
rust Center	Security & more Click Here #2
Resources	Learn more about protecting your privacy and security from Microsoft Office Online. <u>Microsoft Windows Security Center</u> <u>Microsoft Trustworthy Computing</u>
	Microsoft Office Excel Trust Center
Click Here First	The Trust Center contains security and privacy settings. These settings help keep your computer secure. We recommend that you do not change these settings.

Microsoft Office Security Options	? 2
Security Alert - Macro	
Macro Macros have been disabled. Macros might contain virus not enable this content unless you trust the source of	
Warning: It is not possible to determine that the trustworthy source. You should leave this cont content provides critical functionality and you	ent disabled unless the
More information File Path: L:\d Community Care\E-SDRT & E-HRTT\	e-HRTT_practice spreadsheet.xls
 Help protect me from unknown content (recomme Enable this content) 	nded)
This is necessary to	Save your
This is necessary to prevent uploading errors!	changes! /
Open the Trust Center	OK Cancel

*** In Microsoft 2010 you do not get this above security alert... once you go to the trust centre and trust center settings it take you to the macro settings as per the next slide***

Step 4 – Adjust Settings

1	
Trusted Publishers	Macro Settings
Trusted Locations	
Add-ins	For macros in documents not in a trusted location: Disable all macros without notification
#2	O Disable all macros with notification
ActiveX Settings	 Disable all macros except digitally signed macros
Macro Settings	Enable all macros (not recommended; potentially dangerous code can run)
Message Bar	Developer Macro Settings
External Content	Trust access to the VBA project object model
Privacy Options	
	#1
	#3
	×
] [

Step 5 - Click "OK"

Popular	Help keep your documents safe and	your computer secure and healthy.
Formulas		
Proofing	Protecting your privacy	
Save	Microsoft cares about your privacy. For more inf helps to protect your privacy, please see the priv	
Advanced	Show the Microsoft Office Excel privacy state	ment
Customize	Microsoft Office Online privacy statement	
Add-Ins	Customer Experience Improvement Program	Don't forget to
Trust Center	Security & more	save your new
Resources	Learn more about protecting your privacy and se	ecurity from settings!
	Microsoft Windows Security Center	- ,
	Microsoft Trustworthy Computing	/
	Microsoft Office Excel Trust Center	/
	The Trust Center contains security and privacy se settings help keep your computer secure. We re	

SELECTING A WORKSHEET

To select a worksheet, click on the appropriate worksheet label tab located at the bottom left-hand corner of the e-SDRT template.

Entering Data

You can enter information in three (3) ways:

- Type the information into a cell.
- Select from the list of available codes.
- Copy (Ctrl+C) the data from one cell and paste (Ctrl+V) it into another cell.

COPYING DATA FROM PREVIOUS VERSION SPREADSHEETS

Note: The e-SDRT spreadsheet application has gone through several generations of development. If you cut and paste from an old version of the e-SDRT to a new version of the e-SDRT, you will end up with corrupted files and have uploading challenges or error messages.

It is important to understand what a source and a destination spreadsheet are. The source spreadsheet is the spreadsheet that you are copying from, in this case a previous version or file. The destination spreadsheet is the spreadsheet you are copying to (newer version or new file).

- 1. Open an Excel program session. In the window, open the source spreadsheet and disable the macros.
- Select the data you want to copy by holding down the left mouse button and blocking the area to be copied. Copy the data by pressing [Ctrl] + C on your keyboard or by right-clicking on the highlighted area and selecting Copy from the pop-up menu.
- 3. Open a separate Excel program session. Open the destination spreadsheet and enable the macros.
- 4. Click in the first cell where you would like the data to appear.
- 5. Paste the data by pressing **[Ctrl] + V** on your keyboard.
- 6. Save the destination spreadsheet.

PRINTING WORKSHEET DATA

Tip: Before printing confirm the area to be printed: Select area to be printed; click on File; Set Print area.

To print the data in a worksheet, click the **Printer** icon on the Microsoft Excel top menu bar. The worksheet is automatically sent to your default printer.

OR

If you wish to print more than one copy or send the print job to a different printer:

- 1. Use the options of the Microsoft Excel program (i.e., **File Print**) to access the **Microsoft Windows Print** form.
- 2. Select the print parameters and click the **OK** button. The print job is sent to the selected printer.
- 3. If the **Print** window remains open, click the **Close** button.
- **Tip:** You can see what the worksheet will look like before you print by clicking on the **Preview** button in the **Microsoft Windows Print** window.

Microso	oft Excel	- HCC_S	DRT_	commur	nity_M	1onth_Ye	ear.xls								
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File Print or Printer icon

Note: This tool does not have a built-in report feature; therefore, you cannot print a report. After the data is uploaded, it will be processed electronically by the HCC application, after which reports will be made available for download via the HCC Application.

To print data in Excel 2007

- 1. Select the entire area of the page that you wish to print.
- 2. Click on Page Layout, then click on Print Area (using the drop-down menu), then choose Set Print Area.

Note: The print area will not need to be changed each time that particular page is printed, but it will need to be set for each worksheet. It will also remain in effect when the document is saved with a new name, for instance, when one month is saved as the following month and the new information is added. It will need to be adjusted, however, if more information is entered that exceeds the previously set area.

CLIENT INFORMATION WORKSHEET - ADMISSION/READMISSION

The **Admission/Readmission** column (column **D**) of the **Client Information** worksheet displays the following code choices:

Code	Value	Definition
А	Admission	Used for:
		New admissions
		 Client has been discharged from Home Care in the past
		Client has returned to the Home Care Program <u>within the same</u> reporting month but the Primary Reason for Home Care Services
		has changed.
		• Client has returned to the Home Care Program with the same Primary Reason for Home Care Services, but in a different reporting month.
		Note: When a client is admitted to the program, choose the best primary reason for admission in the client information tab. If the client has more than one primary reason, choose the one that would best describe the reason for Home Care services. Only enter one client ID number in this tab; do not use multiple lines of entry with the same client ID# because errors will then occur. Once the client has received the "initial" primary reason for service and those services are no longer required, discharge the client from the client information tab and make sure to fill in the discharge date and reason for discharge. If the client still requires Home Care services (i.e., they will remain in our program for other needs), you will use "A" to admit them in the client information tab using the same client ID# but you will now use a different primary reason for the services they require. Meanwhile, ensure that the admission date is now the current date of admission.
В	Readmission	Used <u>only</u> for clients returning to the Home Care Program <u>within the</u> <u>same month for the "same" Primary Reason for Home Care</u> <u>Services.</u> When a client is discharged and readmitted in the same month, two entries are required.
		Note: The Discharge Date and the Readmission Date cannot be the same
С	Services Continued	Used when the client has been admitted in a previous reporting month and is continuing to receive home care services. The client may not have received services within the month but has not been discharged.

CLIENT INFORMATION WORKSHEET - PRIMARY REASON FOR HOME CARE

The **Primary Reason** for Home Care Services column (Column E) of the **Client Information** worksheet displays the following code choices:

Code	Primary Reason	Definition
A-2	Diabetes	All forms of diabetic disorders including gestational diabetes (a temporary condition during pregnancy).
A-3	Hepatic, Biliary, and Pancreatic	Conditions or disorders of the liver, bile ducts and pancreas. Includes post-operative care for surgical removal/repair of these organs.
A-1	Conditions of the Endocrine	Endocrine gland conditions or disorders. There are 8 endocrine glands, this admission relates to the hormones of the pituitary, thyroid, parathyroid, pancreas, ovaries, testes, adrenals and pineal.
Т	Impaired Fasting Glucose or Impaired Glucose	Impaired Fasting Glucose (IFG) – diagnosed when the fasting blood glucose level is higher than normal
	Tolerance	Impaired Glucose Tolerance (IGT) – diagnosed when the fasting blood glucose level and the blood glucose level after a glucose drink (oral glucose tolerance test) are both higher than normal but not high enough to be called diabetes.
B-1	Cardiovascular Disease/Heart, Circulatory	Conditions or disorders of the lymphatic and blood vessels, cardiac, cardiopulmonary and hypertensive diseases.
B-2	Cerebrovascular Disease and/or CVA	Cerebrovascular conditions or disorders. Vascular system in the brain, TIAs (transient ischemic attacks), CVA (stroke), etc.
G	Respiratory Condition	Conditions or disorders of the respiratory tract: nose, sinus, tonsils, bronchial tubes, lungs, pleura, etc. Includes home care admission for COPD, asthma, breathing difficulties, severe respiratory infections, oxygen monitoring, etc.
C-1	Genitourinary Condition	Conditions or disorders of the urinary, genital, and reproductive systems: bladder, prostate, menopause, breast conditions, uterine, ovary, testes, temporary urostomies, frequent UTIs, intermittent catheterizations, pessary care, etc.
C-2	Renal Condition	Renal conditions or disorders. Includes renal dysfunction, renal insufficiencies, polycystic kidney disease, glomerulonephritis, etc.
D	Gastro-intestinal (including difficulty feeding, nutritional disorders)	Digestive tract conditions or disorders including difficulty feeding, nutritional disorders (conditions or disorders caused by inadequate nutrient intake): mouth, esophagus, stomach, duodenum, small intestine and colon. This includes HCC admission for ostomy care, nasogastric feeds or PEG feeds, GI hernia repair, appendectomy, etc.
F	Musculoskeletal Condition (arthritis, fracture, amputation, other)	Inflammatory joint conditions or disorders, conditions or disorders due to a bone lesion, other conditions or disorders of the musculoskeletal system. Includes HCC admissions such as post- operative surgical care or personal care/assistance from Total knee replacement, total hip replacement, amputation, fractured bones, sprained or strained muscles, osteoarthritis, arthritic joint temporary immobility

CODE LISTS AND DEFINITIONS - APPENDIX C

Code	Primary Reason	Definition
H	Skin and Subcutaneous Condition (acute, surgical and chronic wound care)	Short-term conditions or disorders of the skin and subcutaneous tissue (furuncle, impetigo, eczema, dermatitis, pruritus, corns, acne, hives, sunburn, etc.). Long-term/ongoing conditions or disorders of the skin and subcutaneous tissue (furuncle, impetigo, eczema, dermatitis, pruritus, corns, acne, hives, sunburn, etc.).
Ρ	Auto-immune condition (Lupus, RA, etc.)	Conditions or disorders caused by a pathology in which an organism produces antibodies against its own constituents.
E-1	Central Nervous System Condition (MS, Parkinsonism, MD, CP)	Conditions or disorders of the nervous system and spinal cord.
E-2	Dementia and related conditions (Alzheimer, etc.)	Disorders in which the main dysfunction is a clinically significant cognitive or memory impairment, which represents a major, change from earlier functioning.
E-3	Transitory Mental Disorders	Disorders of varying intensity giving rise to significant psychological distress that can be resolved when appropriate assistance is delivered in a timely manner. Includes, schizophrenia, paranoias, neuroses, depression, etc.
E-4	Developmental delays with or without significant behaviours	Developmental delays with or without significant behaviours, e.g. Autism, FAS, Down's Syndrome.
V	Acquired Brain Injury	(ABI) – Any type of brain damage that occurs after birth. ABI may be sustained by trauma, infection, disease, lack of oxygen, and stroke, or it may be sustained insidiously from prolonged alcohol or substance abuse, tumours or degenerative neurological diseases.
U	Addictions	Conditions or disorders caused by dependency on substances such as alcohol, medications, tobacco, illicit or prescription drugs, etc. HCC admissions for care related to addictions or treatments.
J	Cancer	Conditions or disorders due to a malignant tumour. HCC admissions for clients going through cancer treatment, e.g. radiation skin care or monitoring, neupogen injections, psycho social care, CVC care, de- accessing continuous chemo infusions, etc.
К	Frail Elderly	Conditions or disorders due to advancing age which exacerbate the physiological aging process and cause dependency. Age 55 and over. Includes admission for high risk, e.g., high risk for falls, high risk for harm, high risk for choking, etc.
Ν	Severe Blindness	Conditions or disorders caused by loss of vision, partial/complete
0	Severe Deafness	Conditions or disorders caused by loss of hearing, partial/complete.
	Communicable Disease	Conditions or disorders due to a communicable foreign agent (bacteria, virus, fungus, parasite).
R	HIV/AIDS	Conditions or disorders caused by HIV-positive status or AIDS pathology.
Q	Lack of Diagnosis	Under investigation, tests ordered, conditions Not Yet Diagnosed.
W	Other	DO NOT USE THIS CODE

CLIENT INFORMATION WORKSHEET - SOURCE OF REFERRAL

The **Source of Referral** column (Column I) of the **Client Information** worksheet displays the following code choices:

Code	Source	Definition
A	Client	A direct request for services from the client, either in person or by telephone.
В	Family Member, Neighbour, etc.	Any family or community member requesting services for a client.
С	Physician	A request for services from a doctor in private practice.
D	Social Services	A request for services from a worker in a social agency, either within the community or from outside the community.
E	Hospital	A request for services from a professional working within a hospital.
F	Associations for the Handicapped	A request for services from an association for the handicapped.
G	Auto Insure	A request for services from an auto insurer.
Н	Regional Health Authority	A request for services received from a professional employed by the RHA.
I	Mental Health Crisis Centre	A request for services from a Mental Health Crisis Centre.
J	Private Practice Worker	A request for services from any professional other than a physician.
К	Rehabilitation Centre	A request for service received from a physical rehabilitation centre, a psychiatric rehabilitation centre or an alcohol/drug abuse rehabilitation centre.
L	Workers Compensation Board	A request for service from a workers' compensation board.
М	Other Health Care Providers	Other health care providers not found in this list.

CLIENT INFORMATION WORKSHEET - CLIENT TYPE

The **Client Type** column (Column **J**) of the **Client Information** worksheet displays the following code choices:

Code	Client Type	Definition
A	Acute	Outcomes are predictable and recovery is expected in a short timeframe. OR Need immediate or urgent care (<u>within 3 months</u>) to improve or stabilize a medical or post-surgical condition. If in the program for more than 3 months <u>you must discharge and change client type</u> .
В	End of Life	Client whose health condition is not responsive to curative treatment. Lifespan expected to be less than six (6) months.
С	Rehabilitation	Client with activity limitations and/or temporary or permanent impairments. There is potential for significant improvement in functional status.
D	Long Term Supportive	Client with multiple, complex health conditions who is at risk for institutionalization. Condition may be unstable and/or medically fragile
E	Maintenance	Client whose chronic health condition or functional limitation is stable. Additional resources are needed for assistance with personal care or activities of daily living.
Z	Other	DO NOT USE THIS CODE

CLIENT INFORMATION WORKSHEET - REASON FOR DISCHARGE

The **Reason for Discharge** column (Column **S**) of the **Client Information** worksheet displays the following code choices:

Code	Reason for Discharge
Α	Client no longer requires service OR the client type has changed
В	Client referred to other health service
С	Client withdrew/terminated services
D	Client moved out of area
E	Client died
F	Unable to reach/contact client
G	Physical environment unsuitable for service delivery
Z	DO NOT USE THIS CODE

HOME CARE SERVICES WORKSHEET – CATEGORY OF SERVICE

The **Category of Service** column (Column L) of the **Home Care Services** worksheet displays the following code choices:

Code	Service	Definition
Α	Assisted Living	Non-professional client care required to allow the client to remain
		living independently in his/her home, such as meal services, home
		management and transportation assistance
В	Nursing Services	Professional nursing services required to meet client care needs.
С	Personal Care	Client care required to meet the (personal care) needs of the
		client
D	Professional	Services provided by professionals other than nurses (paid for by
	Therapies	the Home Care Program)
E	Case	Time and tasks necessary to ensure coordinated, appropriate
	Management	client care.
	Services	
F	In-Home Respite	Client care provided at client's home to relieve the usual caregiver

HOME CARE SERVICES WORKSHEET – SERVICE

Each of the **Category of Service** codes has a related list of **Service** codes which are described below.

HOME CARE SERVICES WORKSHEET – SERVICE - ASSISTED LIVING

Α	Assisted Living	Non-professional client care required to allow the client to remain
		living independently in his/her home, such as meal services, home
		management and transportation assistance

When this Category of Service, **Assisted Living**, is selected, the **Service** column (Column **M**) displays the following code choices:

Code	Service	Definition
А	Home	Services required to keep the home in a safe, hygienic state, e.g.,
	Making/Home	cleaning, laundry, routine housekeeping, shopping for groceries
	Management	(requires specific approval) and/or other services. Grocery
		shopping must not jeopardize scheduled care and not replace
		family responsibility.
В	Meal Services	Includes meal preparation in the home, Meals-on-Wheels,
		Congregate Meals.
С	Transportation	May include recreational transportation (for congregate dining and
	Assistance	day programs), medical transportation or transportation for
		groceries and supplies. Any medical equipment or supply delivered
		to the client's home on behalf of the client or caregiver.
D	Water Delivery	Delivery of drinking water, when necessary.
E	Wood Cutting	Necessary cutting of wood when home does not have other
		methods for heating or cooking.
F	Home Repairs	Minor repairs/maintenance required to keep or return home to a
	and Maintenance	safe condition or to install safety devices. Those repairs that are
		not under the Band housing authority.
G	Adult Day	Home Care Program client attends outside the home, which
	Program	provides stimulation for the client. (i.e. berry picking, crafts and
		bingo)
Z	Other	DO NOT USE THIS CODE

CODE LISTS AND DEFINITIONS - APPENDIX C

HOME CARE SERVICES WORKSHEET – SERVICE - NURSING SERVICES

В	Nursing	Professional nursing services required to meet client care needs.
	Services	

When this Category of Service, Nursing Services, is selected, the Service column (Column M) displays the following code choices:

Code	Service	Definition
A	Health Teaching of Clients and/or Informal Caregivers	Teaching clients/informal and formal caregivers to meet care needs by enhancing their knowledge, skills and confidence.
В	Monitoring for Therapeutic Intervention	The client's state of health is assessed and observed regularly. The findings are reported to the health care professional to guide treatment or therapy. For example, may include blood pressure monitoring, vital signs, neurological, weight, blood glucose, etc.
С	Medication Administration and Management	Medications are prepared, and administered through various routes, by the Home Care nurse with orders from the physician. The HC nurse observes the medication effects, educates the client and, reports any adverse signs and symptoms to the physician or attending health practitioner, monitors prescriptions, medication reconciliations, etc.
D	Therapeutic Care	The spiritual and emotional care necessary for healing and rehabilitation
E	Wound Management	Wound assessment and monitoring For example, may include simple and complex dressings and monitoring negative pressure wound therapy when client discharged with this requirement and equipment and dressing changes.
F	Nursing Procedures and Treatments	Treatment and/or procedure ordered by a physician or nurse practitioner and performed by a nurse, including delegated acts and blood work.
G	Foot Care	Advanced foot care for clients with chronic conditions such as diabetes performed by nurses certified in foot care.
Z	Other	DO NOT USE THIS CODE

HOME CARE SERVICES WORKSHEET – SERVICE - PERSONAL CARE

When this Category of Service, **Personal Care**, is selected, the **Service** column (Column M) displays the following code choices:

Code	Service	Definition
A	Bathing/Toileting –Therapeutic Bath	Hygienic care including hair care, mouth care, back care, peri- care, skin care, bowel care, shaving, etc. For example: toileting assistance with diaper changes, urinals, commodes and toilet, catheter care.
В	Foot and Nail Care	Basic nail care for such clients with uncomplicated feet without chronic conditions like diabetes or chronic vascular disease. For example cleaning and filing of nails.
С	Feeding	Meal set-up or assisting with direct feeding includes oral feeding and alternatives. For example NG, PEG, etc.
D	Mobilization	Walking assist, preventative exercise programs. Transfers and lifts, home visit to assist with transferring from bed to wheelchair, in and out of shower or any other transfer assistance.
E	Rehabilitation Exercises	A directive/prescribed exercise regime given out by a PT/OT assisted by staff
F	Direct Observation/ Transfer Skill	Direct Observation used for monitoring compliance with a treatment regime such as taking medications. Examples may also include visit to reassure client, provide family support, and provide attendant/assistance at medical appointment AND Health Education: Reinforcement of client health education that leads to self-management of care Transfer skills: refers to procedures usually performed by a nurse that may be delegated to a personal care worker, such as taking blood pressure, applying simple dressings or doing blood glucose testing (exceptions in Quebec).
Z *	Other	Translation

*this code is still valid for translation only

CODE LISTS AND DEFINITIONS - APPENDIX C

HOME CARE SERVICES WORKSHEET – SERVICE - PROFESSIONAL THERAPIES

D	Professional	Services provided by professionals other than nurses (paid for by
	Therapies	the Home Care Program)

When the Category of Service, **Professional Therapies**, is selected the <u>Services</u> column (<u>Column M</u>) displays the following code choices:

CODE	Service	Definition
А	Podiatry	Services of a podiatrist/chiropodist.
В	Nutrition Counseling	May include the services of a dietician or a nutritionist.
C	Occupational Therapy	Professional services to assess clients' equipment and renovation needs and to develop therapy programs to assist the clients in adapting to necessary alterations in ways of doing their work, personal care and home management.
D	Physical Therapy	Professional services to assist the clients to strengthen, heal or make adjustments with how they use their body.
E	Speech Therapy	Professional services to assist the client following an alternation in his/her communication abilities.
F	Mental Health Consultation	Services of a mental health professional or psychologist.
Z*	Other Professional Services	Traditional healer, holistic or homeopathic professional.

*this Z code is still valid

HOME CARE SERVICES WORKSHEET – SERVICE - CASE MANAGEMENT

E	Case	Time and tasks necessary to ensure coordinated, appropriate client
	Management	care.
	Services	

When the Category of Service, **Case Management**, is selected the <u>Services</u> column (<u>Column M</u>) displays the following code choices:

Code	Service	Definition
A	Hospital	Assistance with the planning and assessment of needs for
	Discharge	equipment support and care discussion with hospital discharge
	Planning	coordinator and/or receipt of referral from facility before the
В	Initial	client's discharge from a medical care facility An interview conducted to determine Home Care service needs of
D	Assessment	the client. Assessment will determine anticipated involvement of
	Assessment	the informal care giver, and to develop the mutually agreed goals
		of care, including the frequency and duration of care (Care Plan)
С	Reviews /	Reassessment of care needs to update the Plan of Care and plan
Ŭ	Assessments	for discharge from the home care program. Should be done at a
		minimum annually or more frequently in response to change in
		client care need.
D	Consultation with	Conference with physician or other interdisciplinary team
	Physicians	members to discuss potential concerns about client, clarify orders
		or to provide progress report for response to treatment plan.
E	Charting	Overall Charting - Recording of Client interactions, assessment
		findings and other objective and subjective data pertinent to Client
		care. Charting activities that are related a client but may or may
		not involve a home visit or a client interaction.
F	Consultation with	Discussions with family or other informal caregiver related to
	Family Members	Client care, response to treatment/care plan, and to discuss any
G	Case	concerns or resolve issues. Discussion involving any persons involved in the client's care, i.e
G	conferences	doctor, nurse, physiotherapist, PSW, or other informal caregiver.
	COMPTENCES	Usually for complex care situations or where discrepancies or
		concerns have been identified. May also include the Client and
		family members to allow for resolution of issues and maintenance
		of cohesive, mutually agreed upon plan of care for consistency
		and accountability.
Н	Establishing	Developing, maintaining and coordinating linkages between
	linkages/liaison	multiple care givers such as pharmacists, dieticians, NIHB
		equipment orders, provincial health authorities/Regional Office
		personnel, or other programs to promote optimum client care in an
		efficient and safe manner.
I	Intake	Collection and review of all relevant data relating to a request for
		care. Includes determination of eligibility, review of physician's
		orders and facility discharge planning information when a client
		arrives in the community or a referral is received.

IN HOME RESPITE

F	In-Home Respite	Client care provided to relieve the usual caregiver in the client's
		home.

There is no **Service** code associated with this category of service.

HOME CARE SERVICES WORKSHEET – SERVICES NOT PROVIDED SECTION

The **Reason** column (Colum **Q**) in the **Services Not Provided** section displays the following code choices:

Code	Reason
Α	Insufficient funds
В	Understaffing
С	Lack of specialists
D	Lack of trained personnel
E	Informal caregiver able to provide service
F	Unsafe environment
G	Client refusal
Н	Client not at home
I	Lack of supplies/equipment
Z	DO NOT USE THIS CODE

UPLOADING THE e-SDRT SPREADSHEET - APPENDIX D

UPLOADING THE e-SDRT SPREADSHEET

In order to transfer this information to the HCC program office, you have two options, depending on whether or not you have access to the HCC Application.

Note: You will not see the upload spreadsheet button if you have not been authorized by Regional e-Health to upload data.

Option 1- If you have access to the Internet:

- 1. Log on to the HCC Application at <u>http://www.fnihis.org/hcc-eng.html</u>. (access passwords will be provided by regional technical staff–see *Appendix A Education, Training and Contact Information for their coordinates*),
- 2. In the top menu bar, choose **Administration**,
- 3. In the Administration menu at the left of the screen, **click e-SDRT Excel Spreadsheet Upload**. The **Excel Spreadsheet Upload** screen will be displayed.

	HCC Reports
Administration Menu	Excel Spreadsheet Upload
Change Password	
e-SDRT/HCC Excel Spreadsheet Upload	* Indicates Mandatory
	Please specify the File Name of the Excel spreadsheet by clicking on the Browse button.
	Region Ontario
	File Name * Browse
	Please note that only files saved in Microsoft Excel 2002, 2000, 98 and 97 format can be uploaded. Other formats must be converted before submitting the file.
	Click on the Upload button to start uploading the file into the regional database

4. Click the **Browse** button. In the pop-up screen that appears, navigate to the file that you wish to upload, and double click on the file name. The system will display your file name in the **File Name** field.

	Home	Reports	Administration	Help	Français	Log Out
V	HCC Reports					3
Administration Menu	Excel Spread	isheet Upload				
Change Password e-SDRT/HCC Excel Spreadsheet Upload	* Indicates Mand	atory				
e-HRTT Excel Spreadsheet Upload	Please specify t Region	Ontario	excel spreadsheet by click			
			nmunity Care \E-SDRT (crosoft Excel 2002, 2000, re submitting the file.			
Session Status er Name: Annie Fleurant	Upload		loading the file into the reg			
aged on since: 23-JUN-2011 16:14 EDT	Please note that	it may take up to 10 r	minutes to upload the file ((500 kb file with)	28.8 kbps modem).	

5. Click the **Upload** button. The system will transfer your file to the database and display the following message if the transfer is successful:

All data has been successfully uploaded. # of rows processed in Client Sheet. # of rows processed in Service Sheet

6. If your community has more than one file, repeat the process as many times as necessary to transfer all your files.

Note: The HCC application will upload files created with MS Excel 97, 98, 2000, 2002, 2003 and 2007. Communities should not use Excel 95, as it does not support the functions required to display messages and lists of codes. Users should contact their regional help desk for an upgrade and then convert the file into one of the above formats.

Tip: If communities use Excel 2007 and 2010 to fill in report files, they must save the document as Excel 1997-2003 workbook (.xls) as .xlsx documents will not upload.

UPLOADING THE e-SDRT SPREADSHEET - APPENDIX D

Note: When several spreadsheets are submitted by the same community for the same month, the HCC Upload program checks three fields (Community or Tribal Council Name, Staff Name, Year/Month) to determine if the contents must be added to the existing .data or replace it. If all three fields in both files are identical, then the information in the second and subsequent files overwrites the contents of the first. If the second file has a different Staff Name, then that information is added to the existing information for that community.

If you attempt to upload a file that contains incomplete mandatory fields or logic errors, such as a discharge date that precedes the admission date, the system will display a validation error along with a comprehensive table listing the errors and suggestions to correct them. As you can see in the screen image provided below, to facilitate the correction process, details include the worksheet name (Client or Service), the specific row, and a description of the error.

Change Password e-SDRT/HCC Excel Spreadsheet Upload e-HRTT Excel Spreadsheet Upload		Validat You mus	tion Error at correct the	follow	ing error(s) before proceeding:	
			Work Sheet	Row	Error	
		C	CLIENT	10	Admission Date must be within Year/Month for a Readmission or Admission.	
		C	CLIENT	11	Client Type is mandatory.	
			CLIENT	1.1.1	Admission Date is mandatory	
			LIENT	13	Client Type is mandatory.	
			CLIENT		Admission Date for a continuing client must be earlier than Year/Month	0
	ssion Status		LIENT	1000	Admission Date for a continuing client must be earlier than Year/Month	
	Annie Fleurant				Date of Service does not fall between an Admission Date and Discharge Date	×
	A STORE A STATE OF A ST				Date of Service less than Admission Date.	
Region:	ce: 23-JUN-2011 16:14 EDT Ontario			_	Date of Service does not fall between an Admission Date and Discharge Date	2
egun.	omano				Date of Service less than Admission Date.	
			SERVICE	2012	Date of Service does not fall between an Admission Date and Discharge Date	
			100 A 10		Date of Service less than Admission Date.	
					Date of Service does not fall between an Admission Date and Discharge Date	
		S	ERVICE	28	Date of Service less than Admission Date.	
		-	ERVICE		Date of Service does not fall between an Admission Date and Discharge Date	
		S	ERVICE	32	Date of Service less than Admission Date.	3
		S	ERVICE	33	Date of Service does not fall between an Admission Date and Discharge Date	
		s	ERVICE	33	Date of Service less than Admission Date.	
		s	ERVICE	34	Date of Service does not fall between an Admission Date and Discharge Date	
		S	ERVICE	34	Date of Service less than Admission Date	8

UPLOADING THE e-SDRT SPREADSHEET - APPENDIX D

Make the corrections to your spreadsheet, save it, and repeat the upload process described above.

<u>44</u>	Home		Reports	Administration	Help	1 0	Français	Log Out
<u>v</u>	HCC Reports							
Administration Menu	Excel Spread	lsheet Uplo	ad					
Change Password e-SDRT/HCC Excel Spreadsheet Upload	Validation E You must corre		ng error(s) before	proceeding:				
	Work	Sheet Row			Error			
	CLIENT	9	Admission Date	must be within Year/	Month for a Re-	admission	or Admission	1.
	CLIENT	r 10	Admission Date	must be within Year/	Month for a Re-	admission	or Admission	1.
	CLIENT	r <mark>11</mark>	Admission Date	must be within Year/	Month for a Re-	admission	or Admission	1.
	CLIENT	12	Admission Date	must be within Year/	Month for a Re-	admission	or Admission	1.
	CLIENT	13	Admission Date	must be within Year/	Month for a Re-	admission	or Admission	n.
	CLIENT	14	Admission Date	must be within Year/	Month for a Re-	admission	or Admission	n.
Consider Status	SERVIC	CE 9	Date of Service i	s not within the Year	Month of this fil	е		
Session Status	SERVIC	CE 10	Date of Service i	s not within the Year	Month of this fil	е		
er Name: User 1	SERVIC	E 11	Date of Service i	s not within the Year	Month of this fil	е		
gged on since: 08-MAR-2005 12:45 EST gion: Ontario	SERVIC	E 12	Date of Service i	s not within the Year	Month of this fil	e		
gion. Ontano	SERVIC	E 13	Date of Service i	s not within the Year	Month of this fil	е		
	SERVIC	E 14	Date of Service i	s not within the Year	Month of this fil	е		
	SERVIC	CE 15	Date of Service i	s not within the Year	Month of this fil	•		

When your file is accepted, the system will display the following message: "All data has been successfully uploaded." We recommend making a copy or printing this page for your files.

Administration Menu	Excel Spreadsheet Upload
Change Password e-SDRT/HCC Excel Spreadsheet Upload e-HRTT Excel Spreadsheet Upload	* Indicates Mandatory Please specify the File Name of the Excel spreadsheet by clicking on the Browse button.
	Region Ontario File Name * Browse Please note that only files saved in Microsoft Excel 2002, 2000, 98 and 97 format can be uploaded. Other formats must be converted before submitting the file.
Session Status er Name: Annie Fleurant Iged on since: 23-JUN-2011 16:14 EDT glon: Ontario	Click on the Upload button to start uploading the file into the regional database Upload
	Please note that it may take up to 10 minutes to upload the file (500 kb file with 28.8 kbps modem).

Option 2 - If you DO NOT HAVE ACCESS to the Internet:

Save the e-SDRT spreadsheet on a CD or USB memory stick and contact your Regional Home and Community Care Office (*refer to Appendix A – Education/Training/Contact Information*).

TROUBLESHOOTING

This appendix describes methods for using the e-SDRT spreadsheet in a successful, effective manner. When well executed, these best practice initiatives will help users discover proven tactics that will improve the quality of the e-SDRT spreadsheet data. These guidelines provide information on how to enter concise data in order to generate accurate reports and prevent uploading delays.

If you have further questions about using the e-SDRT spreadsheet, support is available to you regionally. Regional help desk contact numbers are provided in Appendix J–Contact Information.

Note: Some of the screen capture above is from an earlier version of the e-SDRT template and are to be used as reference only.

CLIENT INFORMATION WORKSHEET

Example of validation errors can be: inconsistencies between the worksheets, invalid community name, use of small case letters instead of capital letters etc.

Tip: Print the validation error sheet for ease-of-reference when correcting errors on your Excel spreadsheet

Admini	stration Menu	Excel Spreadsh	preadsheet Upload					
		Validation Error You must correct the		ing error(s) before proceeding:				
		Work Sheet	Row	Error				
		CLIENT	10	Admission Date must be within Year/Month for a Readmission or Admission.				
		CLIENT	11	Client Type is mandatory.				
		CLIENT	11	Admission Date is mandatory				
		CLIENT	13	Client Type is mandatory.				
		CLIENT	17	Admission Date for a continuing client must be earlier than Year/Month				
10 42.14	And a state of the second s	CLIENT	19	Admission Date for a continuing client must be earlier than Year/Month				
	sion Status Annie Fielirant	SERVICE	25	Date of Service does not fall between an Admission Date and Discharge Date				
and the second	n sinoa: 23-JUN-2011 10:14 EDT Ontario	SERVICE	25	Date of Service less than Admission Date.				
		SERVICE	28	Date of Service does not fall between an Admission Date and Discharge Date				
rayon.		SERVICE	26	Date of Service less than Admission Date.				
		SERVICE	27	Date of Service does not fall between an Admission Date and Discharge Date				
		SERVICE	27	Date of Service less than Admission Date.				
		SERVICE	28	Date of Service does not fall between an Admission Date and Discharge Date				
		SERVICE	28	Date of Service less than Admission Date.				
		SERVICE	32	Date of Service does not fall between an Admission Date and Discharge Date				
		SERVICE	32	Date of Service less than Admission Date.				
		SERVICE	33	Date of Service does not fail between an Admission Date and Discharge Date				
		SERVICE		Date of Service less than Admission Date.				
		SERVICE	34	Date of Service does not fall between an Admission Date and Discharge Date				
		SERVICE	1	Date of Service less than Admission Date.				
		SERVICE	42	Date of Service does not fall between an Admission Date and Discharge Date				

1. Overlapping Admission Dates

Data Entry Problem	Best Practices
Fields: Admission Date, Readmission Date	Admissions for a client cannot overlap, therefore:A discharge and a subsequent
Users are entering an admission date that causes overlapping admissions (i.e., the user enters an admission date that is on or prior to the client's last discharge	readmission cannot occur on the same day. The Readmission Date must be later than the last Discharge Date.
date).	 A discharge and a subsequent new admission cannot occur on the same day. The new Admission Date must be later than the last Discharge Date.

Example: Overlapping Admission Dates

This screen **is only** an example

-SDRT/HCC					Com	imunity or Triba	I Council Name Staff Name			
ote: Mandatory	columns are	marked	in red.	Insert Row(s) / I	Inserer rangée(s)	Year/M	lonth (yyyy/mm)	2012/03		
English / Fra	inçais	Sort / Tri	er D	elete Row(s) / S	upprimer rangée(s	e) Helj	p / Aide	Version x0	5.0	
	Client Information					mission/Discha	rge	Refe	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason f Discharg
Α	В	C	D	E	F	G	Н	1	J	S
A	1925/03/27	F	A	E-2	2012/03/15	2012/03/16	2012/03/20	В	D	С
A	1925/03/27	F	В	E-2	2012/03/15	2012/03/20				

2. Inconsistent Client Identifiers

Data Entry Problem	Best Practices
Fields: Client Identifier, Birth Date, Gender	Information on the same client must remain consistent:
The client information (client identifier,	 when reporting from one month to the next,
birth date, gender) for the same client is different from one month to the next.	 when the same client appears on multiple spreadsheets (e.g., two nurses providing services to the same client and each nurse uploading a separate spreadsheet for the month) See example below.

Example: Inconsistent Client Information for the Same Client This screen **is only** an example

First Nations a	nd Inuit H	ome ar	nd Commu	nity Care Prog	Iram					
e-SDRT/HCC A	Application	1			Com	nmunity or Triba	I Council Name	Ottawa		
Client Informa	tion Works	sheet					Staff Name	Danie J		
Note: Mandatory	columns are	marked	in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	lonth (yyyy/mm)	2012/03		
English / Fra	English / Français Sort / Trier				upprimer rangée(s	s) Hel	p / Aide	Version x0		
	Client Information					mission/Discha	rge	Ref	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmissior	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason for Discharge
А	В	C	D	E	F	G	Н		J	S
A	1925/03/27	F	A	E-2	2012/03/15	2012/03/16	2012/03/20	В	D	C

-SDRT/HCC	Application				Com	munity or Triba	al Council Name	Ottawa		
lient Informa	tion Works	heet					Staff Name	Danie J		
ote: Mandatory columns are marked in red.				Insert Row(s) / I	nserer rangée(s)	Year/M	lonth (yyyy/mm)	2012/03		
English / Fra	nçais S	Sort / Tri	er	Delete Row(s) / Su	upprimer rangée(s	s) Hel	p / Aide	Version x0		
	Client Information					mission/Discha	rge	Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	I	J	S
A	1925/03/27	М	A	E-2	2012/03/15	2012/03/20	2012/03/20	В	D	С

3. Assigning Client Identifiers

Data Entry Problem	Best Practices
Field: Client Identifier	Client identifiers must:
Two clients within a community are	 be unique to each client within a community for the life of the client,
assigned the same client identifier, or one client in a community has two different identifiers.	 not to be re-used or assigned to a different client.

Example: Assigning the Same Client Identifier to Different Clients This screen **is only** an example

-SDRT/HCC	Application	1			Com	imunity or Triba	al Council Name	Ottawa		
Client Informa	tion Works	sheet				_	Staff Name	Danie J		
lote: Mandatory	columns are	marked	in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	Ionth (yyyy/mm)	2012/03		
English / Fra	nçais	Sort / Trie	er	Delete Row(s) / Su	upprimer rangée(s	e) Hel	p / Aide	Version x0	5.0	
	Client Information					mission/Discha	rge	Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmissior	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	1	J	S
A	1925/03/27	F	A	E-2	2012/03/15	2012/03/20	2012/03/20	В	D	С
A	1958/08/30	М	A	Т	2012/03/17	2012/03/17		С	С	

4. Gaps in the Data for a Reporting Period

Data Entry Problem	Best Practices
Gaps are occurring in the data when some client information records are omitted from the spreadsheet.	• Information for active clients should be copied from month to month as long as the client remains in the Home Care program, whether or not the client has not received services for the reporting month.
Example The user does not submit data for the Services Continued client since the client did not receive services in the reporting month. This would also result in a gap in the data.	 If a Services Continued client did not receive services in the reporting month, the client should still be included in the Client Information Worksheet with an Admission/Readmission code of "C - Services Continued".

Example: User Fails to Report on Active/Service Continued Client #2 in the Month of December

This screen **is only** an example

-SDRT/HCC	100 CT-				Con	nmunity or Triba	I Council Name			
lient Informa	tion Works	sheet				-	Staff Name	Danie J		
ote: Mandatory	columns are	marked	in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	lonth (yyyy/mm)	2012/12		
English / Fra	nçais	Sort / Tri	er [Delete Row(s) / Su	upprimer rangée(s	s) Hel	p / Aide	Version x0	5.0	
	Client Information					mission/Discha	rge	Refe	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	B	С	D	E	F	G	Н	1	J	S
A	1925/03/27	F	A	E-2	2012/12/10	2012/12/11		A	A	
В	1958/08/30	М	A	Т	2012/12/12	2012/12/13		С	E	
С	1944/04/13	F	A	A-2	2012/12/15	2012/12/16		C	В	1

-SDRT/HCC / lient Informa					Con		I Council Name Staff Name			
ote: Mandatory	columns are	marked	in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	lonth (yyyy/mm)	2013/01		
English / Fra	English / Français Sort / Trier				upprimer rangée(s) Hel	p / Aide	Version x0	5.0	
	Client Information					mission/Discha	rge	Refe	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason f Discharg
А	В	С	D	E	F	G	Н	1	J	S
А	1925/03/27	F	A	³ E-2	2012/12/10	2012/12/11		А	A	
С	1944/04/13	F	A	A-2	2012/12/15	2012/12/16		С	В	

5. Valid Sequence of Client Records

Data Entry Problem	Best Practices
The appropriate sequence for	Users must follow the appropriate sequence of client
Admission / Readmission /	status in the program.
Service Continued / Discharge must be followed.	The diagram below shows the sequences that are valid.
	The arrows indicate the allowable progression from one
Example 1	state to the next.
On the same spreadsheet, the	
client is shown as admitted and	
receiving continued services.	Services Continued
Example 2	Admission Readmission
In November the client is shown	
as receiving continued services,	Discharge
and in November the client is shown as being admitted.	
Shown as being autilited.	

Example: Admission Record and Services Continued Record in the Same Spreadsheet This screen **is only** an example

-SDRT/HCC /					Com	munity or Triba	I Council Name Staff Name	Trouveren and		
ote: Mandatory			in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	Ionth (yyyy/mm)	2012/12		
English / Fra	English / Français Sort / Trier				upprimer rangée(s	s) Hel	p / Aide	Version x0	5.0	
Client Information					Adı	mission/Discha	rge	Refe	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharg
Α	В	С	D	E	F	G	Н	1	J	S
A	1925/03/27	F	A	K	2012/12/10	2012/12/11		A	A	
A	1925/03/27	F	С	K	2012/12/10	2012/12/11		A	A	
TROUBLESHOOTING - APPENDIX E

-SDRT/HCC	1. S.				Com	al Council Name Staff Name				
lote: Mandatory	columns are	marked	in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	Year/Month (yyyy/mm)			
English / Français Sort / Trier				Delete Row(s) / Su	upprimer rangée(s	s) Hel	p / Aide	Version x0	5.0	
Client Information					Admission/Discharge			Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	<u> </u>	J	S
A	1925/03/27	F	С	K	2012/12/10	2012/12/11		A	A	

Example: Month To Month Sequence of Services Continued Record then Admission Record

This screen **is only** an example

First Nations a	and Inuit H	ome ar	nd Commu	nity Care Prog	Iram					
e-SDRT/HCC	Application	1			Com	munity or Triba	I Council Name	Ottawa		
Client Informa	Client Information Worksheet					_	Staff Name	Danie J		
lote: Mandatory columns are marked in red.			in red.	Insert Row(s) / Inserer rangée(s)		Year/N	Year/Month (yyyy/mm)			
English / Français Sort / Trier				Delete Row(s) / Su	upprimer rangée(s	e) Hel	p / Aide	Version x0	5.0	
Client Information					Adı	mission/Discha	rge	Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	1	J	S
A	1925/03/27	F	A	K	2012/12/10	2012/12/11		A	A	

6. Readmission Code Validation

Data Entry Problem	Best Practices
Field: Admission/Readmission	The client can only be entered as a readmission if the client was discharged and
A user mistakenly specifies a readmission code with a different Primary Reason for Home Care Services.	then readmitted in the same reporting month with the same Primary Reason for Home Care Services as on the date of discharge. Otherwise, you must code the client as a new admission.
	Note: If the client is readmitted with the same Primary Reason for Home Care Services in a consecutive reporting month, this is also considered a new admission.

Example: Readmission Code with a Different Primary Reason This screen **is only** an example

	+7 - C4 - 💌 Home Insert Page La	yout Formulas Da	ata Review	View DVMO Label	- 30M	[_sgals [Compatibility Mode] -	THIS ENDIT EXCER				A () O d
tų.	X Cut Arial	• 10 • A' A'			it :Center - S + % + % S	Conditional Format as	a i i i i i i i i i i i i i i i i i i i	8 8	Insert Delete For	∑ AutoSum * 27 mat 2 Clear * Sort & Editing	Find & Elect +
		f.		Magainen	(1) (NUMDE	12.	sayara.		0.00	Control	
	A	В	С	D	E	F	G	н	1	J	к
	First Nations a e-SDRT/HCC A	Application	1	nd Commu	nity Care Prog		munity or Triba	I Council Name			
	Client Informa							Staff Name			
	Note: Mandatory	ote: Mandatory columns are marked in red.			Insert Row(s) / I	/Inserer rangée(s) Year/Month (yyyy/mm)			2005/12		
	English / Fra		Sort / Trie		Delete Row(s) / Se			p / Aide	Version x0	5.0	
		Client Information				Adı	mission/Discha	rge	Ref	erral	
	Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
	A	В	С	D	E	F	G	н	1	J	S
	A	1924/12/27	F	A	ĸ	2005/11/10	2005/12/11	2005/12/15	A	A	A
	A	1924/12/27	F	В	A-1	2005/11/10	2005/12/18		A	A	
-											
L											
-										-	

P											
	H Client Information Hon	and the same this is the same of the same			- UA			84	· · · · · · · · · · · · · · · · · · ·		

7. Consistency in Use of Admission/Readmission Date

Data Entry Problem	Best Practices
Field: Admission Date	The Admission Date field must be
	completed consistently from one month to
Sometimes, when a client is readmitted, the	the next. The date on which the client is
original admission date is used in error rather than	readmitted becomes the new Admission
the date of readmission.	Date.

Example: Consistency in Admission/Readmission Date This screen **is only** an example Month of December 2012

-SDRT/HCC	Application)			Con	nmunity or Triba	al Council Name	Ottawa		
Client Informa	tion Works	sheet				_	Staff Name	Danie J		
lote: Mandatory	columns are	marked	in red.	Insert Row(s) / I	Inserer rangée(s)	Year/N	Year/Month (yyyy/mm)			
English / Français Sort / Trier			er D	elete Row(s) / S	upprimer rangée(s) Hel	p / Aide	Version x0	5.0	
Client Information					Ad	mission/Discha	rge	Refe	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharg
Α	В	C	D	E	F	G	Н	1	J	S
A	1924/12/27	F	A	K	2012/12/10	2012/12/11	2012/12/15	A	A	A
A	1924/12/27	F	A	A-1	2012/11/10	2012/12/18		A	A	

8. Overwriting of Previous e-SDRT Data

Data Entry Problem	Best Practices
A user uploads a spreadsheet twice in a month and	When a second spreadsheet
overwrites the previously-uploaded data.	upload is required, the second
	spreadsheet must contain all of
Example	the data from the previous upload
On December 28, a user uploads a spreadsheet	as well as any new data.
containing e-SDRT data for the month (for example,	
2 entries). On December 30, the same user (using	The system will prompt the user
the same Community or Tribal Council Name, Staff	with a message indicating that the
Name and Month) uploads a second spreadsheet	data will be overwritten.
containing only the data not found on the first	
spreadsheet (1 additional entry). The first	
spreadsheet is overwritten, and only the data in the	
second spreadsheet will be compiled into a report.	

Example: First Spreadsheet Upload Overwritten by Second Spreadsheet Upload This screen **is only** an example

-SDRT/HCC					Com	imunity or Triba	Il Council Name Staff Name	1000 mice 55			
Client Information Worksheet Note: Mandatory columns are marked in red. English / Français Sort / Trier				Insert Row(s) / I	nserer rangée(s)	Year/N	Year/Month (yyyy/mm)				
				Delete Row(s) / Supprimer rangée(s) Help / Aide			Version x0 5.0				
Client Information					Admission/Discharge				Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge	
Α	В	C	D	E	F	G	Н	1	J	S	
108	1927/02/15	F	С	A-1	2010/03/15	2010/03/16		С	D		
109	1947/02/21	F	С	C-2	2011/04/20	2011/04/20		B	D		

First Nations a	and Inuit H	ome ar	nd Commun	nity Care Prog	Iram				X	
e-SDRT/HCC /	Application	n			Con	nmunity or Triba	al Council Name	Ottawa		
Client Informa	tion Works	sheet				_	Staff Name	Danie J		
Note: Mandatory columns are marked in red.				Insert Row(s) / I	v(s) / Inserer rangée(s) Year/Month (yyyy/mm)			2012/12		
English / Français Sort / Trier				Delete Row(s) / St	upprimer rangée(s	s) Hel	p / Aide	Version x0	5.0	
	Client Information				Admission/Discharge			Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason for Discharge
Α	В	C	D	E	F	G	Н	1	J	S
110	1953/10/21	M	А	A-3	2012/12/10	2012/12/11		G	С	

9. Valid Age

Best Practices
The age of the client must be
appropriate to the Primary Reason for Home Care Services code
selected.

Example: Client Age with Inappropriate Reason for Home Care Services This screen **is only** an example

e-SDRT/HCC / Client Informa					Com	munity or Triba	Il Council Name Staff Name			
					s) / Inserer rangée(s) Year/Month (yyyy/mm)					
English / Français Sort / Trier				Delete Row(s) / Su	upprimer rangée(s	i) Helj	p / Aide	Version x0	5.0	
	Client Information					nission/Discha	rge	Referral		
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	1	J	S
111	2012/09/25	М	С	K	2012/12/01	2012/12/01		С	A	-

10. Missing Discharge Date

Data Entry Problem	Best Practices
Fields: Discharge Date/Reason for Discharge	Always remember to check the Discharge Date column to ensure that
If you fill in a Reason for Discharge, but forget to enter a corresponding Discharge Date, then when you submit the worksheet to the HCC website, you will receive an error message.	any Reason for discharge entries have corresponding dates.

Example: Missing Discharge date (if Discharge Date has been entered) This screen **is only** an example

First Nations a e-SDRT/HCC /			nd Commu	inity Care Prog		nmunity or Triba	l Council Name	Ottawa		
Client Informa	tion Work	sheet					Staff Name	Danie J		
Note: Mandatory	columns ar	e marked	l in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	lonth (yyyy/mm)	2012/12		
English / Fra	nçais	Sort / Tri	er	Delete Row(s) / St	upprimer rangée(s	s) Hel	o / Aide	Version x0	5.0	
	Clie	nt Inform	ation		Ad	mission/Discha	rge	Ref	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/do	Gender	Admission/ Readmissio		Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	1	J	S
112	1985/01/23	3 F	A	B-1	2012/10/10	2012/11/03		С	E	D

HOME CARE SERVICES WORKSHEET

11. Date of Home Care Service Delivery

Data Entry Problem	Best Practices
Field: Date of Service	When entering the Date of Service,
	specify the actual date of service
Users are entering dates for the Date of Service that are inconsistent with the actual date on which the	delivery.
service was delivered.	This is especially important when
	the client has been discharged and
Example	readmitted in the same month.
On the Client Information worksheet, the client is	
shown as having been discharged and readmitted in	
the same month. On the Home Care Services	
worksheet, the user enters the last day of the month	
for all service dates for a client, then enters all hours	
for the month. This indicates erroneously that all	
services for the month were delivered only after the	
client was readmitted.	

Example: Actual Date of Home Care Service Delivery

This screen is only an example

-SDRT/HCC / Client Informa lote: Mandatory	tion Works	sheet	in red.	Insert Row(s) / I	nserer rangée(s)		I Council Name Staff Name Ionth (yyyy/mm)	Danie J		
English / Fra	nçais	Sort / Trie	er	Delete Row(s) / Su	upprimer rangée(s	s) Helj	p / Aide	Version x0	5.0	
	Client	Informa	ation		Adr	mission/Discha	rge	Refe	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
A	В	С	D	E	F	G	Н	1	J	S
1	1927/01/04	F	A	A-3	2012/12/07	2012/12/07	2012/12/21	Α	A	В
1	1927/01/04	F	В	A-3	2012/12/07	2012/12/28		A	A	

First Nations and Inuit Home and Community Care Program e-SDRT/HCC Application Community or Tribal Council Name Ottawa Staff Name Danie J **Home Care Services Worksheet** Insert Row(s) / Inserer rangée(s) Note: Mandatory columns are marked in red. Year/Month (yyyy/mm) 2012/12 English / Français Sort / Trier Delete Row(s) / Supprimer rangée(s) Help / Aide **Home Care Services Services Not Provided** Date of Service Number of (yyyy/mm/dd) -OR - Day of Hours of Service Number of Home Category of Com. Service Attempted Home Hours **Client Identifier** Reason Service Provided Visits/Events Space Visits Service (dd) Ρ Α Κ L Μ Ν 0 Q R т 2012/12/31 2.00 2 1 A A 1 2012/12/31 A В 1.00 1 С 3.00 2012/12/31 A 2 1 1 2012/12/31 A D 2.00 1

12. Out of Range Home Care Service Delivery Dates

Data Entry Problem	Best Practices
Field: Date of Service	The Date of Service specified on the
Users are mistakenly entering Home Care	Home Care Services worksheet must be
Service Dates that are after the client's	between the Admission Date and the
Discharge Date.	Discharge Date.

Example: Home Care Service Dates that are After the Discharge Date This screen **is only** an example

First Nations a			nd Commu	nity Care Prog	Iram					
e-SDRT/HCC	Application	l:			Con	nmunity or Triba	al Council Name	Ottawa		
Client Informa	tion Works	sheet					Staff Name	Danie J		
Note: Mandatory	columns are	marked	in red.	Insert Row(s) / I	nserer rangée(s)	Year/N	lonth (yyyy/mm)	2012/12		
English / Fra	nçais	Sort / Tri	er	Delete Row(s) / Su	upprimer rangée(s) Hel	p / Aide	Version x0	5.0	
	Client	t Informa	ation		Ad	mission/Discha	rge	Ref	erral	
Client Identifier	Birth Date (yyyy) or (yyyy/mm/dd)	Gender	Admission/ Readmission	Primary Reason for Home Care Services	Referral Date (yyyy/mm/dd)	Admission Date (yyyy/mm/dd)	Discharge Date (yyyy/mm/dd)	Source of Referral	Client Type	Reason fo Discharge
Α	В	C	D	E	F	G	Н	1	J	S
а	1927/01/04	F	A	G	2012/12/11	2012/12/12	2012/12/19	A	A	A

First Nations and Inuit Home and Community Care Program

e-SDRT/HCC / Home Care Se Note: Mandatory	ervices \	Norks		d.	Insert Row(s	Con s) / Inserer rangée(al Council Name Staff Name Ionth (yyyy/mm)	Danie J		
English / Fra	nçais	Sort	/ Trier		Delete Row(s)	/ Supprimer rangé	e(s) H	lelp / Aide			
				Н	ome Care Servi	ces		Ser	vices Not Prov	ided	
Client Identifier	nt Identifier Date of Service (yyyy/mm/dd) - OR - Day of Service (dd) Category			Service	Hours of Service Provided	Number of Home Visits/Events	Number of Attempted Home Visits	Reason	Hours	Com. Space	
А	K		L		M	N	0	Р	Q	R	Т
а	2012/1	2/27	A		A	2.00	2				
а	2012/1	2/27	A		В	1.00	1				
а	2012/1	2/27	A		C	3.00	2				
а	2012/1	2/27	A		D	2.00	1				

e-SDRT REPORT TYPES

Once the e-SDRT spreadsheet has been uploaded and processed, the e-SDRT reports become available online via the HCC application. The following reports are available in both French and English, and are available in monthly and annual formats:

- Community Cumulative Report
- Community Total Services Report
- Tribal Council/Health Authority Total Services Report
- Regional Total Services Report
- National Total Services Report

Note: Not all authorized individuals have access to these reports.

More information about each of these reports is provided below.

Note:

- The Cumulative Reports (CRs) contain confidential patient information whereas the Total Services Reports (TSRs) do not. CRs are available only to the authorized individuals that have upload capability.
- The regional and national Total Services Reports (TSRs) do not contain confidential data.

Community Cumulative Report (CR) – Monthly

- The monthly format is the same as before.
- Available to authorized individuals that **DO** have upload capability. One line per admission cycle (admission to discharge).
- Nursing Services and Case Management Services are broken out; hence, the length of the report will vary according to the quantity of these services provided.

Community Cumulative Report (CR) - Annual

- The <u>annual</u> format is now available.
- Available to authorized individuals that **DO** have upload capability.
- One line per client.
- The length of the report varies according to the number of clients reported on. (Approximately 20 clients per page.)
- Provides the sum of hours and the number of home visits.

Community Total Services Report (TSR)

- The monthly and annual reports are available.
- Available to authorized individuals that **DO** have upload capability.
- Computations in the monthly report have been improved.
- Approximately 11 pages for all report types (monthly, annual).

Tribal Council/Health Authority Total Services Report (TSR)

- This is a report available in <u>monthly</u> and <u>annual</u> report formats.
- Available to authorized individuals that have access to report downloads for a specific community.
- 11-15 pages depending on the length of the appendix.
- Includes an appendix (may be as short as one page) listing the communities (associated with the Tribal Council or health authority) that did not report.
 - The appendix for the monthly report lists the communities that did not report in that month.
 - The appendix for the annual report lists the communities that did not report in each month of the reporting period. The report shows the months included in the report and has an X to indicate that the community did not report in a particular month.

Regional Total Services Report (TSR)

- Regions **<u>DO NOT</u>** have upload capability.
- Two reports: mandatory and non-mandatory data.
 - Mandatory
 - This is a report available in <u>monthly</u> and <u>annual</u> report formats.
 - Approximately 5 pages long.
 - Contains the minimum mandatory reporting information to meet accountability requirements.
 - Non-mandatory
 - This is a report available in monthly and annual report formats.
 - Data is amalgamated from all communities, Tribal Councils and health authorities in the region.
 - Approximately 11 pages long.
 - Includes an appendix (may be a few pages) listing all communities, Tribal Councils and health authorities (with upload capability) in the region that did not report.
 - The appendix for the monthly report lists the communities that did not report in that month.
 - The appendix for the annual report lists the communities that did not report each month of the reporting period. The report shows the months included in the report and has an X to indicate that the community did not report in a particular month.

National Total Services Report (TSR)

- This is a report available in monthly and annual report formats.
- National **DOES NOT** have upload capability.
- All diabetes data is collapsed into a single line item under Primary Reason for Services Provided.
- Approximately 11 pages of data, plus the appendix.
- Includes an appendix (may be several pages; will vary in length) listing all communities (nationally) that did not report.
 - The appendix for the monthly report lists the communities that did not report in that month.
 - The appendix for the annual report lists the communities that did not report each month of the reporting period. The report shows the months included in the report and has an X to indicate that the community did not report in a particular month.

DOWNLOADING e-SDRT REPORTS

Once your files have been uploaded and processed, the **Cumulative Reports** and the **Total Services Reports** will become available online through the HCC Application (within two or three working days). These reports are available in the following formats: monthly and annually.

Tip: Once your monthly spreadsheets have been processed, reports will be available to you by the same means that you used to send your data in (i.e., HCC Application, e-mail, Canada Post).

To download the **Cumulative Reports** or **Total Services Reports** for your community:

- 1. Log on to the HCC Application (access passwords will be provided by regional technical staff–see Appendix J–Contact Information for their coordinates).
- 2. On the top menu bar, choose Reports.
- On the Reports menu at the left of the screen, click on Home and Community Care Reports, click on Service Delivery Reports. The Service Delivery Reports screen is displayed.

	Home Client Search Reports Administration Help Français Log O	ut
	HCC Reports	2
Reports Menu	Service Delivery Reports	
 Home and Community Care Reports Service Delivery Reports 	* Indicates Mandatory	
	Please enter the search criteria, then click the Get the List of Reports button to display the list of reports.	
	Report Type * Community Service Community *	
	Year * Period *	
	Language *	
Session Status	Get the List of Reports Clear	

- 4. Select **Community** from the **Report Type** drop-down list, and then select the **Service Community**, the **Year**, the **Period** and the **Language**.
- 5. Click the **Get the List of Reports** button. The List of Reports panel appears at the bottom of the screen, displaying the appropriate **Total Services** and **Cumulative Reports** for the selected fiscal year.

Note: The reports that are available for download appear as a hyperlink. If a report is not listed, this means that it has not yet been generated. If you are unable to view or download reports for your community, you may not have the appropriate security permissions and should contact your regional help desk.

1000	User 17-FEB-2005 15:49 EST	List of Reports	
egion:	Ontario	Report Type	Community
		Service Community	Wahgoshiq
		Year	2004
		Period	Monthly
		Language	English
		Cumulative Reports	Total Services Reports
		01-Apr-2004 - 30-Apr-2004	01-Apr-2004 - 30-Apr-2004
		01-May-2004 - 31-May-2004	01-May-2004 - 31-May-2004
		01Jun-2004 - 30Jun-2004	01Jun-2004 - 30Jun-2004
		01Jul-2004 - 31Jul-2004	01Jul-2004 - 31Jul-2004
		01-Aug-2004 - 31-Aug-2004	01-Aug-2004 - 31-Aug-2004
		01Sep-2004 - 30Sep-2004	01Sep-2004 - 30Sep-2004
		01Oct-2004 - 31Oct-2004	01Oct-2004 - 31Oct-2004
		01Nov-2004 - 30Nov-2004	01Nov-2004 - 30Nov-2004
		01Dec-2004 - 31Dec-2004	01Dec-2004 - 31Dec-2004
		01Jan-2005 - 31Jan-2005	01Jan-2005 - 31Jan-2005
		01-Feb-2005 - 28-Feb-2005	01-Feb-2005 - 28-Feb-2005
		01Mar-2005 - 31Mar-2005	01Mar-2005 - 31Mar-2005
			ouse pointer on the link and press the left mouse button.
		To download a report, position the mous	e pointer on the link and press the right mouse button.
			to view and print report files. If it is not installed on your computer, you can ease click <u>here</u> to go to the Adobe web site.

This is a fictional example using fictional data.

Note: Difference between .pdf and .txt : .pdf provides easy to read tables. .txt is for creating charts and graphs and also requires additional skills (see appendix E-Improving your reports into Excel for user customizing)

- 6. Left click on a hyperlinked report name to view the report, or right click to download it (select **Save Target As** from the drop-down menu).
 - Click on PDF, open the file
 - Click on PDF, download the file
- **Tip:** When you right click and select **Save Target As**, the report file will be highlighted in a **Save As** popup window listing its default file name. If you wish to change this name, overwrite the highlighted File Name. To save this file to your computer, click the down arrow in the **Save** in field, select your preferred location (e.g., My Documents), then click the **Save** button. The **Download Complete** dialogue box appears. Click the **Close** button. You can now retrieve the file from your selected location.

Rename your downloaded files clearly:

For example: CommunityName_MONTH_Year.xls

- Ottawa_JUL_2011.
- Ottawa_JUL_2011_Jean (if you have several people uploading)

SAMPLE REPORTS

The next two pages display a sample of the Cumulative Report and the Total Services Report.

Note: To interpret the Cumulative Report, you will need to convert the alphabetical codes (e.g., Referral, Client Type, Nursing Services Codes). The list of codes and their meaning is available in the table below.

Sample - Cumulative Report

Thisma land Administion (Cforchange Deferme Bone Visible (4) Provide (1) Associated Lifeting Description (1) Description (Muu Muu 1 14-000-00 0	Muu Muu 1 14-000-00 0	F	rst Nations :	and inu Care			Cammur	ytr				CO c de	MMU	EREI INITY Delive (c SE	ery R	T eporti	ng			Lome Region Reput	0.02010	THE		Onle	gasng ukr 2005			
1 23-7123-54 M C C -1 -3 2 -3 -6 7 1 9 5 5 1 C 1.25 0 6.25 5.25 1 2 22-478-03 7 C A-1 01-786-14 E C 3 4 2 6 1 14-508-75 4 C A - - - - - 4 12 5ED 594 7 2 1 01-786 16 12 7X81 06 17 C 3 2 L.E 3 1 0 2.6 4.6	1 33-F128-91 41 C C 2-3 G 7 2 9 5 1 C 1.25 D 6.25 1.25 J 2 22-AJR-15 7 6 A-1 01-JNE-14 L C 3 4 2 6 2 24-AJR-15 4 0 01-JNE-14 L C 3 4 2 6 1 12 12 14-CURL-15 1 01-JNE-16 C A 2 0 4 12 52 1 01-JNE-16 C A 2 0 0.6	1 33-F128-91 41 C C 2-3 6 7 1 9 5 1 C 1.25 0 2 20-ADR-05 7 C A-1 01-DRE-04 E C 2 20-ADR-05 7 C A-1 01-DRE-04 E C 2 20-ADR-05 4 C A 2 C 1 10-DRE-04 C A 2 C 4 10-DRE-04 C A 2 C 4 10-DRE-04 C A 2 C		lien: 1	6821WA	i i i ch	e	τź	isticn/Eisc	161Qe	Dafe	(cm)	Bon	e Vist	ta (₩)						Assist	ed Li v is	4				8	PLLY	.dat
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С 14-2011-15 И С 0 03-378-14 С А И 32 565 94 7 Л. 3 03 378-15 12 358 12 С 0 3 2 1.6 3 3 1 С 2.6 4.6	С 14-2014-75 И С 0 03-378-141 С А. И 32 683 91 7 Л. 1 03 578-142 5783 СС 17 С С 3	сан-стин-триссовоз-лик-на са 4 вредони 7 л. вод лик на вредони са 2.6 4.6 2.6 4.6												2			•	5	1	c		1.25	D			6.25		ಿ	I
			:	14-208	1-75 1	c	ø	03-JW	-14		с	x												80					
										4 17			3		3				1.6	3	3		a			2.6	4.6		

*						OMM	NUNI	TY					Comm								
First Nations and Inuit Home and Co	ommunit	ty		Elect	tronic					orting			Regio								
Care Program					Te	empla	te (e-	SDRT)				Repor	ting P	eriod:	N	Nonth -	Apr-2	010		
			2			N	umber o	f Occur	rences	s by Ge	nder p	er Age	e Group			ž		51	2		
		Total		0 -	5 yrs	6 - 1	l0 yrs	11 -	16 yrs	17 -	25 yrs	26 -	- 45 yrs	46	- 55 yrs	56 -	64 yrs	65 -	74 yrs	75 y	rs +
	М	F	Total	M	F	M	F	М	F	M	F	М	F	М	F	M	F	M	F	M	F
Number of Clients	6	4	10	0	0	0	0	0	0	0	0	0	0	0	0	4	0	2	0	0	4
PRIMARY REASON FOR HOME CARE SERVICES																					
Diabetes - Diagnosed Over One Year	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Conditions of the Endocrine	0	3	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Diabetes - Diagnosed in Past Year	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Diabetes - Early Signs of or Existing Cardiovascular Disease	12	0	12	0	0	0	0	0	0	0	0	0	0	0	0	12	0	0	0	0	0
Diabetes – Early Signs of or Existing Cardiovascular and Renal Disease	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Diabetes - Pregnant Diabetic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Hepatic, Biliary, and Pancreatic	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiovascular Disease/Heart, Circulatory	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gastrointestinal	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
)ifficulty Feeding (Tube Feeds,)ysphagia, etc.)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Sample - Total Services Report

REPORT LABEL DEFINITIONS

This document is to be used in conjunction with Appendix F of the e-SDRT User Manual in order to correctly interpret each of the labels on the Cumulative and Total Services Reports.

Explanation of e-SDRT report percentages

Each e-SDRT report includes service delivery details according to category. These categories are: Nursing Services; Personal Care; Professional Therapies; Case Management; In-Home Respite; and Assisted Living. Within each category is a list of the activities that are associated with it. For example, in the category Nursing Services, you will find details such as Health Teaching for Clients and Informal Caregivers, Monitoring for Therapeutic Intervention, Medication Administration and Management, etc. Each of these individual activities is assigned a percentage related to the overall percentage within that category. For example, in the box below you can see that Health Teaching for Clients and Informal Caregivers represents 12.31% of the activities within Nursing Services. In addition, at the bottom of each category is a line representing the total hours of service delivery, as well as its percentage, for that category. In the example below you can see that over 86,000 hours of nursing services were delivered, representing 9.55% of all services delivered, including personal care, case management, etc.

Average Length of Stay, in Days		583.00		
Number of Home Visits		376,511	94.64%	
Number of Attempted Home Visits		21,304	5.36%	
Total Home Visits		397,815		
Total Hours of Services Provided		907,909.94		
Total Hours of Services not Provided		17,055.70		
Hours of Services Provided 75 yrs + (included in total)		342,881.22		
		Hours	% Breakdown of Hours/Category	
URSING SERVICES	N		\frown	
Health Teaching for Clients and Informal Caregivers	12	10,674.80	12.31	
Monitoring for Therapeutic Intervention		31,256.95	36.04%	
Medication Administration and Management		12,969.50	14.96%	
Therapeutic Care		2,183.75	2.52%	
Wound Management		14,097.10	16.26%	
Foot Care		7,119.75	8.21%	
Nursing Treatments and Procedures		4,350.50	5.02%	
Other		4,069.25	4.69%	
Total Hours of Mursing Services		86,721.60	9.551	
		Hours	% Breakdown of Hours/Category	
VERSONAL CARE				
Bathing/Toileting/Oral Care/Skin Care/Hair Care/Dressing		89,137.25	54,19%	
Foot and Nail Care		4,990.25	3.03%	
Feeding		7,447.75	4.53%	
Mobilization		6,879.75	4.18%	
Rehabilitation Exercises		5,548.25	3.37%	
Direct Observation Therapy/Transfer Skills		34,274.83	20.84%	
Other		16,205.99	9.85%	

	TOTAL SERVICES REPORT
Label	Definition
Average Length of Stay	The sum of the days from admission to discharge divided by the number of discharged clients. Sum of Days is a count of the days from admission to discharge, inclusive. For example, if a client is admitted on Monday and discharged on Friday, this is a count of 5 days. Discharge counts the distinct clients (that is, if a client identifier appears twice as a discharge, it is only counted as one distinct client). For example, if the spreadsheet shows that there have been 6 discharges in the period, but one client identifier appears twice (one client has been discharged twice in the same month), this is counted as 5 client discharges.
Number of Home Visits	The sum of home visits.
Number of Home Visits Percentage	The Number of Home Visits / Total Home Visits X 100.
Number of Attempted Home Visits	The sum of Attempted Home Visits.
Number of Attempted Home Visits Percentage	The Number of Attempted Home Visits / Total Home Visits X 100.
Total Home Visits	The sum of Number of Home Visits + Number of Attempted Home Visits.
Hours of Services Provided	The sum of Hours of Services Provided.
Hours of Services not Provided	The sum of Hours of Services not Provided.
Total Hours of Assisted Living	The sum of Hours of Services Provided per service, with the Total being the sum of all Hours of Services Provided for Assisted Living.
Total of Hours of Assisted Living Percentage	The Total Hours of Assisted Living / Hours of Services Provided X 100.
Home Making/Home Management Percentage	The sum of Home Making/Home Management Hours / Total Hours of Assisted Living X 100.
Meal Services Percentage	The sum of Meal Services Hours / Total Hours of Assisted Living X 100.
Total Hours of Nursing Services	The sum of Hours of Services Provided per service, with the Total being the sum of all Hours of Services Provided of Nursing Services.
Total Hours of Nursing Services Percentage	The Total Hours of Nursing Services / Hours of Services Provided X 100. The individual percentages per service is the sum of hours for each service / Total Hours of Nursing Services X 100.
Total Hours of Personal Care	The sum of Hours of Services Provided per service, with the Total being the sum of all Hours of Services Provided of

TOTAL SERVICES REPORT									
Label	Definition								
	Personal Care.								
Total Hours of Personal Care Percentage	The Total Hours of Personal Care / Hours of Services Provided X 100. The individual percentages per service is the sum of hours for each service / Total of Hours of Personal Care * 100.								
Total Hours of Professional Therapies	The sum of Hours of Services Provided per service, with the total being the sum of all Hours of Services Provided of Professional Therapies.								
Total Hours of Professional Therapies Percentage	The Total of Hours of Professional Therapies / Hours of Service Provided X 100. The individual percentages per service is the sum of hours for each service / Total of Hours of Professional Therapies X 100.								
Total Hours of Case Management Services	The sum of Hours of Services Provided per service, with the total being the sum of all Hours of Services Provided of Case Management Services.								
Total Hours of Case Management Percentage	The Total of Hours of Case Management / Hours of Service Provided X 100. The individual percentages per service is the sum of hours for each service / Total Hours for Case Management X 100.								
Total Hours of In-Home Respite	The sum of Hours of Services Provided per service, with the Total being the sum of all Hours of Services Provided of In-Home Respite.								
Total Hours of In-Home Respite Percentage	The Total Hours of In-Home Respite / Hours of Service Provided X 100. The individual percentages per service is the sum of hours for each service / Total Hours for In-Home Respite X 100.								
Number of Clients	The count of clients classified by gender, gender-age, and a total count. Number of Clients counts the distinct clients only once in the same reporting period. For example, if the same client identifier appears 3 times, the count is 1. Note: Number of clients refers to clients who have been given services during a specific timeframe and were discharged.								
Primary Reason for Home Care Services	The count of clients classified by gender, gender-age, and a total count, per Primary Reason for Home Care.								
Total Primary Reason for Home Care Services	The count of clients classified by gender, gender-age, and a total count.								
Admission/Readmission	The count of clients classified by gender, gender-age, and a total count, per Admission/Readmission/Services Continued, excluding Discharge. Services Continued is a count of all clients having a code A, B and/or C, <u>that are not discharged in the ending month of the reporting period</u> . Therefore, the Services Continued number represents the active continuing number of clients entering the next reporting period. Important note: It is important to upload your spreadsheets								

TOTAL SERVICES REPORT								
Label	Definition							
Clients Discharged	 every month. If data is missing at the end of a reporting period, this will have an effect on the reports. As an example, if you do not upload data at the end of a quarter (June, Sept, Dec, March), the Services Continued count will be set to 0 going into the next quarter, even if you have uploaded data for the first two months of the quarter. This applies to annual Total Services Report. The count of clients classified by gender, gender-age, and a total 							
Chefits Discharged	count, per Discharge. Discharge counts the distinct clients (that is, if a client identifier appears on a spreadsheet twice as a discharge, it is only counted as one distinct client).							
Nursing Services	The count of clients classified by gender, gender-age, and a total count, per nursing service.							
Total Nursing Services	The count of clients classified by gender, gender-age, and a total count.							
Case Management	The count of clients classified by gender, gender-age, and a total count, per case management service.							
Total of Case Management	The count of clients classified by gender, gender-age, and a total count.							
Source of Referral	The count of clients classified by gender, gender-age, and a total count, per referral type. Source of Referral counts every Source of Referral code. This value may be higher than the total number of clients if a client has more than one Source of Referral. Important Note : Gaps in the data will result in inaccurate reports. If this field is left blank from one reporting period to the next, the system will interpret this as two distinct Sources of Referral rather than only one Source of Referral that has been continuous. This applies to the annual Total Services Report.							
Total for Source of Referral	The count of clients classified by gender, gender-age, and a total count.							
Client Type	The count of clients classified by gender, gender-age, and a total count, per client type. Client Type counts every instance of a client type code. This value may be higher than the total number of clients if a client has more than one Client Type. Important Note: Gaps in the data will result in inaccurate reports. If this field is left blank from one reporting period to the next, the system will interpret this as two distinct Client Types rather than only one Client Type that has been continuous. This applies to the annual Total Services Report.							
Total for Client Type	The count of clients classified by gender, gender-age, and a total count.							

TOTAL SERVICES REPORT									
Label	Definition								
Reason for Services Not Provided	The count of clients classified by gender and a total count, per Reason for Services Not Provided. Reason for Services Not Provided counts every instance of a Reason code. This value may be higher than the total number of clients if a client has more than one Reason for Services Not Provided. Important note : Gaps in the data will result in inaccurate reports. If this field is left blank from one reporting period to the next, the system will interpret this as two distinct Reasons for Services Not Provided rather than only one Reason for Services Not Provided that has been continuous. This applies to the annual Total Services Report.								
Total of Reason for Services not Provided	The count of clients classified by gender and a total count.								
Client Type	The sum of hours per client type classified by Service Category (Assisted Living, Nursing, Personal Care, Professional Therapies, Case Management Services, In Home Respite).								
Total Hours of Services Provided	The sum of the Total Number of Hours of Services Provided. The percentage per client type by service category is the individual Total Hours of Services Provided by Client Type per service category / Total Hours of Services Provided by Client Type X 100. The percentage per client type is the Total Hours of Services Provided by Client Type / Total Hours of Services Provided X 100.								

CUMULATIVE REPORT - MONTHLY

Label	Definition						
Date of Birth	The date of birth of the client.						
Gender	The gender of the client.						
Admission/Readmission	The count of clients classified by gender, gender-age, and a total count, per Admission/Readmission/Services Continued; excluding Discharge. Services Continued is a count of all clients having a code A, B and/or C, who are not discharged in the ending month of the reporting period. Therefore, the Services Continued number represents the active continuing number of clients entering the next reporting period. Important note: It is important to upload your spreadsheets every month. If data is missing at the end of a reporting period, this will have an effect on the reports. As an example, if you do not upload data at the end of a quarter (June, Sept, Dec, March), the Services Continued count will be set to 0 going into the next quarter, even if you have uploaded data for the first two months of the quarter. This applies to annual Total Services Report.						
Primary Reason for Home	The count of clients classified by gender, gender-age, and a total						
Care	count, per Primary Reason for Home Care.						
Administration Date							
Referral							
Client Type	The count of clients classified by gender, gender-age, and a total count, per client type. Client Type counts every instance of a client type code. This value may be higher than the total number of clients if a client has more than one Client Type. Important Note: Gaps in the data will result in inaccurate reports. If this field is left blank from one reporting period to the next, the system will interpret this as two distinct Client Types rather than only one Client Type that has been continuous. This applies to the annual Total Services Report.						
Meal Service (hrs), Other Assisted Living Services (hrs)							
Client Identifier	Assumed unique within a community; that is, only one client within a community should ever have that client identifier. Important Note : The client identifier is case sensitive. For example, ZA004 is counted as one client and za004 is counted as a second client.						

CUMULATIVE REPORT - MONTHLY

Label	Definition									
Length of Stay (days)	The difference in days between the admission and discharge dates, per client for discharged clients. This is a count of days from admission to discharge inclusive. For example, if a client is admitted on Monday and discharged on Friday, this is a count of 5 days.									
Home Visits (#)	The sum of the Number of Home Visits.									
Attempted Home Visits (#)	The sum of the Number of Attempted Home Visits.									
Total Home Visits (#)	The sum of Number of Home Visits + Number of Attempted Home Visits.									
Home Management (hrs)	The sum of hours of Home Management.									
Personal Care Services (hrs)	The sum of hours of Personal Care.									
Nursing Services	The sum of hours of Nursing Services per service.									
Nursing Service Codes	The alphabetic code assigned for specific nursing activities. These codes are listed if a client received a nursing service and the associated hours for that service are in the adjoining column.									
Case Management (hrs)	The sum of hours of Case Management per service. Linked to Case Management Codes in that the value in Case Management corresponds to the adjoining value in Case Management Codes.									
Case Management Codes	The code value for a specific service. The sum of hours is in the adjoining Case Management column.									
Professional Therapies (hrs)	The sum of hours of Professional Therapies.									
In Home Respite (hrs)	The sum of hours of In Home Respite.									
Total Client (hrs)	The sum of Nursing Services and Case Management.									
Grand Total (hrs)	The sum of Total Client and Total and Professional Therapies and In-Home Respite.									
Services Not Provided (hrs)	The sum of all hours for Services Not Provided, while Reason for Services Not Provided is the most common reason (the code appears the greatest number of times). In the case of two reasons occurring an equal number of times, then the application defers to code value I – Other Reason. Important note : If you see a code of I - Other Reason on the report, this may indicate that there are two or more reasons that have appeared an equal number of times. In the case of a tie, the system defaults to code I. You should review the data to determine which reasons occur most frequently.									
Reason	The code value that is numerically the most common reason.									

IMPORTING YOUR REPORTS INTO EXCEL FOR USER CUSTOMIZING – APPENDIX I

Importing your Reports into Excel for user customizing

Saving a Report as a Txt File

1. From the Reports page, select the report you want to customize by clicking on the corresponding <u>text</u> as shown below, using your right mouse button.

Total Services Reports /										
Reporti	Reporting Period Format									
01-Apr-2005	30-Sep-2005	<u>pdf , text</u>	29-Jun-2006							

2. Save the txt file into the folder of your choice.

Importing Your Report into Excel

- 1. Open Excel, and from the File menu, click **New**.
- 2. From the File menu, select **Open**.
- 3. Double-click on the txt file report.

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	as determined that yo hoose Next, or choose e			es your data,	
Choose the file ty	ype that best describe	s your data:			
C Delmited	- Characters such	as commas or	tabs separate eac	h field.	
C Fixed width	- Fields are aligned	d in columns w	ith spaces between	n each field.	
0					
Preview of file C	Start import at gow: Oppoments and Setti		Fle grigin:	Windows (ANSI)	•
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1 2 Albany - N 3 Average Lo 4	Documents and Setti Sonth - AUG-2008 mgth of Stay, i	\1000_2005 .n. Days-~0	5_MD5_TSR_E.txt.	Windows (ANSI)	• • •

- 4. Select **Delimited**, and click **Next**.
- 5. In the **Delimiters** box, deselect the Tab checkbox, and select the **Other** checkbox.

IMPORTING YOUR REPORTS INTO EXCEL FOR USER CUSTOMIZING – APPENDIX I

Delimiters		
Г <u>Т</u> аb	🗖 Se <u>mi</u> colon	<u> ⊂</u> omma
	🔽 Other: 🗠	

6. Add a ~ next to Other: as shown.

The location of the tilde (~) symbol on different keyboards

This character can be found several ways: 1) by using the tilde key on your keyboard, 2) by using the alt key on your keyboard, 3) through Microsoft Excel, or 4) through the Microsoft Windows Character Map Utility.

Using the tilde key

The tilde key is not visible on all keyboards. If it is, it is usually located beneath the *Esc* key to the left of the number 1 key. Select *Shift* while pressing on the ~ key. On the French keyboard, access the tilde by selecting the <u>right</u> *Alt* key while clicking on the key to the right of the letter L (which is usually the colon key).

Using the alt key

While pressing *Alt* on your keyboard, type in number 126 on the number keypad to the right of your keyboard. This approach will not work if you use the numbers above the letters section of the keyboard.

Microsoft Excel

In Microsoft Excel, go to the *Insert* button at the top of the menu, then click on *Symbol*. If the tilde is not located in the available selections, you may have to click on *More Symbols*. Then, to locate the tilde, click on the *Subset* drop-down menu and select *Basic Latin*. You will then see various alphanumeric characters. Scroll down until you find the tilde and select it. This will insert the tilde into your document.

Microsoft Windows Character Map Utility

The Character Map utility is available on all Windows machines and can be used to copy and paste accented letters and other foreign language characters into any Windows application. The Character Map is similar to the Insert Symbol tool found in some Windows applications such as Microsoft Excel.

1. Click on the Start (Windows Icon) menu in the lower left and select Programs.



2. Select Programs » Accessories » System Tools » Character Map.

IMPORTING YOUR REPORTS INTO EXCEL FOR USER CUSTOMIZING – APPENDIX I

3. A window should open which displays a series of characters in a grid as in the image below.

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- 4 Hit the *Select* key, then *Copy*. You can now paste the tilde wherever you like by selecting CTRL V (or by going to the *Edit* Menu and selecting *Paste*).
- 5 Click **Next**, and click Finish.

The report is imported into Excel.

To resize the columns on the Excel spreadsheet:

- 1. Select the columns that have text in them.
- 2. Slide the cursor at the top in between any two columns until the resizer 并 appears, and double-click.
- 3. The columns resize themselves, and your report is ready for customizing.