Initial Contact Form

1. Last Name: *

5. Form Date: *

6. Worker: *

2. First Name: *

3. Other Name: (e.g., maiden)

4. Birth Date: *

7. Lives in target area?

- Yes
- No
- Unknown

8. Primary/Preferred Language: *

- English
- Spanish
- Arabic
- Bengali
- Chinese
- French
- Haitian-Creole
- Italian
- Korean
- Polish
- Russian
- Urdu
- Yiddish
- Albanian
- Cantonese
- German
- Greek
- Hindi
- Japanese
- Mandarin
- Tagalog

9. Would you like to become pregnant in the next year?

- Yes
- No
- Unsure

- [ ] Other:

Demographics As reported by client.

10a. Sex Assigned At Birth: *

- ○ Female
- ○ Male
- ○ Indeterminate

10b. Gender Identity: *

- ○ Female
- ○ Male
- ○ Non-binary
- ○ Transgender Female
- ○ Transgender Male
- ○ Declined To Answer
- ○ Indeterminate
- ○ Other:

10c. Sexual Orientation:

- ○ Bisexual
- ○ Lesbian, Gay or Homosexual
- ○ Straight or Heterosexual
- ○ Unknown
- ○ Asked, But Unknown
- ○ Other:

11. Ethnicity: *

- ○ Hispanic/Latinx
- ○ Not Hispanic/Latinx
- ○ Declined to self-identify

12. Race: (Check all that apply) *

- ☐ White
- ☐ Black/African-American
- ☐ Asian (Unspecified)
- ☐ Asian (Bangladeshi)
- ☐ Asian (Burmese)
- ☐ Asian (Chinese)
- ☐ Asian (Filipino)
- ☐ Asian (Indian)
- ☐ Asian (Japanese)
- ☐ Asian (Korean)
- ☐ Asian (Nepalese)
- ☐ Asian (Pakistani)
- ☐ Asian (Thai)
- ☐ Asian (Vietnamese)
- ☐ Asian (Bhutanese)
- ☐ Asian (Cambodian)
- ☐ Asian (Hmong)
- ☐ Asian (Indonesian)
- ☐ Asian (Laotian)
- ☐ Asian (Malaysian)
- ☐ Asian (Mongolian)
- ☐ Asian (Sri Lankan)
- ☐ Other Asian
- ☐ American Indian/Alaska Native
- ☐ Native Hawaiian/Pacific Islander (Unspecified)
- ☐ Pacific Islander (Guamanian and Chamorro)
- ☐ Pacific Islander (Native Hawaiian)
- ☐ Pacific Islander (Samoan)
- ☐ Other Pacific Islander
- ☐ Declined to self-identify
- ☐ Unknown

☐ Other Race:

Contact Details Optional.

First Contact

13a. Was the client contacted: *

- ○ Missed Calls
- ○ Left Messages
- ○ Appointment Cancelled
- ○ Decided to enroll
- ○ Decided to not enroll
- ○ Other

Other:

Second Contact

14a. Was the client contacted:

- ○ Missed Calls
- ○ Left Messages
- ○ Appointment Cancelled
- ○ Decided to enroll
- ○ Decided to not enroll
- ○ Other

Other:

Third Contact

15a. Was the client contacted:

- ○ Missed Calls
- ○ Left Messages
- ○ Appointment Cancelled
- ○ Decided to enroll
- ○ Decided to not enroll
- ○ Other

Other:

16. Primary Presenting Need:

17. Action Taken: (Check all that apply)

- ☐ Provided information and/or referral
- ☐ Completed Screening Assessment
  (continue to and complete Screening Assessment Form)
- ☐ Will schedule follow-up for Screening Assessment
  (complete Screening Assessment Form at a later date)

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Screening/Assessment Form

Client Name:

1. Intake Date: *

2. Worker: *

3a. Living Arrangement:

- ○ Lives alone or with child/children
- ○ Lives with spouse/partner
- ○ Lives with parent(s)
- ○ Lives with partner's parent(s) or other related adults
- ○ Lives with other unrelated adults
- ○ Lives in foster/group home
- ○ Homeless/no permanent residence
- ○ Refused/Unknown
- ○ Other:

4. Highest Grade Completed:

- ○ Less than 8th
- ○ 8-11
- ○ High school graduate/GED
- ○ Vocational school after HS
- ○ Some college
- ○ Associates degree
- ○ Bachelor's degree or higher
- ○ Refused/Unknown

5. Currently enrolled in education/training program?

- ○ Yes
- ○ No
- ○ Unknown

6a. Currently is working for pay?

- ○ Yes
- ○ No
- ○ Unknown

6b. Current job is: (Check all that apply)

- ☐ Full-time
- ☐ Part-time
- ☐ Temporary

7. Receiving any of the following benefits?

(Check all that apply)

- [ ] TANF
- [ ] Emergency Assistance
- [ ] SSI/SSD
- [ ] Food stamps
- [ ] WIC

8. Total number of people in household:

9. Average total monthly income of household:

$

- [ ] Unknown

10. Average total monthly value of benefits:

$

- [ ] Unknown

11a. Usual source of medical care: *

- ( ) Doctor/clinician's office
- ( ) Hospital outpatient clinic
- ( ) Federally qualified health center (FQHC)
- ( ) Emergency department
- ( ) Urgent care
- ( ) None
- ( ) Unknown
- ( ) Other:

11b. Had well-visit with primary care provider in the past year?

- ( ) Yes

12a. Currently has a dental provider?

- ( ) Yes
- ( ) No
- ( ) Unknown

12b. Had dental visit in the past 6-8 months?

- ( ) Yes
- ( ) No
- ( ) Unknown

12c. Has any dental problems?

- ( ) Yes
- ( ) No
- ( ) Unknown

13a. Currently has health insurance coverage?

*

- ( ) Yes
- ( ) No
- ( ) Unknown

13b. Type of health insurance (Check primary insurance only)

- ( ) Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- ( ) Child Health Plus
- ( ) Private Insurance
- ( ) Unknown

- ○ No
- ○ Unknown
- ○ Other:

Reproductive History

14. Number of previous pregnancies:

(Include current pregnancy, if applicable)

15. Date of last delivery: (if applicable)

16a. Number of previous live births:

16b. Any previous babies born below normal weight?

(Less than 5 lbs 8 oz)

- Yes
- No
- Unknown

16c. Any previous premature births? (36 weeks or less) -->

- Yes
- No
- Unknown

16d. Any previous still births or fetal deaths?

- Yes

17a. Currently pregnant?

- Yes
- No
- Unknown

17b. If so, expected date of delivery:

18a. If not currently pregnant, would like to become pregnant in the next 12 months?

- Yes
- No
- Unknown
- Unsure

18b. If no, currently taking steps to prevent a pregnancy?

- Yes
- No
- Unknown

18c. If yes, types of birth control used:

(Check all that apply)

- Abstinence
- Birth control pill
- Cervical cap (FemCap)
- Female condom
- Spermicide
- Withdrawal/Other
- Birth control implant (Implanon/Nexplanon)
- Birth control vaginal ring (NuvaRing)
- Condom
- Emergency contraception (morning after pill)
- Tubal ligation (female sterilization)
- Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- Birth control patch (Ortho Evra)
- Birth control shot (Depo-Provera)
- Diaphragm
- IUD (Mirena, Paragard)
- Vasectomy (male sterilization)

- ○ No
- ○ Unknown

General Health & Well-Being

19. Taking folic acid supplements? (Or prenatal vitamins, if pregnant)

- Yes
- No
- Unknown

20. Any concerns about a healthy weight?

- Yes
- No
- Unknown

21a. Does potential client use tobacco products or vapes?

- Yes
- No
- Unknown

21b. Does anyone in the household use tobacco products or vapes?

- Yes
- No
- Unknown

22a. Have they traveled recently (approx. past 3-6 months)?

- Yes
- No
- Unknown

22b. If yes, where?

Currently Pregnant Client

23a. Any prenatal visits?

- ○ Yes
- ○ No
- ○ Unknown

23b. If yes, date of first prenatal visit:

23c. Number of prenatal visits:

24. Plan to feed with breast milk?

- ○ Yes
- ○ No
- ○ Unknown

25a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

25b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

26. Has physician indicated any concerns about pregnancy weight gain?

- ○ Yes
- ○ No
- ○ Unknown

27a. Has physician indicated any other concerns about pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

27b. If yes, specify physician's concerns:

28. Selected a method of birth control to discuss with physician?

- ○ Yes
- ○ No

Client with Children Under Twelve Months

29. Do you have any children under twelve months?

--Select--

30. Does baby have health insurance?

- Yes
- No
- Unknown

31. Does baby have a primary medical provider?

- Yes
- No
- Unknown

32. Child(ren)'s usual source of medical care:

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None
- Unknown

33. Currently feeding with breast milk?

- Breast milk only
- Breastmilk and formula/solids
- No

34a. Was child ever fed breast milk?

- Yes
- No
- Unknown

34b. If yes, number of months fed breast milk:

Months

34c. Number of months fed only breast milk:

Months

* Conversions are a follows: (One week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five

35a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends
- No one
- Other:

35b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends

Other:

weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2)

No one

Other:

36. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back				
Alone				
In Crib				

Alcohol Use (AUDIT-C)

37. How often do you have a drink containing alcohol?

- Never (0)
- Monthly or less (1)
- 2-4 times a month (2)
- 2-3 times a week (3)
- 4 or more times a week (4)

38. How many standard drinks containing alcohol do you have on a typical day?

- 2 or less (0)
- 3 or 4 (1)
- 5 or 6 (2)
- 7 to 9 (3)
- 10 or more (4)

39. How often do you have six or more drinks on one occasion?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

40. Screening Result?

- Positive
- Negative
- Refused

41. Was client referred?

- Yes
- No

42. If another evidence based screening tool was used, what was it?

Substance Use (NIDA)

43. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	○	○	○	○	○
Tobacco Products	○	○	○	○	○
Prescription Drugs for Non-Medical Reasons	○	○	○	○	○
Illegal Drugs	○	○	○	○	○

44. In your lifetime, which of the following substances have you ever used?

- ☐ Cannabis
- ☐ Cocaine
- ☐ Prescription stimulants
- ☐ Methamphetamine
- ☐ Inhalants
- ☐ Sedatives or sleeping pills
- ☐ Hallucinogens
- ☐ Street opioids
- ☐ Prescription opioids
- ☐ Other:

45. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

46. Was client referred?

- ○ Yes
- ○ No

47. If another evidence based screening tool was used, what was it?

Domestic Violence (HITS)

48. How often does your partner...?	**Not at all** *Score 1*	**Rarely** *Score 2*	**Sometimes** *Score 3*	**Fairly often** *Score 4*	**Frequently** *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

49. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other

50. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

51. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

52. Was client referred?

- ○ Yes
- ○ No

53. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

54. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	○	○	○	○
Thought that you would be better off dead or of hurting yourself in some way	○	○	○	○

55. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

56. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

57. Was client referred?

- ○ Yes
- ○ No

58. If another evidence based screening tool was used, what was it?

Issues

59. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Substance use	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Physical disability/health problems	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Depression	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Other mental illness/disability	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

59. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Domestic violence	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Marital or relationship difficulties	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for yourself	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Financial difficulties	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Unemployment (self or partner)	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Homelessness/inadequate housing	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

59. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Legal problems	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Social isolation	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Stress or emotional difficulties	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Inadequate food, clothing, or household items	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Smoking	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Problems with teeth or gums (e.g. pain, bleeding)	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

59. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Parenting	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Prenatal/postpartum health issues	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for your child	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Concerns about your child's development	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Accessing dental care	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Information

60. Would like more information about...? (Check all that apply)

- [ ] Family planning/contraception
- [ ] Pregnancy testing
- [ ] Safe sex
- [ ] Exercise, opportunities to exercise
- [ ] Nutrition, access to healthy foods
- [ ] HIV testing
- [ ] STD testing
- [ ] Job search/placement assistance
- [ ] Adult basic education or GED preparation
- [ ] ESL (English as a Second Language)
- [ ] Vocational or job skills training
- [ ] Alcohol
- [ ] Basic needs (housing, food, etc)
- [ ] Depression
- [ ] Domestic Violence
- [ ] Health Insurance
- [ ] Illicit Drug Use
- [ ] Preventative Care / Primary Care
- [ ] Smoking

Pregnant or Parenting

- [ ] Child care programs
- [ ] Parenting skills
- [ ] Lead assessment/testing
- [ ] Child development
- [ ] Safe sleep
- [ ] Environmental health/safety
- [ ] Car seat use
- [ ] Healthy pregnancy
- [ ] Feeding with breast milk and child nutrition
- [ ] Immunizations
- [ ] Accessing dental care
- [ ] Birth Plan / Preterm Birth
- [ ] Infant / New Born Care
- [ ] Postpartum Care
- [ ] Prenatal Care

61. Is Non-Birthing Caregiver?

- ( ) Yes
- ( ) No

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Child Information & Pregnancy Outcomes Form

Client Name:

1. Form Date: *

2. Worker: *

Pregnancy

3a. Did birthing person/client receive prenatal care?

- Yes
- No
- Unknown

3b. Date or trimester began receiving prenatal care?

- First Trimester
- Second Trimester
- Third Trimester
- Unknown Date / Trimester

4. Did birthing person/client visit dentist during pregnancy?

- Yes
- No
- Unknown

5. Did birthing person/client smoke during pregnancy?

- Yes
- No
- Unknown

6a. Did birthing person/client receive doula support?

- Yes
- No
- Unknown

6b. If yes, when? Check all that apply:

- Prenatal
- During Labor
- Postpartum

7. Number of births:

Children

8. Last Name:

9. First Name:

10. Birth Date:

11. Living With Non-Birthing Caregiver?

- Yes
- No

12. First Birth?

- Yes
- No

13. Gestational Age: (In whole weeks)

Weeks

- Unknown Gestational Age

14. Birth Weight:

Lbs

Oz

20. Sex Assigned At Birth:

- Female
- Male
- Indeterminate

21. Ethnicity:

- Hispanic/Latinx
- Not Hispanic/Latinx
- Declined to self-identify

22. Race: (Check all that apply)

- White
- Black/African-American
- Asian (Unspecified)
- Asian (Bangladeshi)
- Asian (Burmese)
- Asian (Chinese)
- Asian (Filipino)
- Asian (Indian)
- Asian (Japanese)
- Asian (Korean)
- Asian (Nepalese)
- Asian (Pakistani)
- Asian (Thai)
- Asian (Vietnamese)

- [ ] Unknown Birth Weight

15. Was a live birth?

- ( ) Yes
- ( ) No

16. Type of Delivery:

- ( ) Vaginal
- ( ) Cesarean

17. Was in an intensive care unit?

- ( ) Yes
- ( ) No

18. Was infant alive at hospital discharge?

- ( ) Yes
- ( ) No
- ( ) Infant not yet discharged

19. Was infant receiving breast milk at discharge?

- ( ) Yes
- ( ) No
- ( ) Unknown

- [ ] Asian (Bhutanese)
- [ ] Asian (Cambodian)
- [ ] Asian (Hmong)
- [ ] Asian (Indonesian)
- [ ] Asian (Laotian)
- [ ] Asian (Malaysian)
- [ ] Asian (Mongolian)
- [ ] Asian (Sri Lankan)
- [ ] Other Asian
- [ ] American Indian/Alaska Native
- [ ] Native Hawaiian/Pacific Islander (Unspecified)
- [ ] Pacific Islander (Guamanian and Chamorro)
- [ ] Pacific Islander (Native Hawaiian)
- [ ] Pacific Islander (Samoan)
- [ ] Other Pacific Islander
- [ ] Declined to self-identify
- [ ] Unknown
- [ ] Other:

23. Date of death (if applicable):

Medical

24a. Has Insurance Coverage? *

- ○ Yes
- ○ No
- ○ Unknown

24b. Insurance Type: (Check all that apply) *

- ☐ Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ Unknown
- ☐ Other:

25a. Post-partum visit scheduled? *

- ○ Yes
- ○ No
- ○ Has already attended
- ○ Unknown

25b. If already attended, was it within 8 weeks of birth?

*

- ○ Yes
- ○ No

25c. If already attended, was it within 12 weeks of birth?

*

- ○ Yes
- ○ No

25d. If already attended, specify when:

26. Has birthing person/client selected a contraceptive method to discuss with their doctor?

- ○ Yes
- ○ No
- ○ Unknown

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Encounter Form

Client Name:

1. Encounter Date: *

2. Worker: *

3. Length of Visit:

Hrs

Mins

4a. Type of Contact: *

- In-person
- Phone
- E-mail
- Text
- Videoconferencing

4b. If in-person, where did it occur?

- Client home
- Other:

Specify other location

5. Who was present at visit? (Check all that apply)

- Client
- Client's partner
- Client's parent(s)
- Client's child(ren)
- Other:

Activities (Check all that apply)

For each client encounter, the Community Health Worker is responsible for ensuring that all materials and information provided is easily understandable (appropriate literacy level), is accessible in the clients' preferred language including use of a language line, and provides clients with basic health information and services needed to make appropriate health decisions.

Health Care:

Family Functioning:

- [ ] Provide general health information
- [ ] Provide family planning/optimal birth spacing info
- [ ] Provide child health information
- [ ] Provide dental health information
- [ ] Provide nutrition/food preparation information
- [ ] Provide safe sex or STD information
- [ ] Provide information of health providers or services
- [ ] Provide advocacy/support or accompany to medical providers and services
- [ ] Provide information on smoking cessation
- [ ] Completed / Reviewed Birth Plan
- [ ] Reproductive Life Plan
- [ ] Immunizations
- [ ] Completed / Reviewed Postpartum Plan

Prenatal/New Parent:

- [ ] Provide education/info re: prenatal care/pregnancy
- [ ] Discuss feelings about baby
- [ ] Provide labor and delivery support
- [ ] Address infant basic care needs (sleeping, bathing, etc)
- [ ] Provide safe sleep information
- [ ] Provide infant feeding information and support
- [ ] Provide breastfeeding information and support
- [ ] Provide information/equipment relating to child safety (car seats, child proofing homes, etc.)
- [ ] Discuss alcohol impacts during pregnancy
- [ ] Discuss Shaken Baby Syndrome
- [ ] Provide support to parents re: stresses of parenting
- [ ] Infant weight check
- [ ] Car seat check

- [ ] Address issues re: violence in the home
- [ ] Discuss family relations
- [ ] Discuss substance use issues
- [ ] Discuss mental health issues
- [ ] Teach, foster communication skills
- [ ] Home Safety checklist

Concrete Activities:

- [ ] Arrange for transportation
- [ ] Provide or arrange for food, clothes, diapers, or household goods
- [ ] Address legal needs
- [ ] Provide info and/or assistance with housing
- [ ] Translation
- [ ] Discuss child support issues
- [ ] Discuss visitation issues
- [ ] Discuss parental rights issues

Program Activities:

- [ ] Complete forms
- [ ] Assess needs, develop or review family service plan
- [ ] Complete client satisfaction survey

Crisis Intervention:

- [ ] Help resolve problems and handle crises

Other Activities:

- [ ] Other:

- [ ] Crib check/crib for kids
- [ ] Cesarean incision
- [ ] Post-partum mother care
- [ ] Preterm birth: signs, symptoms, prevention

Self-Sufficiency:

- [ ] Teach to use public transportation or provide maps or directions
- [ ] Teach how to use calendar or appointment book
- [ ] Address needs for child care
- [ ] Provide advocacy/support and/or accompany to non-medical providers or services
- [ ] Arrange appointment for health care services
- [ ] Job search/placement assistance
- [ ] Adult basic education or GED preparation
- [ ] ESL (English as a Second Language)
- [ ] Vocational or job skills training

Client Medical Visits

Type of Visit *	**Date of Visit** *	**Reason for Visit**	**Weeks Pregnant** (if applicable)
Specify:			
Specify:			
Specify:			
Specify:			
Specify:			

* Records missing required fields will not be saved.

Type of Visit Codes:

1. Annual OBGYN exam
2. Prenatal visit
3. Postpartum visit
4. Routine physical
5. Urgent Care
6. Dental visit
99. Other

Baby Medical Visits

Type of Visit *	**Date of Visit ***	**Reason for Visit**	**Child's Age** (in months)	**Lead screening done at this visit?**
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				
				○ Yes ○ No ○ Unknown
Specify:				

* Records missing required fields will not be saved.

Type of Visit Codes:

1. Well-baby visit
2. Urgent Care
3. Non-well baby visit
4. Dental
99. Other

Baby Immunizations

Type of Immunization(s) *	**Date ***	**Child's Age** (in months)

* Records missing required fields will not be saved.

Type of Immunization Codes:

1. Hepatitis B
2. Rotavirus
3. Diphtheria, tetanus, & acellular pertussis
4. Haemophilus influenzae type b
5. Pneumococcal conjugate
6. Inactivated poliovirus
7. Influenza
8. Measles, mumps, rubella
9. Varicella
10. Hepatitis A
11. Meningococcal
12. Tetanus, diphtheria, & acellular pertussis
13. Human papillomavirus
14. Meningococcal B
15. Pneumococcal polysaccharide
16. COVID-19
17. RSV

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				
			○ Yes ○ No	
Specify:				

* Records missing required fields will not be saved.

Service Codes:

Health Care

1. Adult primary care
2. Child primary care
3. Dental services
4. Early Intervention
5. Family Planning
6. Immunization
7. Lead Testing
8. Mental Health Services
9. Postpartum Care
10. Prenatal Care
11. Other, Specify
26. Health Insurance
45. Alcohol/Substance Use

Educational

12. Breastfeeding
14. Childcare
15. Child Development
16. Child Support
18. Domestic Violence
19. Educational Attainment
20. Employment / Vocational Services
21. Environmental Health / Safety
22. English as a Second Langauge (ESL)
23. Family Resource Center
27. HEAP
28. Early Head Start
29. Head Start
30. Healthy Families New York
31. Healthy Start
32. Home Instruction for Parents of Preschool Youngsters
33. Nurse-Family Partnership
34. Parent Child Home Program

SDOH

13. Car Seat
17. Clothing / Baby Care Items
24. Food Pantry
25. Furniture
38. Housing
44. SNAP (Food Stamps)
47. TANF/DSS Cash Assistance
49. Transportation
50. WIC

35. Parents as Teachers
36. Public Health Nurse / LHD
37. Other Home Visiting Program, Specify
39. Immigration Services
40. Legal Services
41. Nutrition, General
42. Safe Sleep
43. Smoking Cessation
46. Support Groups
48. Translation
51. Other, Specify
52. Doula

Family Member Codes:

1. Client
2. Client's partner
3. Other biological parent of enrolled child (non-partner)
4. Enrolled child
5. Other child
6. Other relative
7. Non-relative

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Discharge Form

Client Name:

1. Discharge Date: *

2. Worker: *

3a. Discharge Reason: *

- Client has met their goals
- Program unable to locate or make contact
- Participant non-compliant or unresponsive
- Participant refused
- Transferred/referred to another PICHC program
- Transferred/referred to a prevention/home visiting program
- Client deceased
- Client unavailable due to school or employment
- CHW left, client refused new CHW
- Safety issues for worker
- Program terminated due to mental health issues
- Family or other household member objects to program
- Out of geographical target area

3d. Living Arrangement:

- Lives alone or with child/children
- Lives with spouse/partner
- Lives with parent(s)
- Lives with partner's parent(s) or other related adults
- Lives with other unrelated adults
- Lives in foster/group home
- Homeless/no permanent residence
- Refused/Unknown
- Other:

4a. Usual source of medical care:

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None

5a. Currently has health insurance coverage?

- Yes
- No
- Unknown

5b. Type of health insurance (Check primary insurance only)

- Medicaid (Fee for Service, Managed Care or Emergency Medicaid)
- Child Health Plus
- Private Insurance
- Unknown
- Other:

5c. Any period of no health insurance coverage since last update?

- Yes
- No

- ○ Child deceased
- ○ Other:

3b. Deceased Client Specification:

- ○ Birthing Client Death Before Labor
- ○ Birthing Client Death During Labor
- ○ Birthing Client Death Postpartum
- ○ Non-Birthing Caregiver Deceased

3c. Client Satisfaction Survey Completed?

- ○ Yes
- ○ No

- ○ Unknown
- ○ Other:

- ○ Unknown

Reproductive History

6a. Been pregnant since last follow-up?

(Exclude pregnancy at program intake)

- ○ Yes
- ○ No
- ○ Unknown

6b. If yes, currently pregnant?

- ○ Yes
- ○ No
- ○ Unknown

6c. If so, expected date of delivery:

6d. If not pregnant since last follow-up or program intake, please list most recent delivery/pregnancy end date:

(if applicable) (includes live/still birth and miscarriage dates)

7a. If not currently pregnant, would like to become pregnant in the next 12 months?

- ○ Yes
- ○ No
- ○ Unknown
- ○ Unsure

7b. If no, have you been consistently using birth control since last follow-up?

- ○ Yes
- ○ No
- ○ Unknown

7c. If yes, types of birth control used since the last follow-up:

(Check all that apply)

- ☐ Abstinence
- ☐ Birth control pill
- ☐ Cervical cap (FemCap)
- ☐ Female condom
- ☐ Spermicide
- ☐ Withdrawal/Other
- ☐ Birth control implant (Implanon/Nexplanon)
- ☐ Birth control vaginal ring (NuvaRing)
- ☐ Condom
- ☐ Emergency contraception (morning after pill)
- ☐ Tubal ligation (female sterilization)
- ☐ Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- ☐ Birth control patch (Ortho Evra)
- ☐ Birth control shot (Depo-Provera)
- ☐ Diaphragm
- ☐ IUD (Mirena, Paragard)
- ☐ Vasectomy (male sterilization)

General Health & Well Being

8. Taking folic acid supplements? (Or prenatal vitamins, if pregnant)

- Yes
- No
- Unknown

9. Any concerns about a healthy weight?

- Yes
- No
- Unknown

10a. Does potential client use tobacco products or vapes?

- Yes
- No
- Unknown

10b. Does anyone in the household use tobacco products or vapes?

- Yes
- No
- Unknown

11a. Have they traveled recently (approx. past 3-6 months)?

- Yes
- No
- Unknown

11b. If yes, where?

Currently Pregnant Client

12a. Any prenatal visits?

- ○ Yes
- ○ No
- ○ Unknown

12b. If yes, date of first prenatal visit:

12c. Number of prenatal visits:

13. Plan to feed with breast milk?

- ○ Yes
- ○ No
- ○ Unknown

14a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

14b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

15. Has physician indicated any concerns about pregnancy weight gain?

- ○ Yes
- ○ No
- ○ Unknown

16a. Has physician indicated any other concerns about pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

16b. If yes, specify physician's concerns:

17. Selected a method of birth control to discuss with physician?

- ○ Yes
- ○ No

Client with Children Under Twelve Months

18. Do you have any children under twelve months?

--Select--

19. Does baby have health insurance?

- Yes
- No
- Unknown

20. Does baby have a primary medical provider?

- Yes
- No
- Unknown

21. Child(ren)'s usual source of medical care:

- Doctor/clinician's office
- Hospital outpatient clinic
- Federally qualified health center (FQHC)
- Emergency department
- Urgent care
- None
- Unknown

22. Currently feeding with breast milk?

- Breast milk only
- Breastmilk and formula/solids
- No

23a. Was child ever fed breast milk?

- Yes
- No
- Unknown

23b. If yes, number of months fed breast milk:

Months

23c. Number of months fed only breast milk:

Months

* Conversions are a follows: (One week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five

24a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends
- No one
- Other:

24b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- Baby's parent
- Partner (not baby's parent)
- Parents
- Other relatives
- Friends

Other:

weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2)

No one

Other:

25. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back				
Alone				
In Crib				

Alcohol Use (AUDIT-C)

26. How often do you have a drink containing alcohol?

- Never (0)
- Monthly or less (1)
- 2-4 times a month (2)
- 2-3 times a week (3)
- 4 or more times a week (4)

27. How many standard drinks containing alcohol do you have on a typical day?

- 2 or less (0)
- 3 or 4 (1)
- 5 or 6 (2)
- 7 to 9 (3)
- 10 or more (4)

28. How often do you have six or more drinks on one occasion?

- Never (0)
- Less than monthly (1)
- Monthly (2)
- Weekly (3)
- Daily or almost daily (4)

29. Screening Result?

- Positive
- Negative
- Refused

30. Was client referred?

- Yes
- No

31. If another evidence based screening tool was used, what was it?

Substance Use (NIDA)

32. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

33. In your lifetime, which of the following substances have you ever used?

- [ ] Cannabis
- [ ] Cocaine
- [ ] Prescription stimulants
- [ ] Methamphetamine
- [ ] Inhalants
- [ ] Sedatives or sleeping pills
- [ ] Hallucinogens
- [ ] Street opioids
- [ ] Prescription opioids
- [ ] Other:

34. Screening Result?

- ( ) Positive
- ( ) Negative
- ( ) Refused

35. Was client referred?

- ( ) Yes
- ( ) No

36. If another evidence based screening tool was used, what was it?

Domestic Violence (HITS)

37. How often does your partner...?	**Not at all** *Score 1*	**Rarely** *Score 2*	**Sometimes** *Score 3*	**Fairly often** *Score 4*	**Frequently** *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

38. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other

39. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

40. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

41. Was client referred?

- ○ Yes
- ○ No

42. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

43. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	○	○	○	○
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	○	○	○	○
Thought that you would be better off dead or of hurting yourself in some way	○	○	○	○

44. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

45. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

46. Was client referred?

- ○ Yes
- ○ No

47. If another evidence based screening tool was used, what was it?

Issues

48. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Substance use	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Physical disability/health problems	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Depression	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Other mental illness/disability	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

48. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Domestic violence	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Marital or relationship difficulties	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for yourself	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Financial difficulties	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Unemployment (self or partner)	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Homelessness/inadequate housing	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

48. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Legal problems	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Social isolation	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Stress or emotional difficulties	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Inadequate food, clothing, or household items	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Smoking	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Problems with teeth or gums (e.g. pain, bleeding)	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

48. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Parenting	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Prenatal/postpartum health issues	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for your child	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Concerns about your child's development	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Accessing dental care	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

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Universal Virtual Home Visiting (UVHV)

Data Management & Information System (UVHV DMIS)

Data Collection Guidance

Updated 1/27/2025

Please use the following five forms to record client information in the Universal Virtual Home Visiting Data Management and Information System (UVHV DMIS). Note that responses to many questions are required for the forms to be submitted. Forms will be rejected without this information. Responses to other questions are requested depending upon a client's individual circumstances.

Use demographics obtained from the referring birthing hospital about potential participants they informed about the project and who expressed interest in participating to initiate enrollment by reporting the following information on the Initial Contact Form. Up to three attempts to contact hospital-identified potential participants should be made.

Initial Contact Form	
Question	**Status**
1. Last Name: *	Required
2. First Name: *	Required
4. Birth Date: *	Required
5. Form Date: *	Required
6. Worker: *	Required
8. Primary/Preferred Language: *	Required
10a. Sex Assigned At Birth: *	Required
10b. Gender Identity:*	Required
11. Ethnicity: *	Required
12. Race:*	Required
Type of referral/recruitment source: *	"Outside Referral" and "Birthing Hospital" are the default selections
First Contact* 13a. Was the client contacted:	Required; Second and Third Contacts required as needed until client contacted
Second Contact 14a. Was the client contacted:	Please try to collect data depending on individual circumstance
Third Contact 15a. Was the client contacted:	Please try to collect data depending on individual circumstance

For contacted clients who agree to enroll upon contact, collect as much as possible of the Screening/Assessment information below as well as Child Information & Pregnancy Outcomes that follows during the first encounter, and during a second or third encounter if needed.

Screening/Assessment Form	
Question	**Status**
1. Intake Date: *	Required
2. Worker:*	Required
11a. Usual source of medical care: *	Required
13a. Currently has health insurance coverage? *	Required
13b. Type of health insurance:*	Required
33. Currently feeding with breast milk?	Please try to collect data
34a. Was child ever fed breast milk?	Please try to collect data
34b. If yes, number of months fed breast milk (*enter as whole or decimal fractions of months, e.g., One Week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2*)	Please try to collect data
34c. Number of months fed only breast milk (*enter as whole or decimal fractions of months, e.g., One Week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2*)	Please try to collect data
Alcohol Use Screening	Please try to collect data
Substance Use Screening	Please try to collect data
Domestic Violence Screening	Please try to collect data
Depression Screening	Please try to collect data
59. Issue...	Please try to collect data

Child Information & Pregnancy Outcomes Form	
Question	**Status**
1. Intake Date: *	Required
2. Worker:*	Required
25. Postpartum visit scheduled? *	Required (if the option “has already attended” is selected, please further indicate if the visit occurred within 8 weeks of birth or 8 Weeks or More after Birth.
19. Was infant receiving breast milk at discharge?	Please try to collect data

Collect the following information for initial enrollment and up to four (five total) encounters.

Encounter Form	
Question	**Status**
1. Encounter Date: *	Required
2. Worker: *	Required
4a. Type of Contact: *	Required
Medical Visits	Please try to collect data depending on individual circumstance
Referrals	Please try to collect data depending on individual circumstance

Collect the following information during the client's final encounter and discharge from the UVHV program.

Discharge Form	
Question	**Status**
1. Discharge Date: *	Required
2. Worker: *	Required
3a. Discharge Reason: *	Required
22. Currently feeding with breast milk?	Please try to collect data
23a. Was child ever fed breast milk?	Please try to collect data
23b. If yes, number of months fed breast milk (*enter as whole or decimal fractions of months, e.g., One Week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2*)	Please try to collect data
23c. Number of months fed only breast milk (*enter as whole or decimal fractions of months, e.g., One week=0.25; Two weeks=0.5; Three weeks=0.75; Four weeks=1; Five weeks=1.25, Six weeks=1.5; Seven weeks=1.75; Eight weeks=2*)	Please try to collect data

CHSR

UVHV

DMIS User Manual

Version 2.0

April 2026



CENTER FOR HUMAN SERVICES RESEARCH
UNIVERSITY AT ALBANY State University of New York

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1. Getting Started

Getting a User ID

1. New users must be created by site administrators (CHSR). A request to create a user can be made by filling out and emailing the User Request Form.

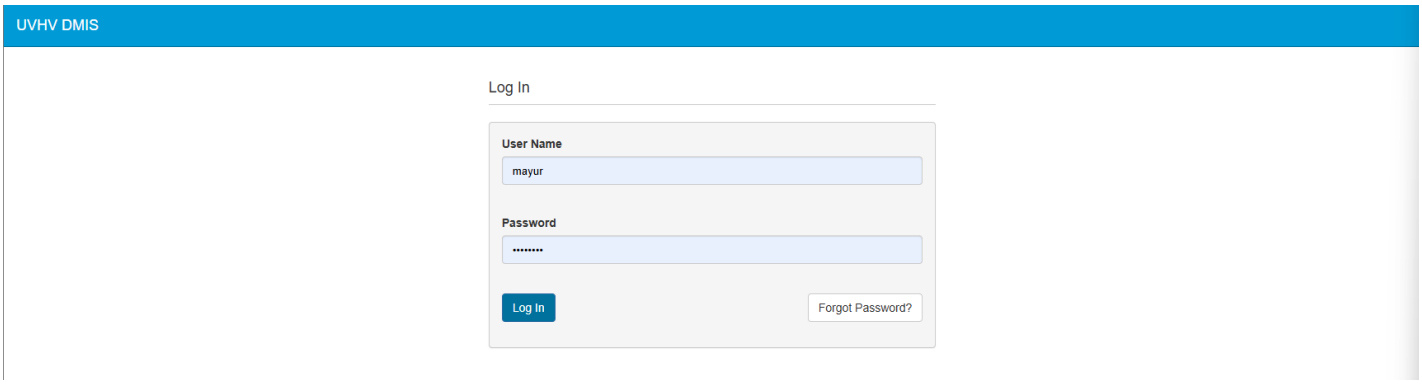
2. Only site administrators (CHSR) can activate/deactivate user accounts. To request account activation/deactivation, please submit a Help Desk Ticket.

Logging In

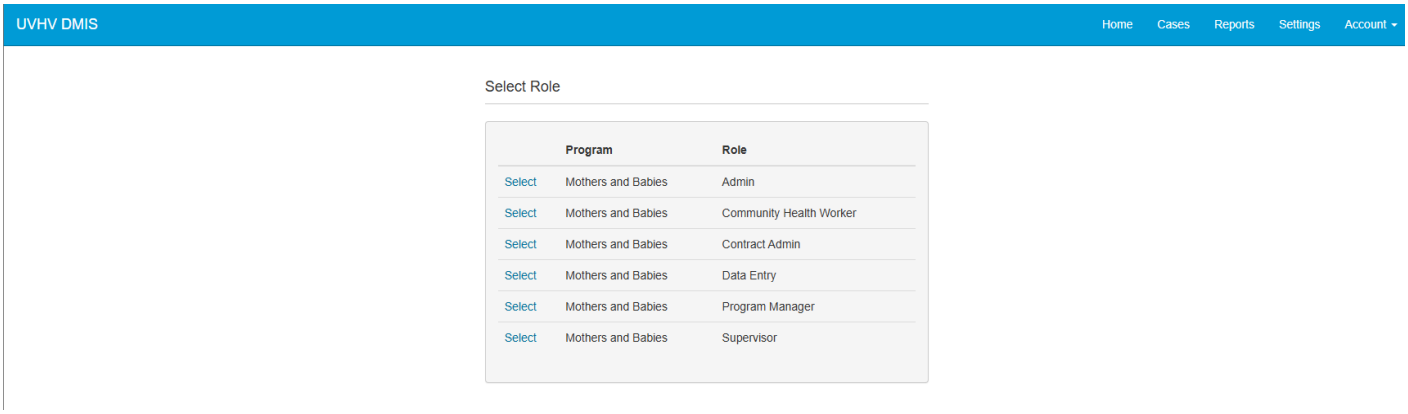
1. In a web browser, preferably Chrome, navigate to https://smhilighttouch.azurewebsites.net/

2. To log in for the first time, you must reset your password. See below, item 1B5.

3. For all subsequent log ins, enter your username and password in the appropriate boxes and click "Submit."



User Role: An account can be associated with one or many roles. If you have multiple roles associated with your account, you will be prompted to choose a role after logging in.

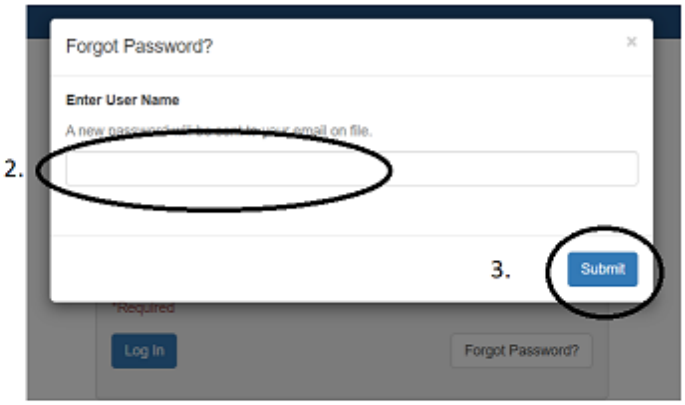


Password Reset: Passwords can be reset via the login page.

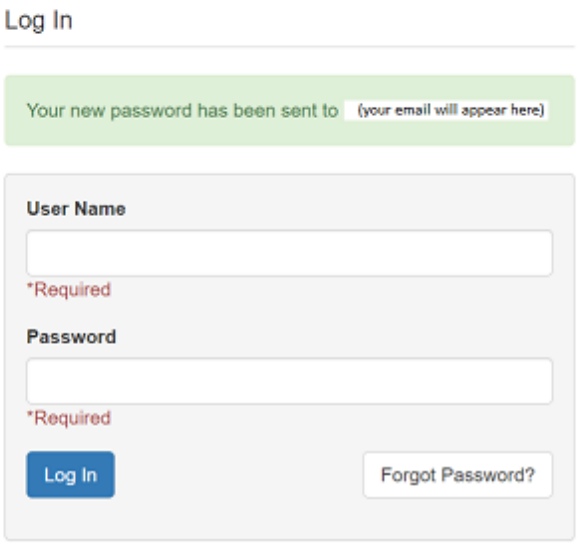
1. Click "Forgot Password?"



2. Enter your User Name in the box
3. Click "Submit"



You will see a message in a green box if you are successful.



2. Using the System

Menu

Home

Technical Support - For help resolving technical issues of any sort, a help desk ticket can be submitted using the “Submit a Ticket” link.

Quick Links

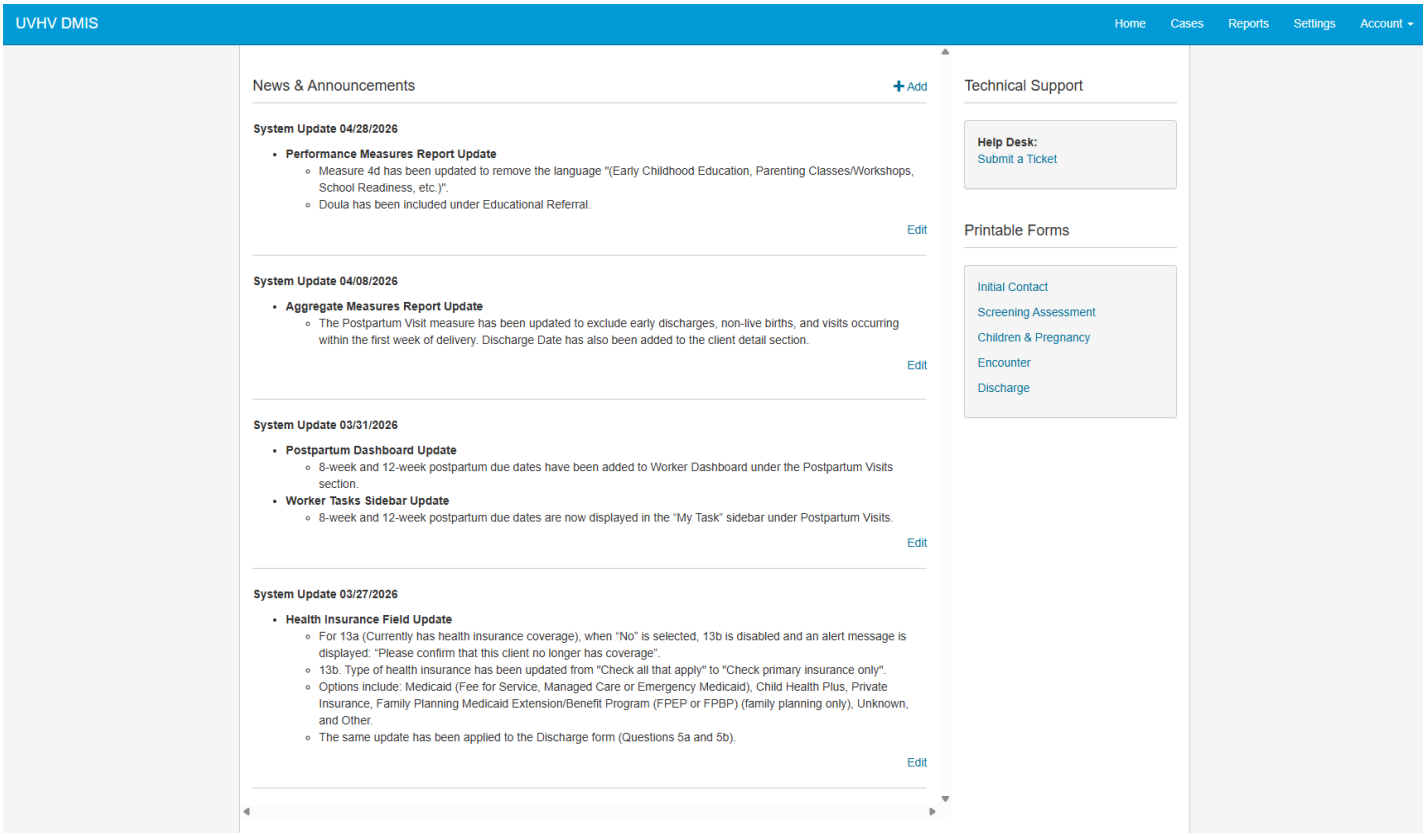
User Manual: A copy of this document.

Program Q&A: An FAQ with some commonly asked questions received from programs.

Import Cases: A feature added to the DMIS allowing for mass import of cases from an external database. Requires external vendor support to transfer the cases properly through the intake and screening forms.

User Manual – Reminders and Ad Hoc: A guide to the new features Reminder and Ad-Hoc Reporting.

Printable Forms - These are available to users who would prefer to fill out a paper form which will then be transcribed into the system. These forms cannot be used to input data directly.

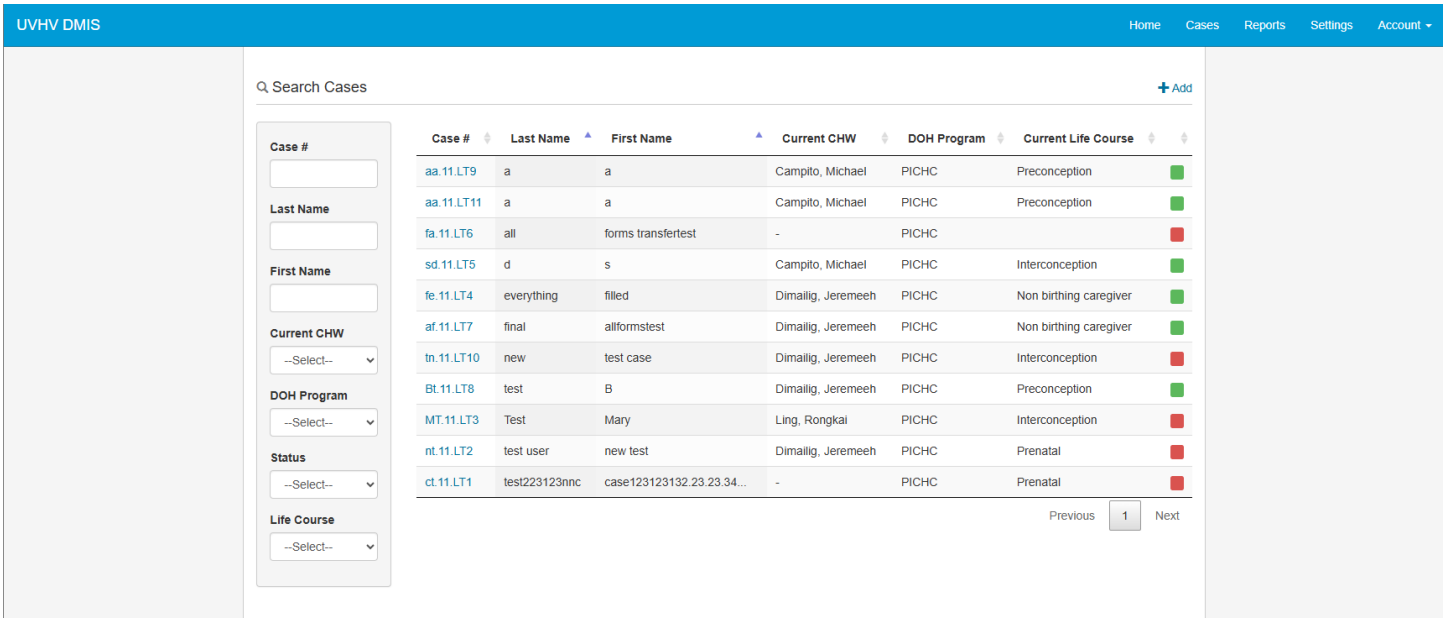


Cases

The “Cases” page displays all clients in the user’s program for Supervisor, CHW and Data Entry roles. For Contract Admin users, this page displays all clients in the system.

The list can be sorted by any column by clicking on the arrows in the appropriate column header.

The list can also be searched by entering text into one or more of the boxes on the left-hand side.



Reports

This section contains a multitude of reports that summarize information across various forms.

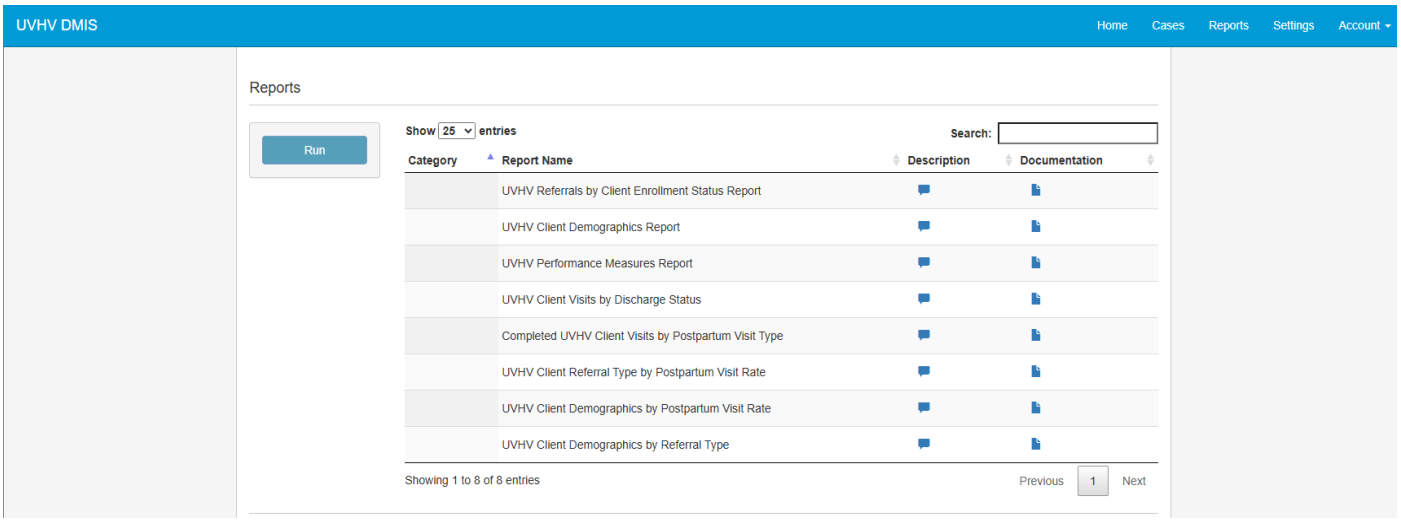
Documentation for each report describing how each item is calculated can be viewed by clicking the file icon.

Reports are run against a specific date window. Dates can be entered after a report is selected.

Reports are calculated based on defined business rules, including client eligibility and selected date ranges.

Postpartum visit measures exclude early discharges, non-live births, and visits occurring within the first week of delivery.

Some reports include detailed client-level breakdowns for auditing and analysis purposes.



Settings

Program Detail

Roles required: Program Manager, Data Entry

Use this form to add or update program specific information such as the program name, manager, address, phone number, etc.

Worker Detail Form: In 'Worker Administration' section, click 'Select' to edit an existing worker or '+ Add' to add a new worker.

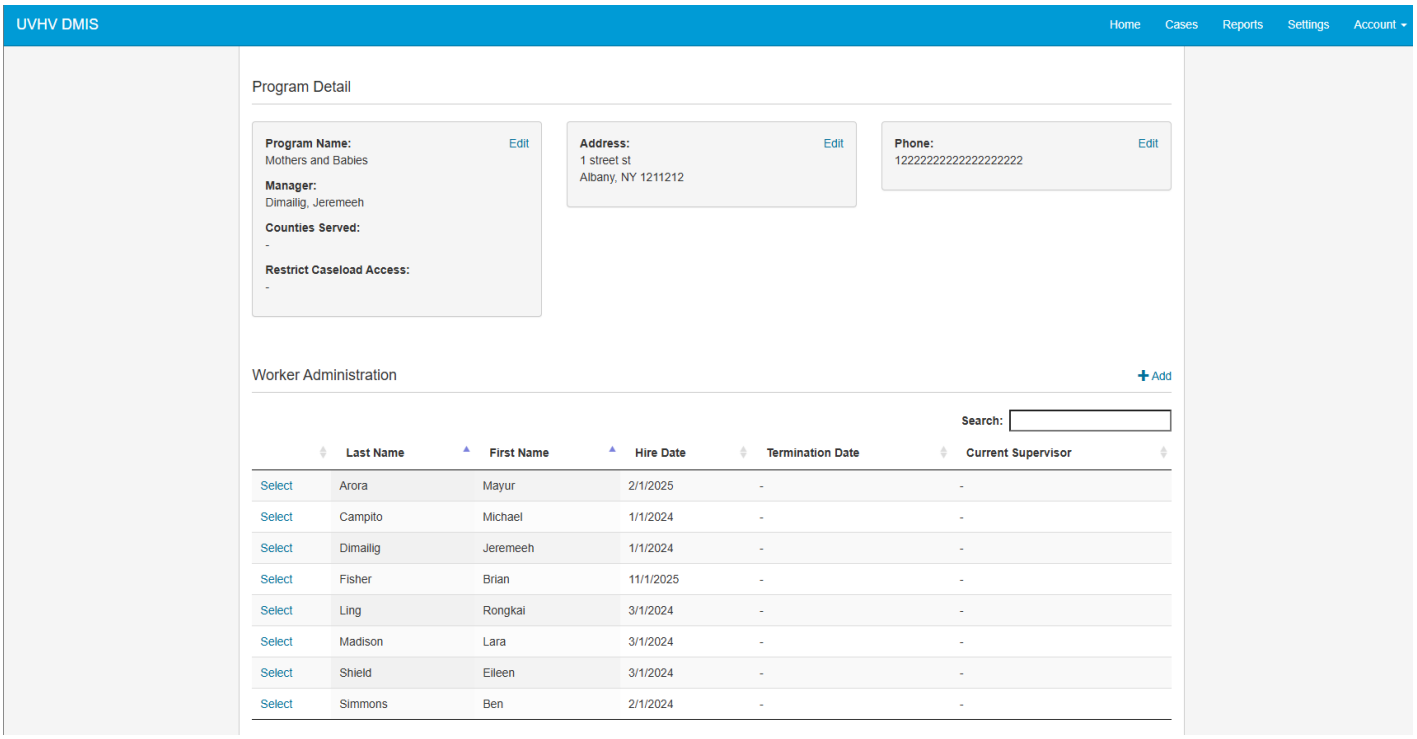
Worker Detail: Update name, hire date, termination date, username, assigned supervisor.

Supervisor History: Add, edit, or delete a supervisor assigned to the worker.

Caseload: Transfer cases to another worker.

Supervisees: Assign supervisees (other workers) to worker.

Link users to worker records by selecting their username in the worker detail section.



User Request Form

Roles required: Contract Admin, Program Manager, Data Entry

Use this form to request new user accounts.

Change Password – Use this form to change your password.
User Manual – A link to this document

Account

User Info – Information about your current log in session is displayed here.

Username

Program

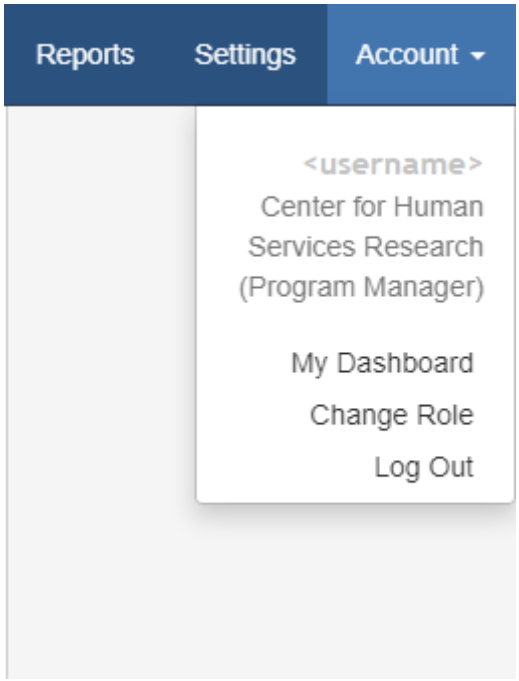
Current Role

My Dashboard - Informational screens that provide summary information tailored to user roles.

For Workers, the dashboard may include a Postpartum Visits section showing upcoming 8-week and 12-week postpartum due dates.

Change Role – Users with multiple roles associated with their account can use this link to change their currently logged in role without having to log out and in again.

Log Out – Click this link to log out of the application.



Creating a New Case

Cases are added to the system via the Cases page accessible from the menu.

Click “+ Add” on the Cases page to create a case by entering an Initial Contact form.

Case Home Page

Case Detail

The name and birth date of the client can be edited by clicking ‘Edit’ on the left side.

To delete a case, click the “X Delete Case” link on the right side. The link is only visible to program manager and data entry users.

On the right side, there will be one of four colored items.

a. Yellow – “Pending” – The case has an Initial Contact form, but no Screening Assessment.

b. Green – “Enrolled” – The case has a completed Screening Assessment

c. Grey – “Expired” – The case was discharged before the Screening Assessment was entered. I.e., there is an Initial Contact and a Discharge form, but no Screening Assessment.

d. Red – “Discharged” – The case was discharged after a Screening Assessment is entered. I.e., the Initial Contact, Screening Assessment and Discharge forms have been entered.

Contact Info

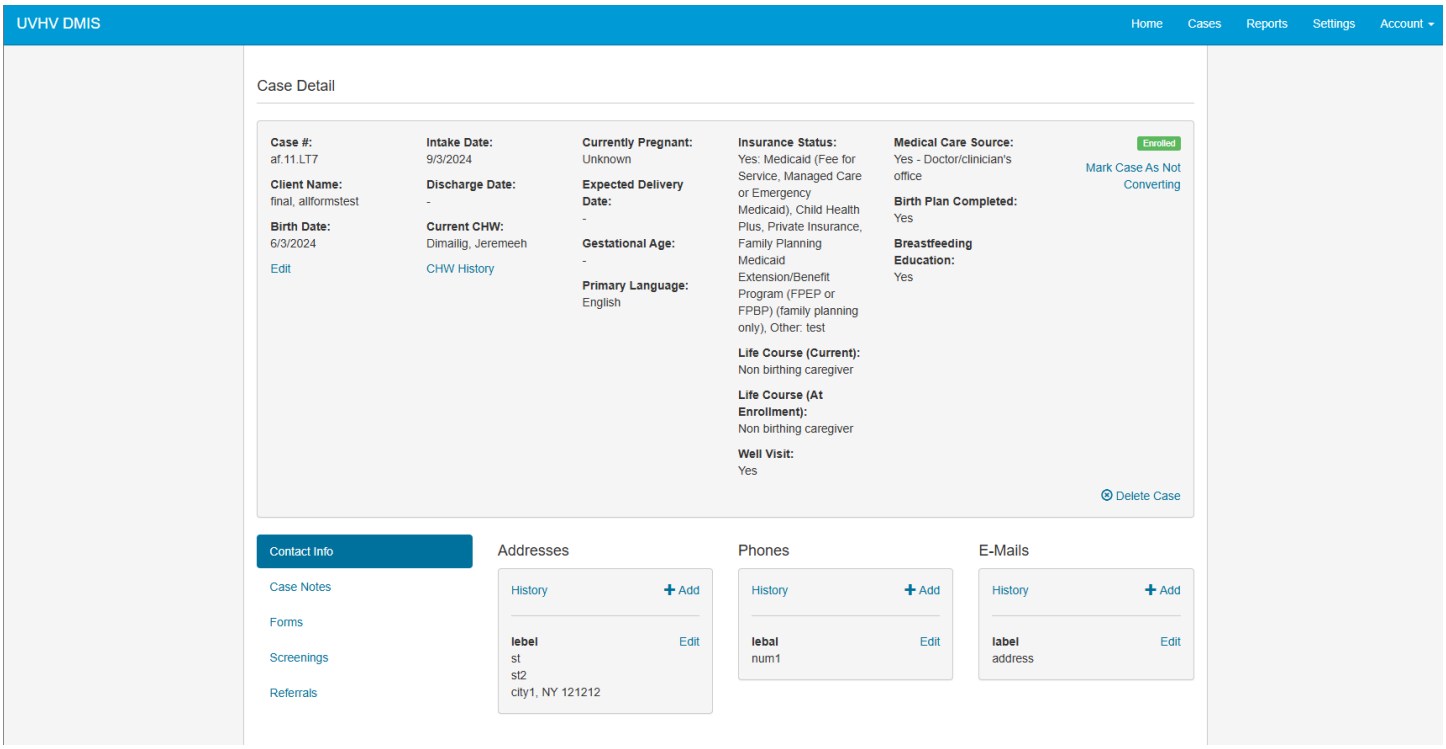
Multiple addresses, phone numbers and email addresses can be stored for each client.

To add, click the “+Add” link in the appropriate section.

Individual entries can be deactivated so that they do not display on the home page. Click “Edit” next to the appropriate entry and click “Deactivate” to remove the entry from the home page.

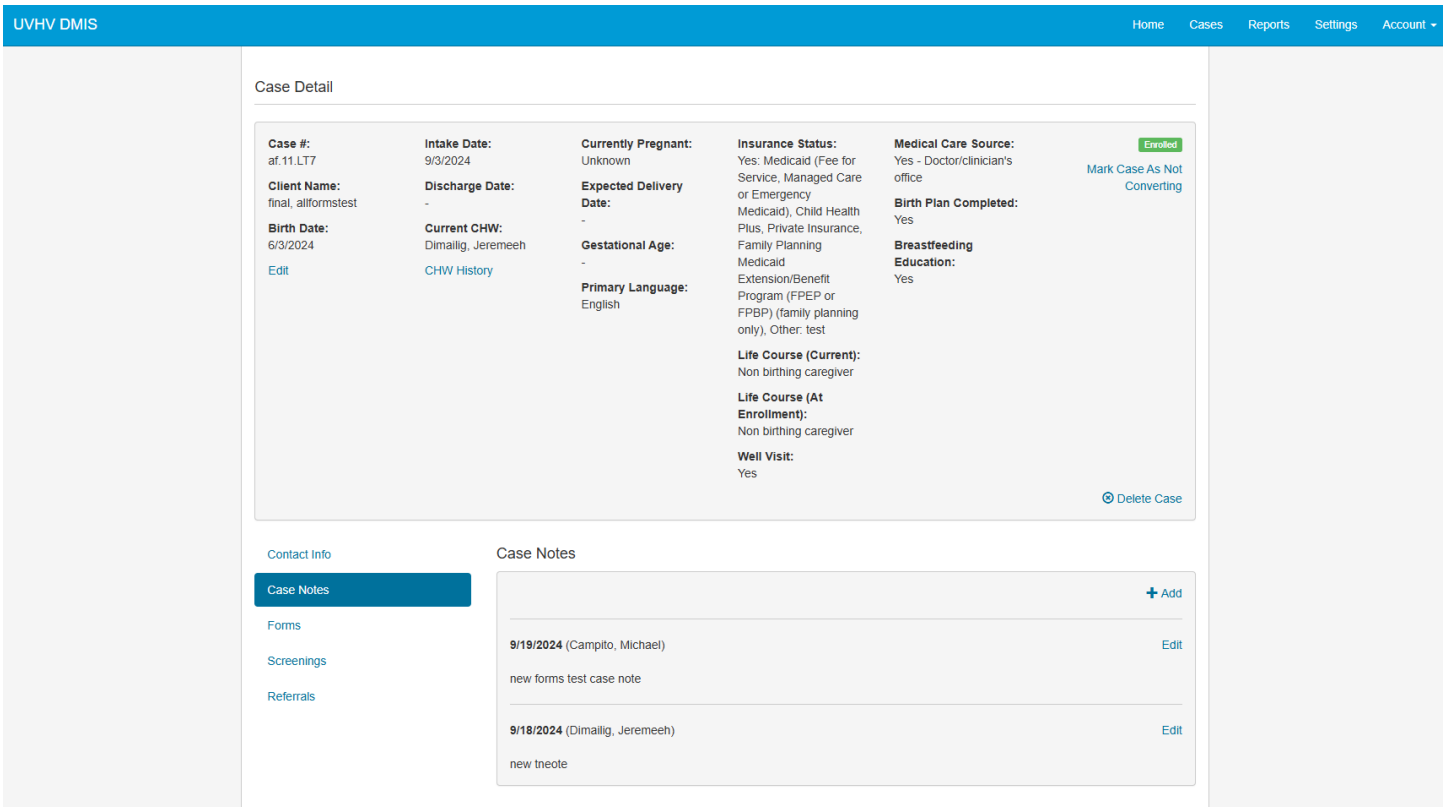
Deactivated entries can be viewed by clicking the “History” link.

To reactivate an entry, open the history and click “Activate” next to the desired entry.



Case Notes - The case notes section can be used to store any information pertaining to the case that should be recorded but does not have a place in one of the existing forms.

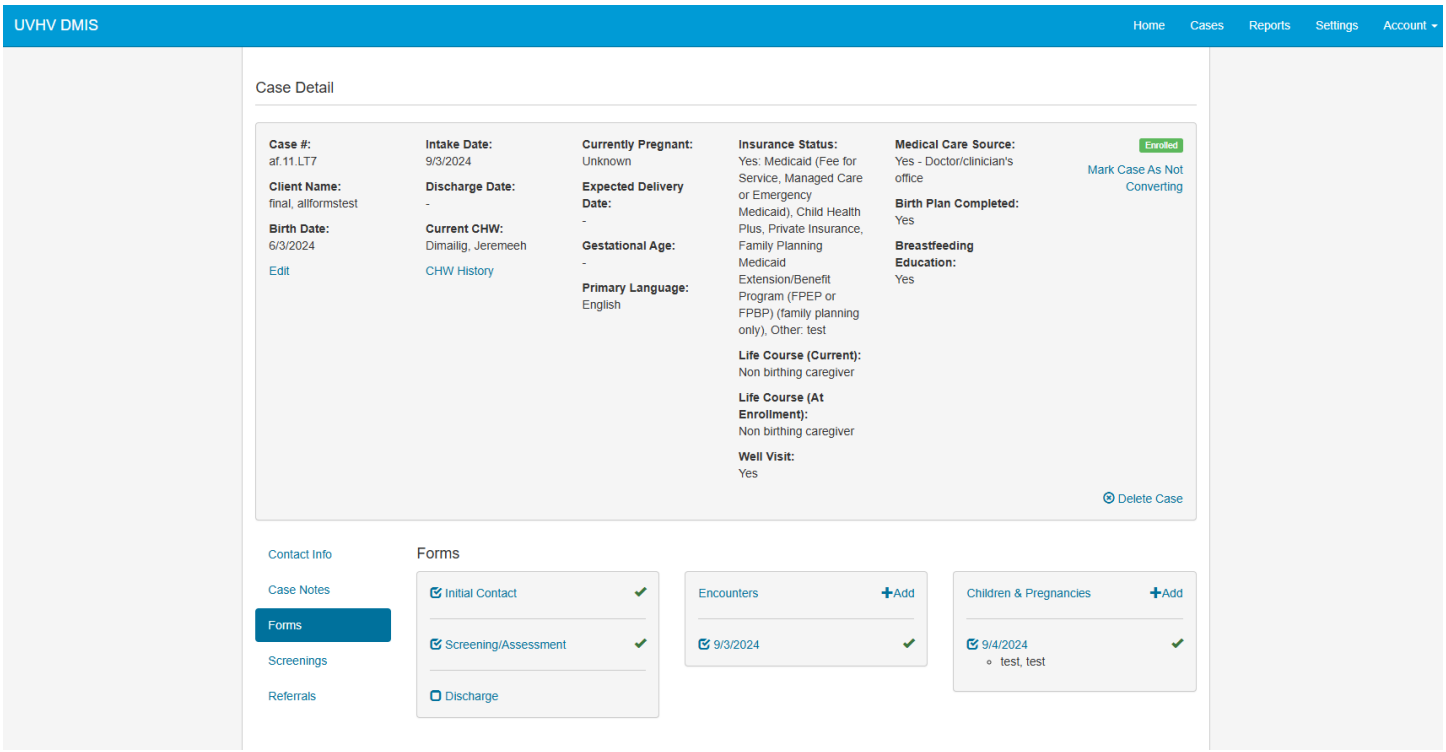
Additional information such as postpartum plan completion status and spoken language may also be displayed on the Case Detail page.



Forms - The forms section contains all the case related forms. This is where all case related data entry can be accomplished.

Some forms include additional questions related to postpartum visits and pregnancy outcomes, which are used in reporting and performance measures.

Health insurance fields have been updated to capture primary insurance only.



a. Initial Contact - This form serves as the starting point for a case. New cases are created by adding initial contact forms.

b. Screening/Assessment

c. Update

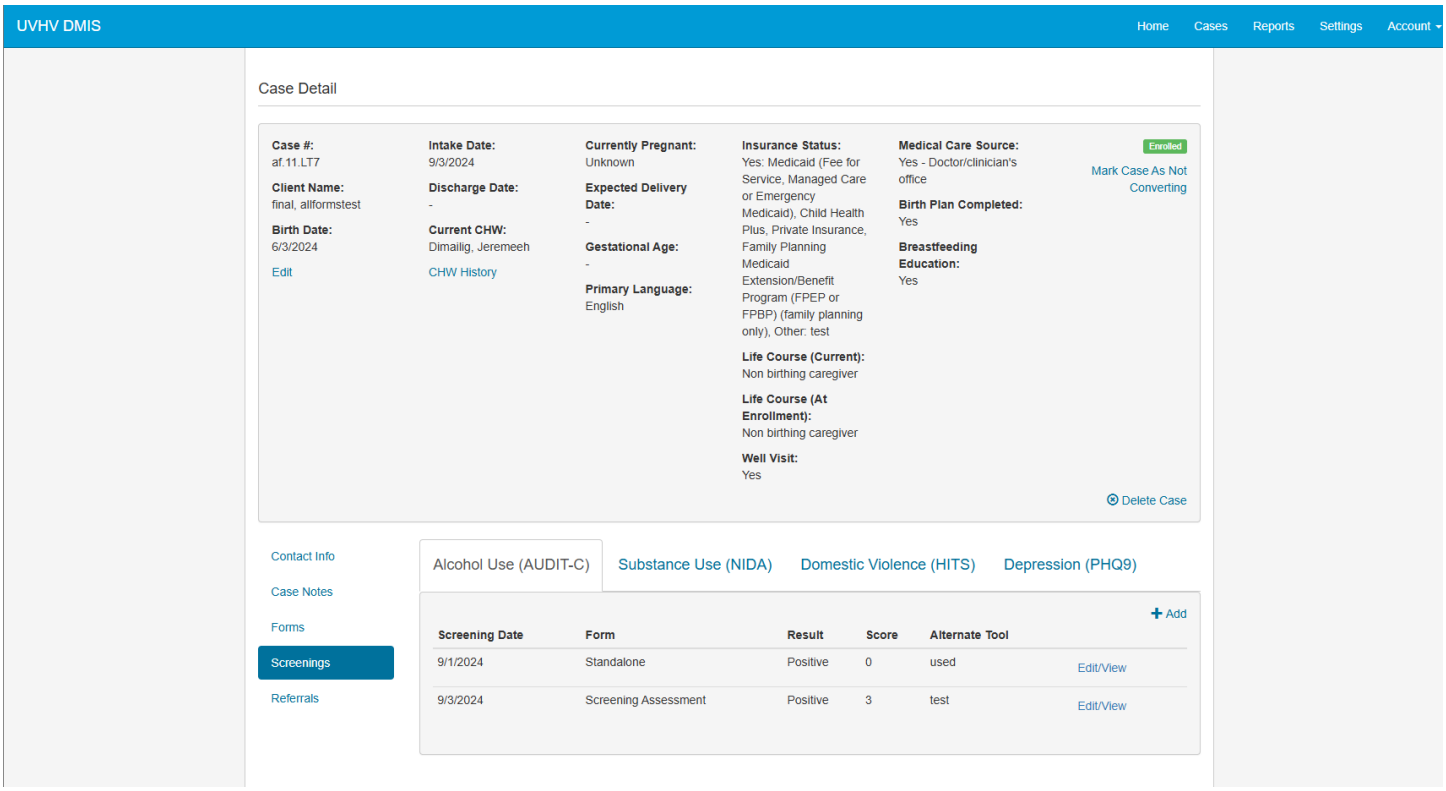
d. Discharge

e. Encounter

f. Child Information & Pregnancy Outcomes

g. ASQ

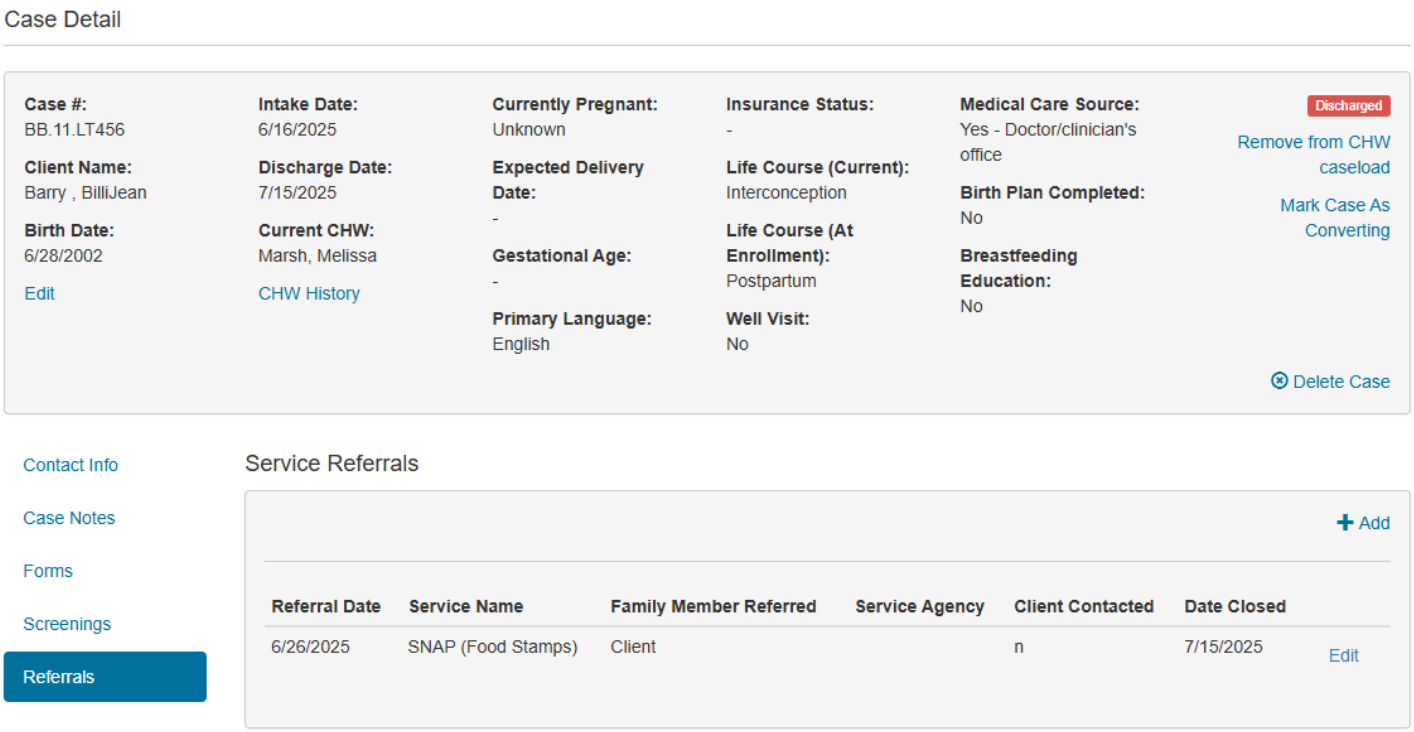
Screenings – The screenings section shows



Referrals – The referrals section shows referrals entered for the case.

Referrals entered in the system are used in reporting and performance measures.

Certain referral types, such as Doula services, are included in reporting categories and may be used for program evaluation.



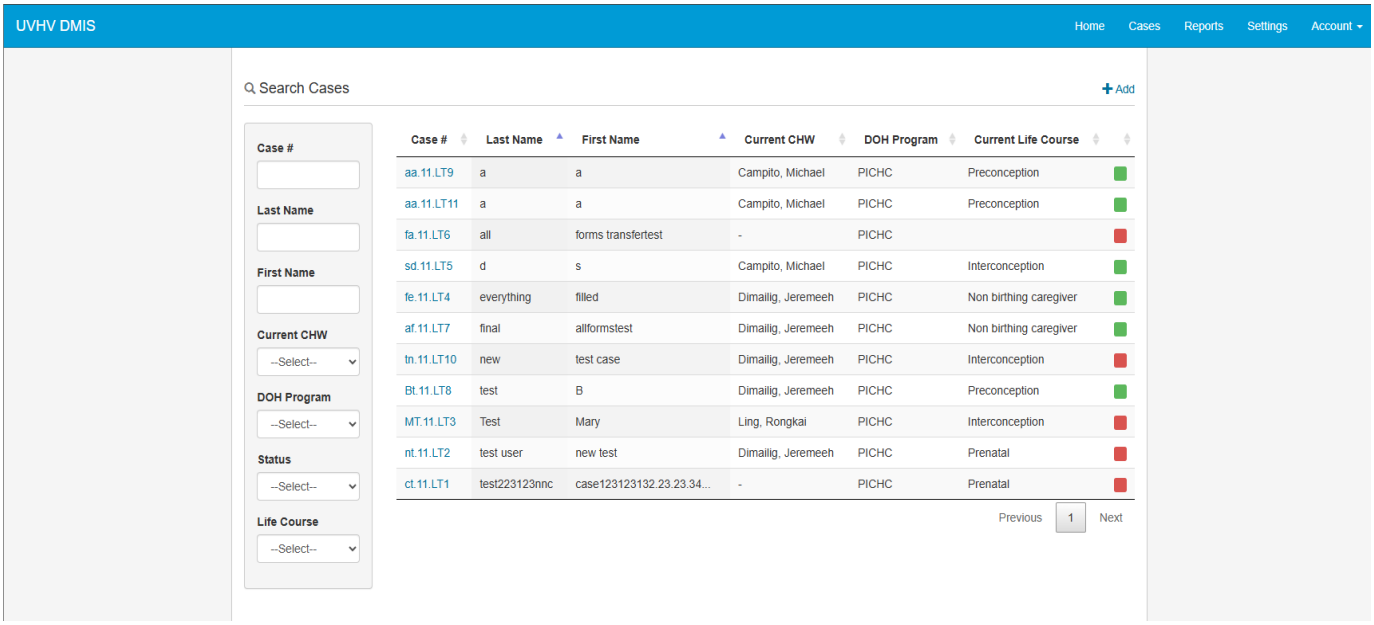
Finding your cases

A list of all cases in your program can be viewed by clicking the “Cases” link in the menu.

The list can be sorted by any column by clicking on the arrows in the appropriate column header.

The list can also be searched by entering text into one or more of the boxes on the left-hand side.

Click on a case number to view the case.



Other Functions

Transfer Cases

Role(s) required: Program Manager

Cases can be transferred between CHWs individually from the Case Details page or in batches on the Worker Detail form.

Case Access

Role(s) required: Program Manager, Data Entry

By default, CHWs can access every case in their program. To restrict case access, program managers should navigate to the Program Detail Form. In the top left panel, click 'edit' to display the 'Restrict caseload access' checkbox. When activated, CHWs will only be able to access cases to which they are assigned.

Supervisor Approval of Forms

Role(s) required: Supervisor

The forms on the case details page: Screening Assessment, Update, Discharge, etc. can be approved by users logged in with a supervisor role.

There is an extra button next to the submit button visible only to Supervisors. If the form is not approved, the button is green and contains the text 'Approve.' If the form is approved, the button is red and contains the text 'Unapproved.'

Once a form is approved, it can't be edited. Therefore, if changes must be made to an approved form, it must be 'unapproved' first.

Approving a form does not save edits.

Supervisor and Worker Side Panels: Informational panels will appear on either side of the screen for Supervisors and Workers. These function much like dashboards, displaying summary information relevant to the user. For these to display, user accounts must be linked to worker records via the Worker Detail Form.

Worker Tasks Sidebar

Role(s) required: Worker

The "My Tasks" sidebar displays items requiring attention based on the user's role, including upcoming 8-week and 12-week postpartum due dates.

Session Timer

When you log in to the system a timer is set to twenty minutes. If you do not interact with the system after twenty minutes, you will be automatically logged out.

Interacting with the system includes clicking links, buttons, and entering data into form fields. Any interaction will reset the session timer.

If you are in the process of filling out a form when the timer expires, any data you've entered will be lost.

Before you are automatically logged out a message will appear with a countdown, prompting you to respond. If you respond before the countdown expires, the timer will be reset to twenty minutes.

3. Frequently asked questions

1. I receive an error message when I try to reset my password.

- A common mistake is to enter your email address when attempting to reset your password. Be sure to enter your username and not your email address.

2. I received a new password, but it does not work.

- If you try to copy and paste the new password, you may inadvertently copy an extra space character at the end of your password. When pasted, the extra space character will cause your password to fail. To avoid this, type your password into the password box.

3. Can we do a data download from our existing agency database (Captain) to avoid duplicate database entry?

- No, this function will not be available.

4. Can all CHWs see all cases and case data?

- By default, CHWs can access every case in their program. To restrict case access, see Function 2.E.2 Case Access.

5. Is there a place to include current file numbers or do all have to use the system's case numbers?

- There is no specific place for current file numbers. The case notes section on the case detail page can be used to store information that does not have a specific place.

6. Is there a way to upload documents (i.e. consents, birth plans)?

- Currently, the system does not support uploading documents.

7. What browsers are supported? Are mobile browsers supported? Will the web page display in a mobile format, or as desktop version?

- Chrome and Edge are fully supported. We do not support Safari or mobile devices but in our rudimentary testing they work well. The web pages will display in mobile and desktop formats.

8. Are the case numbers that are created the same for all the programs using the system? Meaning if a client moved and had to transfer services would this client have the same case number?

- Case numbers are unique across programs. However, the current system cannot transfer cases.

9. Does a program manager who supervises CHWs need both manager and supervisor accounts, or can they see items needing attention in the program manager role?

- In this situation, the user would have two roles, Program Manager and Supervisor, associated with their account. They would need to select the Supervisor role when they log in to see items needing attention.

10. How often does the database refresh?

- The database refreshes in real time. Any data entered will be displayed immediately whether it be in reports, dashboards, etc.

11. Can 2 people be in the same case at the same time entering data or does the system have a safeguard for that?

- Two people can be on the same case at the same time entering data. This could lead to duplication issues.

12. Can supervisors make edits for ALL staff entries?

- Supervisors can make edits for ALL staff entries.

13. Is data entry time stamped?

- Every entry is time stamped. In addition, every time a form is edited or deleted, the entry is logged in a backup table.

14. As a supervisor, can I see the electronic footprint of staff in the system (like how long they were logged in and what they did while they were logged in)?

- The only 'footprint' visible to supervisors would be the entry of case related forms that have yet to be approved. These items appear on the supervisor's dashboard and side panels. The system does track the adding, editing and deleting of forms. This data can be analyzed by site administrators, but it is not readily available to supervisors.

15. It appears that for a client to be enrolled in program the Supervisor must approve the initial contact form. Without that approval the client is listed as Pending and the CHW is not able to add Children and Pregnancies or Update Info. Can this be changed so that the supervisor does not need to approve the form before any of that happens? It will be very burdensome and inefficient for the supervisor to have to approve each one for each client, then the CHW must go back and fill out the remainder of the info for the client.

- Approval of the Initial Contact form is not necessary for further data entry. However, the Screening Assessment is required to enter other forms. Due to the way the system is constructed, the Screening Assessment collects data that future forms use for calculations. Therefore, it must be entered before the other forms.

16. Is there a QA function where we can run a report to see what info is missing so we can make sure we haven't overlooked anything for each client?

- There is not such a report. Standard practices to ensure the quality of the client data entry will have to be used on the initial screening. This will allow the flexibility to complete screening as trust is built between the community health care worker and the client. An update form can be submitted at any time to allow the record of additional or updated screenings to address the client's needs.

17. We wanted to ask about the possibility of doing a bulk data entry. The way it is currently set up is that each individual encounter must be input separately. Depending on the client, this could be quite time intensive to input this data each month, as sometimes we have many, many contacts with the same client. It would be much more efficient to be able to write the number of encounters, the number of each activity, referrals, etc. to that client each month, rather than a specific form for each encounter.

- Not all forms of contact with a client will be considered an encounter. Please only document encounters where there is an exchange of information, and when the following activities are completed, screenings, education, updating medical visits, and/or referrals. Check-ins, reminding clients of upcoming appointments, following up on referrals, via phone or text are not considered an encounter thus should not be documented.

18. What happens when you discharge a client by mistake and it is a client that is active, how can I put it back into enrolled status?

- Deleting the discharge form will change the status of a client back to active. Program Manager and Data Entry users have access to a delete button at the bottom of each form.

19. Why doesn't a CHW appear in the list of workers on forms?

- A Program Manager needs to add this worker on the Program Detail Form.

20. Why is the pregnancy status information on the case detail page incorrect?

- The system tries to determine the status of the client using three pieces of data. If they are entered erroneously, the case detail page may display incorrect information.

    1. The answer to "Currently Pregnant?" on the most recent entry (Screening Assessment, Update, Discharge).
    2. The "Expected Delivery Date" on the most recent entry (Screening Assessment, Update, Discharge).
    3. Pregnancy forms in system.

    If "Currently Pregnant?" is "yes" and there is an expected delivery date, then the system looks for a pregnancy form dated after the expected delivery date. If one is found, it is assumed to be the child that the client was pregnant with when "Currently Pregnant?" was answered "yes." Thus, the case detail page will display "No" for "Currently Pregnant?"

21. Why do I see postpartum due dates on the Dashboard or in My Tasks?

- The system may display upcoming 8-week and 12-week postpartum due dates to help workers track timely follow-up activities. These items are shown based on the user's role.