

HPECD Database User Manual

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Introduction to the User Manual

The manual is divided into three sections.

Section 1 discusses the purpose, use, data sharing, and benefits of the HPECD Database.

Section 2 is an overview of the items that may be visible from the Home page depending on the user's role.

Section 3 has an overview of each Database Page or Form. Keep in mind that there is also an online help menu associated with each page or form.

Section 4 reviews the functional use of the database. When considering functional uses, please review the documentation for the relevant pages or forms in section 2.

Section 5 is the plan in the event of an HPECD database outage; the business continuity plan.

1. HPECD Database Overview

Purpose

The HPECD Database is not considered to be the primary client record. The HPECD database will:

- Help manage the HPECD referral process within the Winnipeg Health Region
- Help manage the referral process for all births, infants and perinatal women and families that have received care in the Winnipeg Health Region and require referral to other RHAs and provinces for Public Health services
- Help manage WRHA Population and Public Health staff work. That is, it will assist in distribution of work.
- Eliminate PHIA non-compliant staff to client tracking systems
- Help us understand the need for distribution of regional staff
- Comply with legislation to generate required reports to funders
- Track service in relation to standards
- Improve program monitoring
- Provide a repository for surveillance
- Track all people who have been provided with care in families
- More easily identify location of health records
- More easily identify open and closed records
- More easily identify client care providers
- Decrease data loss and transcription errors due to hand-offs between staff.
- Assist in avoiding duplicate health records, providing service based on all collected history
- Assist in our accountability to the community and partners.

Data Use

The Database will be used by all WRHA PPH program staff working with HPECD clients including:

- Expectant women and families
- Infants discharged from hospital care that require Public Health services
- Families or women who have experienced a birth
- Families or guardians of newborns or preschool children

The database will also be used by central administrative staff to transfer referrals for the four situations noted above and that have received services in the Winnipeg Health Region to other RHAs and provinces for Public Health services.

PPH program staff using the database include: Administrative staff, Families First Home Visitor, Public Health Nurses, Team Managers and Epidemiology and Surveillance staff.

Data Sharing

Population and Public Health receive all referrals from birthing hospitals and midwives that require follow-up by Public Health staff. We are also the central clearing house for all referrals for infants cared for in Winnipeg hospitals that require public health follow up. We share referrals that are logged in the database with other RHAs, Provinces, and other jurisdictions so that they can arrange appropriate health care services.

Manitoba eHealth will generate a quarterly abstract for Healthy Child Manitoba. This sharing of data is required by the Healthy Child Manitoba Act.

Population and Public Health staff may share information collected in the database with Child and Family Services staff or with parents or guardians as required on an ad hoc basis as required by the Child and Family Service Act.

Benefits

Benefits of the HPECD database include:

- PHIA compliance
- Information available closer to real time
- Reports can be generated by RHA, CA or provider
- Data available for research and evaluation
- Improved human resources and cost management (e.g., staffing to demand or need, overall surge capacity, timing, content and type of training)
- Able to support centralized referral if implemented
- Able to support Baby Friendly requirements
- Database can be modified as necessary over time
- Avoid paper-based reporting

Central and Community Area benefits include:

- Easier distribution and tracking of referrals
- One system is used to track all referrals and case file
- Can dispense with various referral tracking systems, some of which are not PHIA compliant
- Data entry is by the provider – not paper-based resulting in
 - Fewer transcription errors
 - Fewer data losses
- Real time reporting is available to:
 - manage referrals
 - manage work
 - track care to standards
 - improve the quality of our service

Centralized benefits include:

- Able to engage in real time surveillance
- Able to provide accurate and complete reports to funders
- Avoid multiple methods of tracking referrals

2. Home Page

Reports

Referral Summary Report

This report can be found in the 'Reports' section of the home screen. Everyone will be able to use this report.

This report will:

- Replace listing the names of referrals for that day in the daily fax transmissions to each CA
- Assist with managing the central distribution process (e.g., confirming all referrals have been processed, helping to identify referrals being sent to out of region jurisdictions)
- Remove the need for binders or spreadsheets containing personal health information that identify assignments in both Central Intake and CA offices
- Assist with managing assignment of referrals in each CA
- Assist with identifying the location of health records
- Assist with identifying the health care providers associated with each referral
- Assist in identifying which health records should be opened or closed

Although the database will follow client movement from one CA to another, the report is not designed for this purpose.

Personnel

This section will not be visible to most users in the Home Screen. It allows the Database Administrator to work with Personnel information, add new Personnel, assign user groups, and reset passwords. This section is restricted to eHealth only.

Team Managers should provide quarterly updates to provide correct years of service based on partial EFTs or time away from work (e.g., leave of absence).

Every public health staff member currently contributing to or making use of the database is added:

- Select 'Active'
- Select 'Is a provider' for those who are providers who are assigned to client care. The primary ID number is the SAP number.
- Select roles from the drop down list.
- Enter their Last Name and First Name.
- Add the SAP staff identification number
- For FFHVs and Supervisors, add their start date
- Adjustments are made in years or service or fractions thereof. Negative adjustments are made when someone is on leave (e.g., maternity leave, extended sick leave). Positive adjustments are made when someone comes to the position with previous experience. 'Years of Service' and 'Years of Lead Role' are automatically generated after saving the start date and any adjustment. Please create adjustments as necessary, to the level of the second decimal. (1 month=0.083, 2 months=0.17, 3 months=0.25, 4 months=0.33, 5 months=0.42, 6 months=0.5, 7 months=0.58, 8 months=0.67, 9 months=0.75, 10 months=0.83, 11 months=0.92)
- The calculation of 'Years of Service' or 'Years in Lead Role' is completed by pressing save.
- You can see if the calculation of 'Years of Service' or 'Years in Lead Role' is correct by going to 'Personnel Data' for that staff person after saving.

When a person leaves their position, the 'active' designation should be unchecked and the clients associated with that person should typically be reassigned from within the application, not from within the home page. The Database Analyst will not be able to inactivate a staff person until they no longer have clients assigned to them.

Deleting Clients

This Section on the 'Home Page' is not visible to most users and applies only to the Database Analyst. You can contact the Database Analyst through an email to the Help Desk to merge a client if you inadvertently create a duplicate client. You can also ask that an erroneous client be deleted. Deleting a client record is a terminal process. A deleted client record cannot be 'undeleted'.

3. Overview of Each HPECD Database Page or Form

The notes for each page or form are listed in the order they appear on the left hand navigation bar. These notes will provide an overview of how that page is used. It is not intended to completely describe or review every data element in the form. This section is written with the expectation that the HPECD database is open and in front of you and that you have already searched and opened a client's record.

Demographics and History Section

Client Overview

This page is accessible and can be updated and managed by all users.

The *Client Overview* page is the initial page that is displayed when an individual Client record is first opened. The Overview page serves as a snapshot of commonly needed information and can also be used as a quick link to the page where the information is entered. To action or view a summary of this information, double click on the specific information field and it will take you to that page.

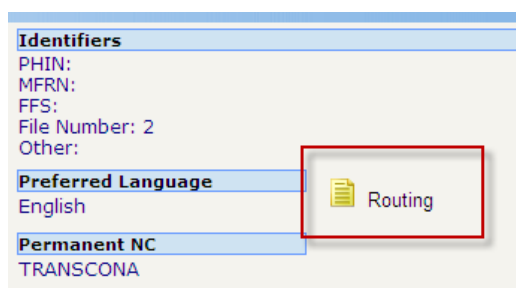
This page allows you to view:

- a. Legal name
- b. Likes to be called
- c. Identifiers
- d. Date of birth
- e. Gender
- f. Self-identified gender
- g. Preferred language
- h. Permanent address
- i. Permanent RHA
- j. Permanent CA
- k. Permanent NC
- l. Temporary address
- m. Temporary RHA
- n. Temporary CA
- o. Temporary NC
- p. Phone numbers
- q. Service providers
- r. Relationships
- s. Routing Notes – which allow entry of where the client record is found and if there is a safety concern that weekend services should be aware of



'Routing' box will show if routing notes are available or not. Clicking on the box will navigation to a routing notes maintenance screen where routing notes for the client can be viewed, added, edited, or errored out.

- Entered By is auto filled and Required



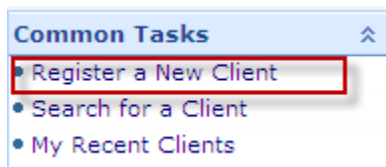
- Entered For is not required
- Effective Date is required
- End Date is optional
- Entered For and Entered By fields will only show if the user has security access to Enter Third Party Notes

For 'Routing Notes', limit comments to

- (1) **The paper health record the personal health information for that client can be found in.**
For example for infants or children who are integrated into a parent's or guardian's file (e.g., Baby Smith is "*Found in Mary Smith's paper health record*"), and
- (2) **Physical location of the health record.** That is permanent or temporary location:
 - Nurses desk or FF Home Visitor
 - Office Central File
 - Pre-Archive
 - Archive
 - In transit to (name of the community area)
- (3) **Tracking referrals outside of the RHA**
 - Referred to (name of the RHA, Province, Territory or Country)
- (4) **Safety planning relevant to weekend services.** If there is a potential that weekend services will provide services they need to know that a safety assessment and any relevant plan were completed. Potentially relevant Safe Visit Plans to address an identified risk must be faxed to Central Intake and are retained in alphabetical order in the weekend services area for one year from the date they were received. Limit comments to:
 - a. SAFT completed - no risk identified
 - b. Safe Visit Plan sent to Central Intake
- (5) **Information from a deleted record was transcribed.** "*Manual Merge completed from duplicate record; including transcription of visits, relationship, referral, perinatal episodes and forms as required.*"

Register a New Client

This page is accessible to all users, but primarily will be managed by Administrative Staff but can also be used by FF Home Visitors, Outreach Workers and PHNs. Registration follows *Manitoba Provincial Client Registry Registration Best Practice Guidelines v 4.4*
<http://clientregistryweb.manitoba-ehealth.ca/crManualsGuides.html>



The 'Register a New Client' page is only used to add a new client to the system and cannot be used for any subsequent editing of client information. This page is one way to create a new client. Another way is through the birth episode in the perinatal episode tab if creating a newborn record.

All clients must have at least one name entry. Where a client only has a single name, the *Manitoba Provincial Client Registry - Registration Best Practice Guidelines v 4.4* advises users to enter the name as both the First Name and the Last Name. Where part of client name is not known, enter "Unknown" for either the First or Last name field, as long as the MFRN, PHIN or Date of Birth are registered.

'Last Name'

- Use first name of parent if 'last name' is unknown e.g *Julie, Julie*
- For newborns use "Mothers" surname as the infants family name e.g *Infant, Smith as mothers name is Jessica Smith.*

'First Name'

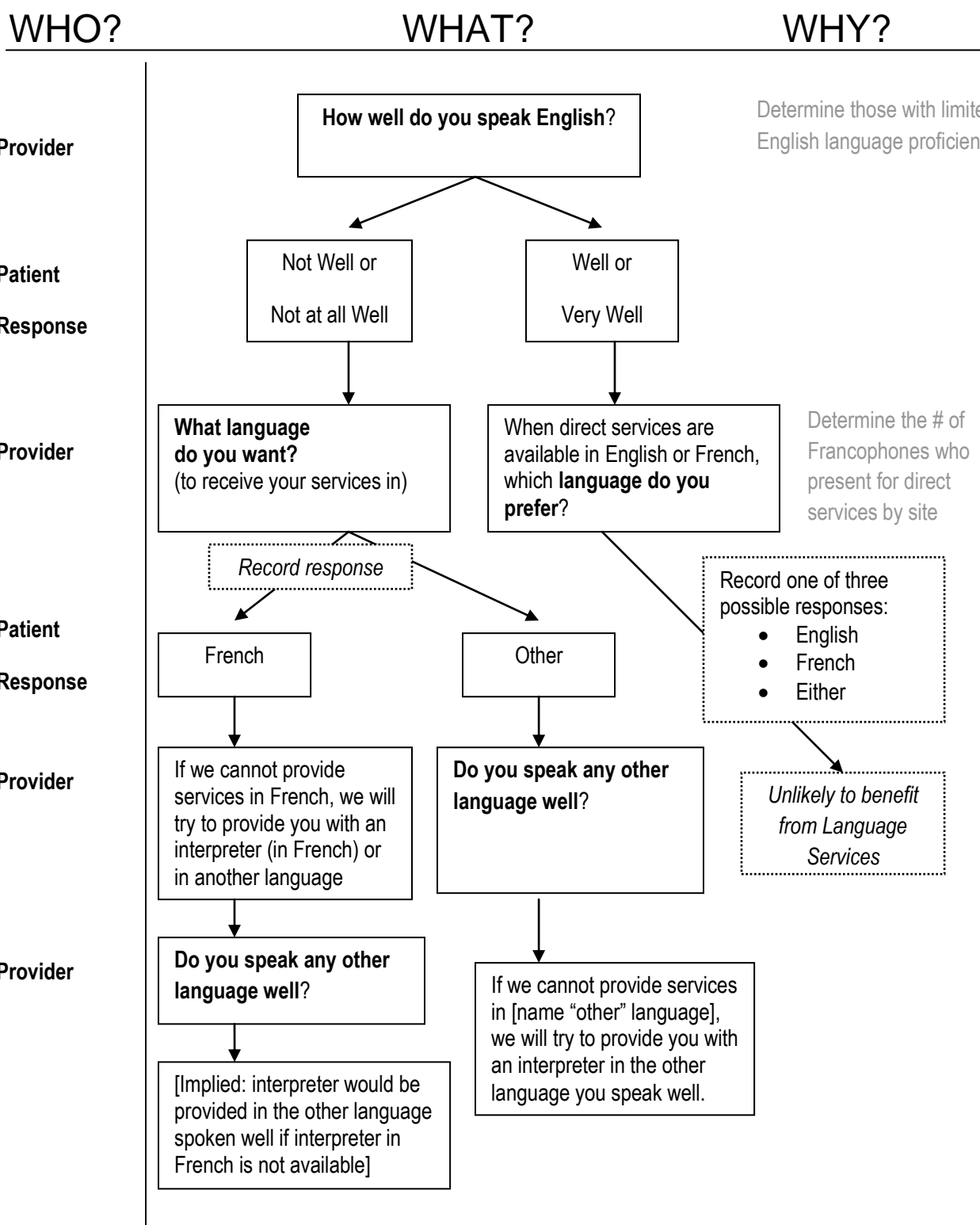
- Use "Infant" for the first name of a newborn who has not been named *e.g Infant, Smith*

The 'Gender' options are:

- Male
- Female
- Undifferentiated (used for infants whose gender is ambiguous or other than male or female at birth)
- Unknown

'Date of Birth' for parent records and relation records only, can be left blank if unknown. Note 'estimated' or 'unknown' when those apply. However, date of birth should be completed accurately whenever possible and should always be completed for the newborn infant.

The language section follows the anticipated WRHA language standard which has not yet been approved.



- 'Preferred Language' is the language the parent prefers their health service communication to be in. If 'Other' is identified, you must specify what other language or languages the person prefers their health communication to be in. If the language is English or French, we make every effort to provide these services with a health care provider who competently speaks the same language. In the event the client has not been asked what their 'Preferred Language' is, select 'English'. Select the appropriate language once the question has been asked.
 - If you are typing in the 'Other' language and the program is generating an error message for the other language that you are trying to enter, it may be that you are using a non-standard term or spelling from that found on the table against which your entry is being checked. The database requires standard terms for the languages as well as accurate spelling. Refer to the attached language table for the appropriate language.
 - To find the language table click 'Help', then 'Table of Contents', then 'Reference Material', then 'Language Codes'.
 - Another way to get there is to Select Help > Show Table of contents > Index tab > Select L > Language codes > Language codes again
- 'Interpreter Required' indicates the need for an interpreter if the preferred language is

The screenshot shows a form with the following elements:

- A dropdown menu labeled 'Preferred Language:' with a blue arrow on the right.
- Three input fields labeled '1', '2', and '3' under the heading 'If other, specify:'.
- A dropdown menu labeled 'Interpreter Required' with a blue arrow on the right.
- A dropdown menu labeled 'Preferred Official Language:' with a blue arrow on the right.

other than English.

- 'Preferred Official Language' refers to those times when there is no interpreter available. The options are English or French. In the event you have not yet asked the client what their 'Official Language' is, select 'Unable to Answer'. Select the appropriate language once the question has been asked.

'Identifiers' list the registration numbers used to identify an individual.

- 'PHIN' refers to the *Manitoba* Personal Health Identification Number. Temporary numbers are not accessible within the database. Only register known PHINs.
- 'MFRN' refers to Manitoba Family Registration Number (previously called MHSC). Only register valid MFRN, no temporary numbers can be issued.
- 'FFS' refers to Families First Screening Number. This number applies only to the child record and should not be registered to the parent's or guardian's record even though the screening form resides in a parent's record. The number should be entered at receipt of a new live born infant or late entry child referral.
- 'File Number' is automatically generated by the system and is a unique identifier for the client in the database.
- 'Federal Service Number' includes the RCMP or Veterans Affairs or Interim Federal Health Program number.
- 'Other' is used to identify other provincial/territorial/federal health insurance numbers as well as treaty numbers and include the name number as well as the number itself.

'Phone' we are typically only registering the preferred phone number, but if the referral has phone numbers, enter them here.

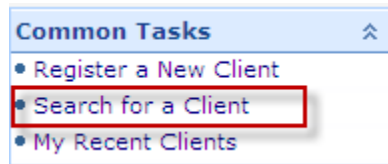
'Address' - When the address is unknown enter 'Unknown' in address field. When the client does not have an address, enter 'No Fixed Address' in the address field.

- 'Postal Address' - The address where a person's correspondence is to be sent when different from the Primary Home Address, also referred to as mailing address. In most urban settings, the client's mailing address is the same as his/her Primary Home Address.

- 'Primary Home' - A client's primary residence is the one he/she usually resides at. This may also be known as the person's permanent or principal residence. If there is additional information that should be included in the address to help someone locate the home, add it in the comments section (e.g., last unmarked door on the hallway).
- 'Temporary' – A type of accommodation address where a person is staying, may be contacted, or receive mail on a temporary basis (e.g., at a relative's place after birth, school/university, shelter). If there is additional information that should be included in the address to help someone locate the home, add it in the comments section.
- 'Vacation Home' – A vacation home may be identified to reach a person while on vacation. If there is additional information that should be included in the address to help someone locate the home, add it in the comments section.

Search for a New Client

This page applies to everyone.



This page allows you to search for individual clients or groups of clients within the application, using one or more search criterion fields including:

- Last Name
- First Name
- Record Status
- Provider
- Office
- Identifier
- Gender
- Date of Birth (must be a complete date)
- Address
- Phone Number

Include Relationships provides the ability to search for associated files created and associated within the database (e.g., spouses file, other relatives). You can select a specific client displayed in the search results page by double clicking on it and access the contents of the electronic health record for that specific client.

You can clear the search to start over.

Using multiple fields in the search function restricts or narrows the number of records that will be displayed. This is not desirable and will result in not finding a pre-existing client and possible duplicate client entries. Keep the search broad, try:

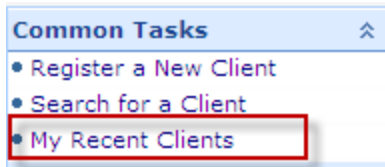
- MFRN only
- Last Name only

As well, **always** check the 'Include Client Relationships' button in your search. This will display all linked clients.

First Name	Record Status	Provider
	All	All
Identifier Name	Identifier Value	Gender
File Number		All
Address	Phone	<input checked="" type="checkbox"/> Include Client Relationships

My Recent Clients

The 'My Recent Clients' page displays the 20 most recent client records that you have accessed. The client's last name, first name, gender, date of birth, record status, address and the organization in which they are members are displayed.



Demographics and History Section

Names

This page applies to everyone. Most frequently Admin will enter most of this information on opening a case, but PHNs, Outreach Workers and Home Visitors may enter this information or additional information as it becomes known to them.

All clients must have at least one name entry. Where a client only has a single name, Manitoba Provincial Client Registry Registration Best Practice guidelines version 4.4 advises users to enter the name as both the First Name and the Last Name. Where all or part of client name is not known, the guideline advises users to enter “Unknown” for either the First or Last name fields.

Where an infant has not been named, use the word “Infant” for the first name. As per Manitoba Health and CIHI Data Standards, the Given Birth Name of baby born in hospital is “Infant”, then the Family Name.

Last Name:	Smith
First Name:	Infant

The Family Name is the Mother’s surname as it appears on the Mother’s Health Care Card (or as registered if no Health Card is available). For multiple births, use a (first) Given Name as follows: Infant A, Infant B, Infant C.

The following name types are options in this Names page: legal, infant, Manitoba Health card, preferred, maiden, alias, nickname, street and unknown.

There is no limit to the number of names that can be entered for a specific Name Type - a client may have multiple aliases for example.

‘Title’ is optional (i.e., Dr., Miss, Mr., Mrs., Ms., Rev.).

‘Display as current’ check box indicates which name is to be displayed on the client name banner. If there is only one name entry for the client, then that name is automatically designated as the current name.

Once saved, a name cannot be deleted.

To register a client’s preferred name, access the ‘Personal Details’ page and add the name under the ‘Likes to be called’ field (see *Personal Details for more information*).

In the event of a name change, the responsibility for correcting the database and the paper health record needs to be clearly negotiated between the PHN and Administrative staff. Not completing a timely name change on a health record will cause unacceptable patient safety risks.

Identifiers

This page applies to everyone. Most frequently Admin will enter most of this information on opening a case, but others may update this information as it becomes known to them.

Predefined identifiers include:

- PHIN
- MFRN
- FF Screen Number - So we can generate reports, this number is only entered on a live born infant or late entry child's health record.
 - Late entries have a screening form if they were born in Manitoba. If the late entry was born outside of Manitoba, a screening form should be completed to the extent possible. For late entry families the documented FF screening number is the original infant screening number or from the paper 'Program Tracking II Form' if there is no original screening number. If the number on the 'Program Tracking II Form' is being used, it should be kept in the paper record but not faxed to HCM.
- File Number (This number is uniquely system-generated for every client registered in the database.)
- Federal Service Number (When using, include the name of the identifier as well as the number.)
- Nunavut Health Number
- Ontario Health Number
- Other can be used for other provincial or territorial numbers or treaty numbers.

Personal Details

This page applies to everyone. Admin will enter all available information when opening a case, but PHNs or Home Visitors may update this information as it becomes known to them.

The Personal Details page does not require that you maintain a history of changes. Information will be overwritten when making changes on this page.

'Likes to be called' refers to any colloquial name or informal name / nickname that the client likes to be addressed by, and is optional.

'Date of Birth' – Will be extracted from 'Client Registration'. If a date is not entered then the "Unknown" checkbox should be selected. To update a client's birth date remove the Unknown flag prior to selecting the calendar icon. To update a client's estimated birthdate remove the Estimated flag and set the birth date.

'Birth time' is only collected for newborns and is normally populated through entry in the 'Perinatal Episodes' page.

'Gender' is based on the Manitoba standard selections: Male, Female, Undifferentiated and Unknown.

'Self-identified Gender' is optional and allows the following selections: Male, Female, Intersex, Gender Variant, Transgender, Transsexual, Two Spirit, Other. Free text is not permitted.

'Marital Status' is optional and includes: Divorced, Common law, Married, Separated, Single/Never married, Widowed and Unknown.

'Preferred Language' includes the following selections: English, French and Other.

'If other – specify' is based on the WRHA Language List. Up to three selections are available.

'Interpreter Required' is a required field if the Preferred Language is French or Other.

'Preferred Official Language' refers to the language the client prefers if they are limited to French and English speaking service. Options in this field are: English, French, Declined to answer, Unable to answer and Unknown.

'Ethnicity' cannot be used at this time. The WRHA has a working group developing the information that will be captured here at some later date.

'Date arrived in Canada' is optional.

Phone Numbers

This page applies to everyone. Admin will generally enter the phone number provided on the referral, but others may enter additional contact numbers as they become known.

If there are multiple phone numbers we only intend to collect the phone number the client prefers to be called at in the event that we want to do a program evaluation (e.g., breastfeeding rates at 6 months). Note: Registering the phone number as preferred using the checkbox, will not change the display in the client overview page.

Addresses

This page applies to everyone. Most frequently Admin will enter most of this information on opening a case, but others may enter this information or additional information as it becomes known to them. Administrative Staff who enter the address associated with a referral into the database confirm that the address is current. If there is concern that information on a referral is incorrect it may be checked in eChart.

The Client Addresses page allows various addresses to be associated with a client record.

This page allows you to see a summary of addresses.

<input type="button" value="Add"/> <input type="button" value="Edit"/> <input type="button" value="Delete"/>			
Address Type	Mailing Address	Address	Historical
Permanent	<input checked="" type="checkbox"/>	87 Paulley Drive, Winnipeg, Manitoba, Canada, R2C 3K3	<input type="checkbox"/>
Temporary	<input type="checkbox"/>	123 anywhere, winni, Manitoba, Canada, R2G 3K3	<input type="checkbox"/>

A template is provided to add or edit an address that includes the following fields:

- Address type is mandatory. Select from the drop down menu. Address types include: Permanent, Temporary, Physical Visit, Under Care, Vacation and Mailing. Permanent, temporary, physical visit, and under care addresses must be entered and current.
 - Homeless people will not typically have a permanent address. They can be registered to the temporary address at which they are staying.
- The 'mailing' address indicator allows an address to be designated as the mailing address for the client without having to re-enter the address. Only one address can be designated the Mailing address at any given time
- Apartment, Suite or Box Number
- Street Address. Contractions such as Ave or St are acceptable.
- City. Includes East and West St. Paul or other municipalities
- State/Province
- Country
- Postal Code
- RHA
- CA
- NC
- 'Historical' Address indicator is used to indicate that the address is no longer current.
- Comments may be used to give special instructions relating to an address
- Last modified by is system generated.
- Last modified date is system generated.

Delete addresses should ONLY be used for Addresses entered in error. To indicate an address that is no longer in use by the client, select the Historical Address indicator.

The 'Mailing' address indicator box is optional and allows an address to be designated as the mailing address for the client without having to re-enter a different 'Mailing' address. Only one address can be designated as the Mailing address at any given time.

Postal Codes are mandatory.

HPECD DATA

Address Type	
Apartment, Suite or Box Number	
Street Address	
City	
State / Province	Manitoba
Country	Canada
Postal Code	
RHA	
Community	
Neighbourhood Cluster	

This enables HPECD to generate a Community Area and Neighbourhood Cluster. Entering the Postal Code will automatically generate the Community Area and Neighbourhood Cluster.

⚠ Important: If a postal code is not in the postal code conversion file no Community Area or Neighbourhood Cluster will be generated. If the postal code is incorrectly attributed to a Community Area or Neighbourhood Cluster in the postal code conversion file, the wrong Community Area or Neighbourhood Cluster will be generated. Community Area and Neighbourhood Cluster are required to do our work and to create reports.

The Process for Incorrect or Absent Postal Codes

For the purposes of routing the referral to the correct community area and of allowing temporary data entry, it may be necessary to enter a 'staged' postal code. To determine the appropriate neighbourhood reference the attached staged Postal Code listing. Include a note that identifies that a correction will be required to the address. When the Postal Code error is corrected the note can be removed.

When a postal code is suspected to be incorrect, check either

<http://www.canada411.ca/area-code-lookup/>

or

<http://www.canadapost.ca/cpotools/apps/fpc/business/findByCity?execution=e1s1>

If a postal code is attributed to the wrong community area or if it is not yet in the database, email the Service Desk to ask them to correct it or add it to the database. eHealth Service Desk will make these changes in the database once they have confirmed it is needed. Once the change has been made by eHealth and the incident resolution email is sent, correct the postal code in the client record.

Staged Postal Codes for Each Community Area

The list below represents those 12 postal codes and their community area assignments. They do not identify a neighbourhood cluster.

PCODE	Rha code	rhaname	CA	CA_Name	NC	NC_Name	verdate
R0R0R1	10	Winnipeg	01	ST. JAMES - ASSINIBOIA	01	ST. JAMES - ASSINIBOIA	2011-06-01
R0R0R2	10	Winnipeg	02	ASSINIBOINE SOUTH	02	ASSINIBOINE	2011-06-01
R0R0R3	10	Winnipeg	03	FORT GARRY	03	FORT GARRY	2011-06-01
R0R0R4	10	Winnipeg	04	ST. VITAL	04	ST. VITAL	2011-06-01
R0R0R5	10	Winnipeg	05	ST. BONIFACE	05	ST. BONIFACE	2011-06-01
R0R0R6	10	Winnipeg	06	TRANSCONA	06	TRANSCONA	2011-06-01
R0R0R7	10	Winnipeg	07	RIVER EAST	07	RIVER EAST	2011-06-01
R0R0R8	10	Winnipeg	08	SEVEN OAKS	08	SEVEN OAKS	2011-06-01
R0R0R9	10	Winnipeg	09	INKSTER	09	INKSTER WEST	2011-06-01

PCODE	Rha code	rhaname	CA	CA_Name	NC	NC_Name	verdate
R0R1R0	10	Winnipeg	10	POINT DOUGLAS	10	POINT DOUGLAS	2011-06-01
R0R1R1	10	Winnipeg	11	DOWNTOWN	11	DOWNTOWN	2011-06-01
R0R1R2	10	Winnipeg	12	RIVER HEIGHTS	12	RIVER HEIGHTS	2011-06-01

Service Providers

This page applies to everyone.

Service Providers are staff assigned responsibility for managing the service to a client. In community areas service providers of clients will typically be a PHN and may also include a Home Visitor or Outreach Worker.

Primary Providers

Primary providers are those who are the main point of contact or main service provider for a client. Primary providers will be marked historical at the time of client close out. To determine who the primary service provider was users will need to consult the paper chart.

Typically only one PHN, and sometimes a Home Visitor or an Outreach Worker should be visible on the overview tab at a time. There may be exceptions to this rule such as when a PHN temporarily takes over the caseload of another nurse on vacation. In this situation two PHNs will show as providing service, the primary nurse and the temporary nurse. It will be difficult to distinguish between the two without looking at the paper health record.

Temporary Providers

Temporary providers are those who are not the primary providers and who have limited contact with a client. Temporary providers may include weekend service nurses or a nurse covering a desk or assignment temporarily. The status of temporary providers no longer providing service should be updated to Historical and they should not be visible on the client overview tab.

Temporary providers may change their status to historical once their interaction with a client is complete.

Every person who provided service should be listed within the Service Providers tab. Anyone who is not the primary or current temporary service provider should have a checkmark within the historical column. This provides program the ability to determine the level of continuity in client care which is important for developing a relationship. 'Service Providers' tab is a quick overview of all those who have provided care to this client.

It will be useful to have a record of all historical service providers. However, if you enter a service provider in error, you can delete the entry from a given client's file. If you select to delete a Service Provider, you will be prompted with a message validating the deletion, giving you the option to approve or cancel the transaction.

An individual Service Provider entry will consist of the following- fields:

- 'Provider Full Name' (populated by the system when the user selects a specific provider)
- 'Role' (populated by the system when the user selects a specific Provider), Relationship (identifies the type of professional).

- 'Historical Provider' indicator may be used to indicate that the service provider no longer serves that client.

You can only edit a Service Provider relationship to a specific client by accessing Service Providers from within the Demographics and History section of the database. Any required Provider demographic information changes such as phone numbers or job position are managed through eHealth.

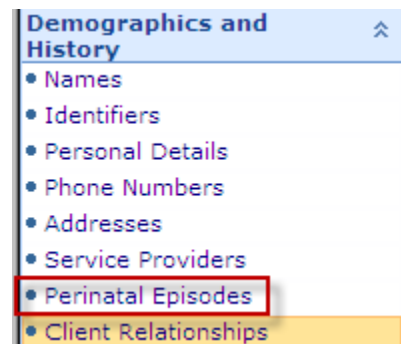
Perinatal Episode

The 'Perinatal Episode' page has two major subsections, 'Prenatal Episode' and 'Birth Episode'.

This page is used primarily by Admin and PHNs. CA Admin will enter the data from any prenatal referral and from the Postpartum or Infant Referral document into a 'Birth Episode'. The PHN ensures correct data entry.

Prenatal Episode

The purpose of the 'Perinatal Episode' is to identify referrals of pregnant woman before birth, or pregnant women we have become aware of through other means. We would only use the 'Prenatal Episode' section of the perinatal episode for prenatal clients.



If information about this 'Perinatal Episode' has already been registered to the client's record, you can identify which pregnancy this new notification is about by looking at the 'Estimated delivery date' column in the summary of 'Perinatal Episodes'.

There must be at least one of either a permanent or temporary address at time of referral.

- 'Permanent Address' refers to the permanent address, if any, of the client at time of referral.
- 'Temporary Address' refers to the temporary address, if any, of the client at time of referral.

'When aware of the pregnancy' refers to the woman's awareness of the pregnancy.

'Gravida' and 'Para' are based on the woman's status during pregnancy.

'Estimated delivery date' is the date the woman reports to you.

'First Visit Date' is the date the PHN visited or made a direct contact.

Permanent Address is the date noted during prenatal service.

Temporary Address is the date noted during prenatal service.

A permanent or temporary address fields is required even if no prenatal service is provided.

Birth Episode

The purpose of the 'Birth Episode' is to identify birth referrals or births we have become aware of through other means.

A 'Birth Episode' can only be entered if a prenatal episode has been saved, even if there is no prenatal service. Please note that a permanent or temporary address fields is required even if no prenatal service is provided.

Most of the data for the 'Birth Episode' can be transcribed directly from the Postpartum or Infant Referral.

Return Save & Return Save Cancel

Prenatal Episode

Permanent Address:

Temporary Address:

When aware of pregnancy?

Gravida:

Para:

Estimated delivery date

First visit date

Birth Episodes

+ Add Error Out Show History

Date of Birth	Gender
---------------	--------

Client Search	Client Overview	Case Activity	Referrals	Visits	Perinatal Episodes
Return	If there is a date- it means we have been involved prenatally		If there is a date- it means we have been involved postpartum		
+ Add	X Error Out	Show History	Estimated delivery date	Date of Birth of First Born For Episode	
	30-04-2014			22-04-2014 12:00	

If the pregnancy has been registered in the database, an 'Estimated Date of Delivery' will be noted. To add a new 'Birth Episode' related to a 'Prenatal Episode', open the relevant 'Perinatal Episode' and push the 'Add' button in the Births section.

We may become aware of an infant or of one or more births related to a particular pregnancy without previous information about the pregnancy. In this case, open a 'Perinatal Episode' and press the 'Save' button *without adding any information about the pregnancy* to add a 'Birth Episode'.

In the event of multiple births more than one 'Birth Episode' may be entered for any one pregnancy. Note that for multiple births, the oldest birth is the only one displayed on the 'Perinatal Episodes' page in the column titled 'Date of Birth for First Born for Episode'.

'Permanent Address' refers to the permanent address, if any, of the client at time of referral. There must be at least one of either a permanent or temporary address at time of referral.

'Temporary Address' refers to the temporary address, if any, of the client at time of referral. There must be at least one of either a permanent or temporary address at time of referral.

For 'LATCHR' values reported to us as between 1-2 enter the lower number.

'Date Discharged (if different)' is the date the infant was discharged if the infant's date of discharge was different from the mother.

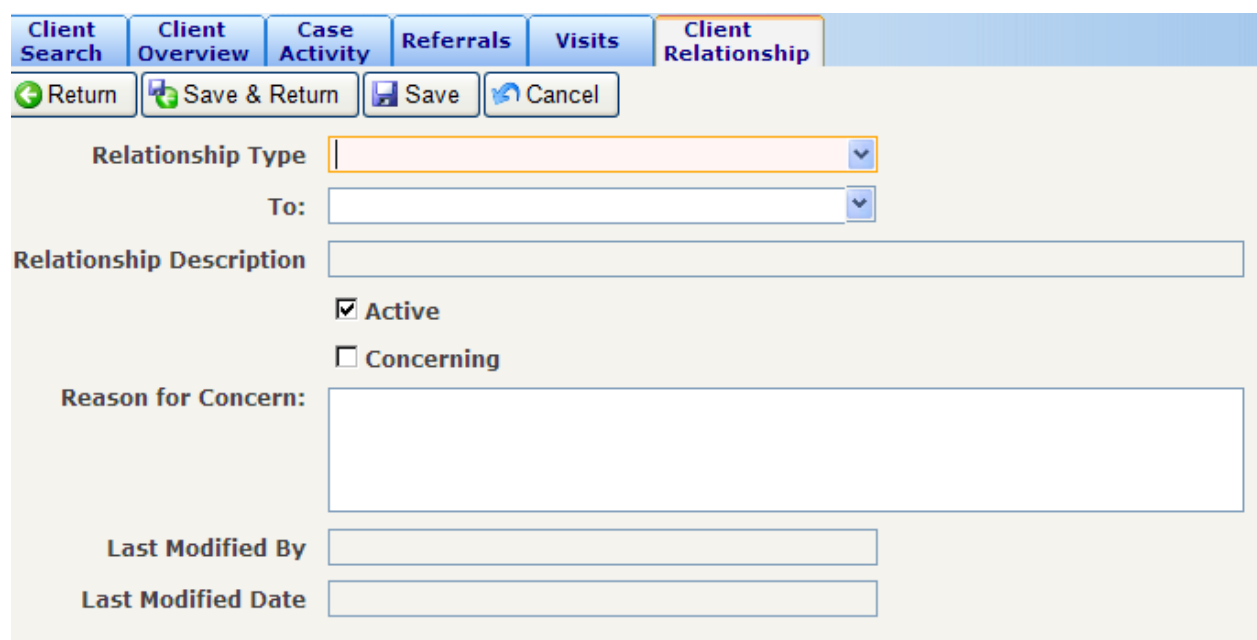
At this time PHNs are not expected to note breastfeeding at two weeks and at six months.

After saving the information about the infant, you will be presented with a button to allow you to 'Create Child Client Record' and include the address. If selected, the address of the person in context will then be added to child's record. Client records generated by pressing "Create Child Client Record" after entering data into the Birth Episode sub-area of the Perinatal Episodes page, will also create a relationship between that infant and its biological mother.

Client Relationships

This page applies to everyone. Admin will enter the relationships identified on the referral, but others may enter additional information as it becomes known to them. This page allows us to track family relationships and composition over time.

Relationships can only be added between 'Open' clients.



The screenshot shows a web application interface for managing client relationships. At the top, there is a navigation bar with tabs for 'Client Search', 'Client Overview', 'Case Activity', 'Referrals', 'Visits', and 'Client Relationship'. The 'Client Relationship' tab is currently selected. Below the navigation bar are four buttons: 'Return', 'Save & Return', 'Save', and 'Cancel'. The main form area contains the following fields and controls:

- Relationship Type:** A dropdown menu.
- To:** A dropdown menu.
- Relationship Description:** A large text input field.
- Active:** A checked checkbox.
- Concerning:** An unchecked checkbox.
- Reason for Concern:** A large text input field.
- Last Modified By:** A text input field.
- Last Modified Date:** A text input field.

Note: If a child records has been created via the Birth Episode sub-area of the Perinatal Episodes page a relationship between that infant and its biological mother will have be automatically generated.

'Relationship Type' selections are limited to: Biological-Parent, Biological-Sibling (includes twins, triplets, etc.), Biological-Child , Adoptive-Parent, Adoptive-Sibling, Adopted-Child, Foster-Parent, Foster-Sibling, Foster-Child, Step-Parent, Step-Sibling, Step-Child , Parent-In-Law , Sibling-In-Law, Child-In-Law, Grandparent, Grandchild, Niece/Nephew, Aunt/Uncle, Cousin, Wife/Husband., Separated Wife/Husband, Divorced Wife/Husband, Widowed Wife/Husband, Spouse, Fiancé, Partner, Friend, Legal Guardian

'Spouse' includes 'common law spouse'.

'Relationship To' is the name the client is related to. This is a required field.

'Relationship Description' is a system generated textual description of the relationship which is populated after saving the record.

The 'Active' indicator is optional and allows a relationship to be designated as either active or inactive. An inactive relationship is a once valid relationship that is no longer active (e.g., a previous partner who is no longer in a relationship).

The 'Concerning' indicator is optional and allows a relationship to be designated as concerning. The 'Reason for Concern' text field is about that particular relationship. It is optional and may be used. However it should never replace the SAFT, Safety Plan or the Safety Alert form on the paper record. An examples of where this may be used is where the biological parent has no legal right to contact their children.

Creating a relationship between one client to another also results in the inverse relationship being created. As a result, if a relationship is changed to be inactive, the inverse relationship is also automatically inactive.

A client relationship entry cannot be deleted from the Client Record once it has been saved. A saved Client Relationship Entry can only be errored out if added to the chart in error. An errored out client relationship entry will be displayed greyed out and with a strike through on the Client Relationship summary page, but will no longer be visible in the Client Overview Page.

Case Activity Section

Change Case Activity Summary

This page applies to everyone. It is a view of all case activity related to that client. In order for the record status to be registered as Active at least 1 case must be registered to their chart.

To display all activities (including the ones entered in error) in the list, click 'Show errored out events'. If you want to hide the errored out case activities, click 'Hide errored out events'. To delete the last case activity event you entered, click 'Error out last event'.



Open Case

See below

Change Status

See below

Close Case

See below

Admin will open a case based on the information received in the referral although PHNs may open a case at any time. An Open Case identifies that a paper file is open somewhere in the WRHA. Opening a case should result in a paper chart to either be retrieved or to be generated. All clients who are served will be opened. Service may be limited to an assessment.

PHNs, Outreach Workers, FFHV or Admin may open a case. PHNs close all cases. See section on closing cases.

⚠ Important: All entries in forms and all pages in both the paper chart and the database must be reviewed for accuracy and completion before closing a case.

Closing a case happens when there is no clinical reason for additional service. Opening and closing Families First Home Visiting services is noted in the Survey and Summary Form.

'Open Date' is the first field that shows when the client was opened.

'Close Reason' cannot be edited once the entry is saved.

- "Declined Service" means that the client refused to participate in any intervention.
- 'Withdrew' means the client declined any service after some had already been provided.

Recommended Workflow/Process for Closing Case Activity

There should be various ways to close case activity. This does not work consistently in the current environment. However all cases should be able to be closed if you use the steps noted below. Please try these steps with current "Active" Cases that need to be closed.

1. Load the Patient to be closed
2. Click on the Case Activity Tab
3. Select the Close Case from the left side panel
4. Update the Close Reason and the Record Status as required
5. Select Save and Return
6. The case should be closed and client marked as Inactive

'Record Status' is limited to *preliminary*, *active* and *inactive*. In some cases this information is noted in the client label under the name.

- *Preliminary* means that the client was registered but there was no case activity.
- *Active* means open.
- *Inactive* means closed.
- *Inactive deceased* means the case is closed because the person is dead.

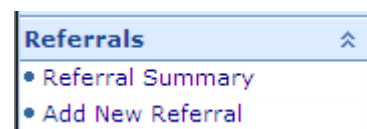
Comments are generally not used.



Referrals Section

Referral Summary

All users may also use this overview of all referrals associated with this client. New referrals are added using this page.



Add New Referral

All referrals are added to the Parent 1 record unless and in the extremely rare situation where there is no parent 1 (i.e., infant cared for in a hotel or shelter).

Admin are the main users of this page, although others may also use it. Any new referral is added using this page. With the exception of duplicate referrals sent in error, all referrals received are entered. This is the last page where Central Intake staff should enter data as the 'Date and Time Referred to the Community Area' section is automatically date and time stamped.

Remember that adding a referral does not automatically *open* a client. Opening a client is a separate function completed within the Case Activity section.

'Referral Status' – If this client was open for service before this referral, note it as a 'Current Episode'. If the client is not open, then note it as a 'New Episode'.

'Date and Time of Discharge' - Is the date and time of discharge noted in the hospital or Birth Centre referral. 'Date and time' only applies when there has been a postpartum referral. Date of discharge applies to Infant referrals, there is not time of discharge for Infant referrals.

'Date and Time Referral Received at Central Intake' – Most, but not all, referrals are routed through Central Intake. Entering the time and date the data was faxed or mail was received at Central Intake allows us to measure the speed and frequency of referral processing.

'Date and Time Referred to Community Area' – This field is generated by the system when opening this page. It gives a close approximation of the time and date when Central Intake sent the referral to the CA. It also includes the date and time of referrals that are not routed through Central Intake (e.g., Late Entry). The date and time stamp may be overridden. The data entry in 'Add a New Referral' should occur within 30 minutes of faxing the referral to the community area. This field must have a value in it, but is ignored for referrals that are generated in the CA.

The screenshot shows a form with the following fields and annotations:

- Date of discharge from hospital or BC:** Annotated with a red arrow pointing to the 'Date and Time of Discharge' field.
- Date and Time of Discharge:** A date and time selection field.
- Date and Time Referral Received At Central Intake:** A date and time selection field.
- Date and Time Referred to Community Area:** Contains the value '09-10-2014 11:11'. Annotated with a red arrow pointing to it from the text 'Automatically date and time stamped to determine timeliness of referral processing from CI and CA'.
- Referral Received by:** A text input field.
- Date and Time Referred to PHN:** A date and time selection field. Annotated with a red arrow pointing to it from the text 'Used for PHN referral Time'.
- Permanent Address:** A text input field.
- Temporary Address:** A text input field.
- Referral Status:** A text input field.

Additional annotations on the left side of the form:

- An arrow points from the text 'Date and time referral was recieved at Central Intake' to the 'Date and Time Referral Received At Central Intake' field.

'Referral Received by' refers to:

- (1) the location in an RHA outside of WRHA that a referral was sent to from Central Intake, or
- (2) in the WRHA it refers to the CA or Centralized Team that the referral was sent to from Central Intake; or
- (3) for a Community Area Generated referral, the office that initiated and is now managing the referral.

'Date and Time Referred to a PHN' is used to identify the time the PHN was assigned. It is completed by the person making the assignment to a PHN at the time of assignment. The purpose of this field is to identify opportunities for improvement.

In the Prenatal Connections team this will typically occur when the client arrives in Winnipeg. This field will serve as a proxy indicator of the date the client arrived in Winnipeg.

'Permanent Address' refers to the permanent address at the time of the referral.

'Temporary Address' refers to the temporary address at the time of the referral.

'Referral Type' identifies the type of referral that is being processed.

⚠ Important: For referrals being processed by Prenatal Connections and Healthy Sexuality and Harm Reduction, it identifies the referral type and the team to which it is being sent. Select the appropriate type of referral. Any 'Referral Type' starting with PC is being sent to Prenatal Connections to manage, and any 'Referral Type' starting with HSHR is being sent to the Healthy Sexuality and Harm Reduction Team to manage.

'Referral Source' should be completed.

'Referring Discipline' should be completed.

For clients of *Adolescent Parent Centre* enter:

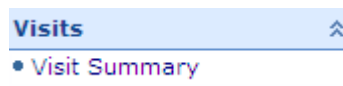
- 'Referral Type' as 'Other'
- 'Referral Source' as 'Wpg – Adolescent Parent Centre' and
- 'Referring Discipline' as 'Other'

'Client Advised of Non-Smoking Policy', 'Client Advised of Pet Policy' and 'Referral Note' are not used at this time.

Visits

Visit Summary

This page applies to PHNs, Home Visitors and Outreach Workers. This page displays the list of events associated with the providers who actually provided service to a family.



Add Visit

All entries are made in the health record of Parent 1, because this is normally where the Screening Forms and, where relevant, the Parent Survey and Summary are located.

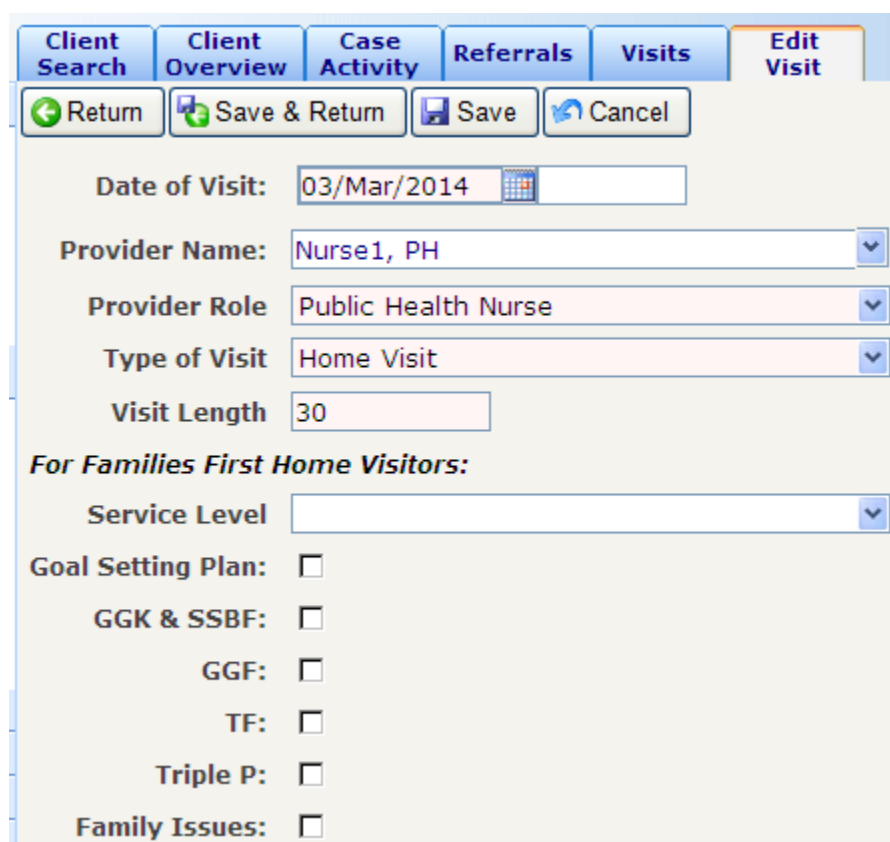
PHNs

PHNs identify:

- date and time day of the first contact
- date (but not time) of any subsequent contact
- their name
- their role
- the type of visit
- visit length in minutes

PHNs should enter individual consultation visits at Healthy Baby and other community group sites. PHNs do not need to log individual consultations for Breastfeeding Clinics here. These individual consultations are logged in the 'Breastfeeding Clinic Appointment Visit Summary' form.

PHNs enter visits into the record of Parent 1.

A screenshot of the 'Add Visit' form in a software interface. The form has a navigation bar at the top with tabs: 'Client Search', 'Client Overview', 'Case Activity', 'Referrals', 'Visits', and 'Edit Visit'. Below the navigation bar are buttons: 'Return', 'Save & Return', 'Save', and 'Cancel'. The form fields include: 'Date of Visit' (03/Mar/2014), 'Provider Name' (Nurse1, PH), 'Provider Role' (Public Health Nurse), 'Type of Visit' (Home Visit), and 'Visit Length' (30). Below these fields is a section titled 'For Families First Home Visitors:' with a 'Service Level' dropdown menu. At the bottom, there are checkboxes for 'Goal Setting Plan', 'GGK & SSBF', 'GGF', 'TF', 'Triple P', and 'Family Issues'.

FFHVs

FFHVs identify:

- date of every visit.
- their name
- their role
- the type of visit (see section on how to use this area for details for noting how to register Creative Engagement)
- visit length in minutes
- the client service level
- all pertinent tools, interventions and issues

FFHV enter visits into the Parent 1 record.

Forms

Breastfeeding Clinic Appointment Visit Summary

This tab is used to enter data on the types of interventions provided to individual clients who receive consultation services from a PHN at the Breastfeeding Clinic. It does not capture the number of people attending the clinic. Group level information about the clinic is noted in a separate database operated by the person noted on the manual form found in Appendix A. Aggregate information about the clinic (only the information in the top part of the form) but not specific information about clients, continues to be sent to the person noted on the manual form found in Appendix A.

Families First Screen

This page applies to everyone, but primarily to Administrative Staff and PHNs. It is only found in the record of Parent 1.

In 2013 screening forms 'depression and/or anxiety' were captured in one field. This has been split into two data elements in the 2014 form, and 'intersex' was added as an option in 'sex'. The database replicates the 2014 form so please be more specific in your response, consistent with the 2014 form. This may change the screening results. If positive include replicate the 2013 score in the 'Parent Survey and Summary Worksheet'.

Parent Survey and Summary Worksheet

This page applies to PHNs with the support of Admin staff upon request. It is always and only used when there is a numerically (≥ 3) or clinical positive Families First screen or when there is a late entry. The Worksheet is only found in the record of Parent 1.

This page allows a high level overview of the client's involvement and eligibility for Families First services.

Save the form using the 'Save as Draft' button until the final closure of the case or until you know that the form has been fully completed. 'Completed By' and 'Completed Date' are only generated when the 'Save and Mark Complete' button is pressed.

'Assessment Date' refers to the date the Parent Survey was completed.

'Assessed By' is the PHN who completed the Parent Survey.

'Screen Complete Date' is the date the Screen was completed.

'Families First Screening (FFS) Form ID Number' is the number from the original paper screening form that is kept in the client record.

'Families First Screening Score' is the score from the Families First Screen.

'Screen Clinical Positive' is the opportunity to identify if this was a clinically positive screen or not.

The 'Reason for no Screen' must be entered if no screen was completed.

Parent 1 is typically, but not always, the biological mother. If the child is living with a parent or guardian other than the biological mother, list the most significant guardian.

Parent 2 is the second most significant person involved in parenting the child.

Parent Survey 'Total Score' is automatically generated for each parent

'Survey Clinical Positive' is the opportunity to identify the family as a clinical positive despite a negative numerical survey.

'Reason survey was not completed' must be completed if the survey was not completed.

'Date enrolled' represents the date any disposition was assigned to this family. If the survey was not completed, then no disposition or disposition date is required.

'Postal Code at Date of Enrollment' is a required field and reflects the postal code of the family at date of enrollment.

'Disposition' refers to the disposition of the family after the survey and must be completed after a numerical or clinically positive survey.

'Has family been in program before?' captures previous involvement with Families First.

'Total number of FFHV home visits' is automatically generated based on completion of Visit Tracking. However, due to a design flaw it counts only Home Visits, not Other Visits. We will be reporting all FFHV visits to HCM directly from the Visit Tracking Summary.

'Total number of FFHVs that have worked with this family' is automatically generated based on completion of Visit Tracking.

'Date of first FFHV home visit' is automatically generated based on completion of Visit Tracking.

'Date of last FFHV home visit' is automatically generated based on completion of Visit Tracking.

'Date of Discharge' must be completed manually upon discharge of the family from the program.

'Reason for Discharge' must be completed manually upon discharge of the family from the program.

'Other Reason Notes' must be completed manually if the 'Other' reason was selected.

'Family's Service Level at Discharge' must be entered manually into this field upon discharge of the family from the program.

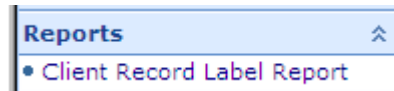
'Postal Code at Date of Discharge' is a required field and reflects the postal code of the family at date of discharge from the FF program.

The screenshot shows a web application interface for a survey form. At the top, there is a navigation bar with tabs for Client Search, Client Overview, Case Activity, Referrals, Visits, and Fill out a Form. Below the navigation bar, there are buttons for Section Navigation, Return, Save as Draft, Check For Errors, and Save and Mark Complete. The main content area is divided into two sections: Signatures and Survey. The Signatures section has fields for Completed By and Completed Date. The Survey section has fields for Assessment Date, Assessed By, Screen Completion Date, and Families First Screening (FFS) Form ID Number.

Reports

Client Label Reports

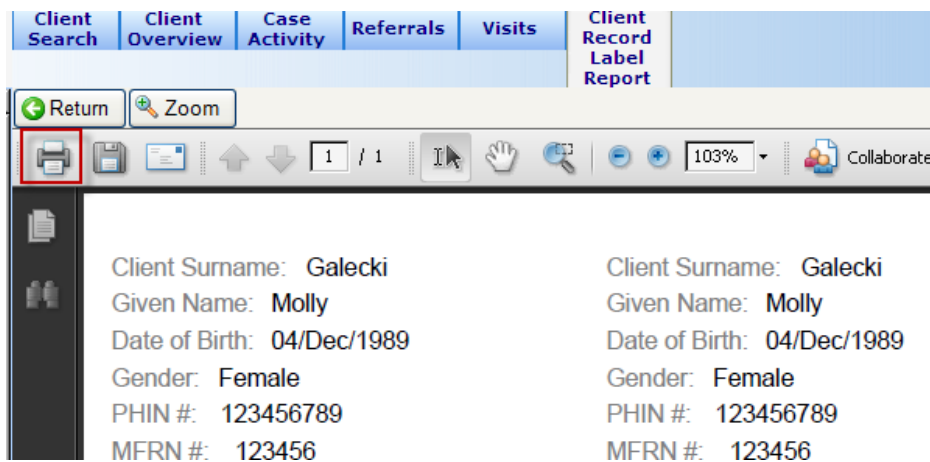
Admin primarily uses this report.



This report is used to generate identifying labels for use in a paper health record.

When hovering over the report, a menu bar will come up with a pdf printer on it. Press the printer icon and the file will be sent to a printer. Load the printer with appropriately sized labels before printing.

The label size is 2 13/16 x 1 1/2 or Grand and Toy #99086 or Avery 45008.



4. Functional Use of the HPECD Database

The notes for each function will provide an overview of how to document in the HPECD Database.

Universal Principles in Database Use

Information in the database is legally considered to be a health record. However, the main health record for the client continues to be the paper record.

Documentation

Standards

In conformity with relevant information management standards, with the exceptions noted in this guideline, documentation in the database should be completed and current within 24 hours of data collection or service. Before closing the client record, all information must be reviewed and approved by the assigned PHN.

Where a pre-existing paper 'client' or 'family record' exists, it should be retrieved and merged with the current health record. There should only be one health record – to the extent that this is possible.

All pre-existing health records should be reviewed as soon as possible to avoid asking clients to repeat information and to provide service based on what is already known about them.

What the Database Replaces and Doesn't

The database will replace the following:

- Healthy Parenting and Early Childhood Development Monthly Summary: Families First Screening & Healthy Parenting and Early Childhood Development Monthly Summary: Families First Parent Survey and Program (2-sided form)
- Problematic records forms
- Client-to-staff assignment and record location tracking systems in community areas
- The following reporting forms to Healthy Child Manitoba (HCM)
 - Families First Discharge/Transfer Summary (except when transferring to another RHA)
 - Families First Program Tracking Form
 - Families First Home Visiting Monthly Summary
 - Families First Quarterly Activity Report
- Community Breastfeeding Data Collection Sheet (replaced with Another Form)

The database will include the following forms that will still be in the paper health record:

- Families First Screening Form
- Families First Program Tracking II Form
- Families First Parent Survey Summary Worksheet
- Families First Discharge/Transfer Summary when transferring to another RHA

The database will not replace:

- Paper health records.
- The following Families First Forms will continue to be used
 - Families First Caseload Management Worksheet
 - Families First Monthly Supervision Summary (Use and Telefax)
 - Families First Safety Teleform (Use and Telefax)
 - MIS (Public Health Stats)
 - Toward Flourishing Monthly Summary

Who the Database Includes

The database is used to track anyone we have provided service to including:

- Expectant women and families
- Infants discharged from hospital care
- Families or women who have experienced a birth

- Families or guardians of newborns
- Families or guardians of preschool children

Any service (e.g., immunization or head lice) related to a preschool child or family with children with a HPECD record is in scope and should have their associated visits tracked.

As well, Central Intake will use the database to track referrals for people who have received services in Winnipeg and have been routed through it to:

- Other Manitoba RHAs
- Other Provinces
- Other Countries

Client Identity

Only enter client information if there are at least two unique identifiers for that person. The exception is an infant for whom you may only have a date and time of birth and where the other unique identifiers are associated with the parent.

If there is insufficient information to identify a client with at least two unique identifiers (e.g., PHIN, full name, date of birth), create another client rather than incorrectly assuming that the client you found is the same one. If at a later date you understand the two entered clients are the same person, ask the Database Analyst to merge the files to create a single client chart.

If demographic information is suspected to be incorrect or incomplete, among other sources consider use of eChart to collect relevant information.

Referral Summary

All Referral Summary reports should be exported to an excel spreadsheet for further manipulation if necessary. Any spreadsheet developed from this report is NOT PHIA COMPLIANT. Electronic PDF versions of this report are also NOT PHIA COMPLIANT.

Electronic versions of these reports should not be saved except as noted in the business continuity plan.

Selection criteria build on each other. The more specific your request is, the more specific will be your output.

Keep in mind that the Referral Summary Reports will not identify any referrals received before June 9, 2014 as these were not back entered.

If 'Provider' is specified, the results will be limited to referrals for the named service provider. The report will not match to historical service providers. If a client has been associated with more than one service provider (e.g., PHN and Home Visitor), there will be a row for each service provider in the report. If a Referral Summary Report was generated using the provider selection and referrals for client records that are closed show up, then the service provider has not been appropriately made historical. Please correct these errors when found and ensure that all other entries are correctly completed.

If community area and/or RHA and/or Prov/Territory are specified as criteria, results will be limited to those referrals. If no provider is associated with a referral it may mean that none was assigned or that the provider was made historical as the case was closed.

If a client has been associated with more than one service provider (e.g., PHN and Home Visitor), there will be a row for each service provider in the report.

The report prioritizes matching as follows: Temporary Address (1st choice), Primary Home address (2nd choice), or Postal Address (3rd choice). The report will not match to historical addresses or to errored out referrals.

'Date of direct referral to community area' is not included in this report. This report will display referral entries with any of the following two dates. If they don't have these dates they will not be in the report:

- Date received at central intake
- Date referred to community area

Any referrals sent to the Prenatal Connections team have a PC prefix. Any referrals sent to the Healthy Sexuality and Harm Reduction team have HSHR as a prefix. Take this into account when interpreting reports.

Referrals Summary Report
Between none and none for staff All for community area All for RHA All for province/territory All

RHA	Prov/Territory	Staff Assignment	Referral Type	File Number	Surname	Given Name	Date & Time Received at Central Intake	Date & Time Referred to Community Area	Referral Status
Winnipeg	Manitoba	Three, FFHV	Breast Feeding	3	Claus	Jessica	06/Jan/2014 00:00	25/Feb/2014 09:40	New Episode
Winnipeg	Manitoba	Nurse1, PH	Breast Feeding	4	Pratt	Paula	06/Jan/2014 00:00	06/Jan/2014 12:17	New Episode
Winnipeg	Manitoba		Community Area	7	Pratt	Lincon	12/Jan/2014 09:00	12/Jan/2014 19:26	New Episode
Winnipeg	Manitoba		Community Area	2	Galecki	Molly	28/Feb/2014 00:00	28/Feb/2014 09:07	New Episode
Winnipeg	Manitoba	Three, FFHV	Post-Partum	4	Pratt	Paula		29/Jan/2014 11:03	New Episode
Winnipeg	Manitoba	Nurse1, PH	Post-Partum	4	Pratt	Paula		29/Jan/2014 11:03	New Episode
Winnipeg	Manitoba	Three, FFHV	Prenatal	4	Pratt	Paula	07/Jan/2014 00:00	28/Jan/2014 18:39	New Episode
Winnipeg	Manitoba	Nurse1, PH	Prenatal	4	Pratt	Paula	07/Jan/2014 00:00	28/Jan/2014 18:39	New Episode

Referral Summary Reports are displayed as a PDF unless another option is selected. If you intend to manipulate data, select 'Excel 2007 or later'. To sort information in the report:

- Highlight the rows in the report
- Right click and select 'Format Cells'
- Ensure that 'Merge cells' is not selected
- Go to the 'Data' ribbon and select 'Sort'
- Select the column you wish to sort by
- Press 'OK'

Special Situations

Serving Individuals or Families in a Group Setting

Context: (1) Nurses are accountable for their practice. Part of a nurse's professional accountability is documenting their assessment, plan, intervention or evaluation and communicating it to others in the health care team. (2) In some situations individual or family clients seen in a group setting may be cared for by another PHN or by another CA.

Procedure: Request at least two unique identifiers (e.g., relatively unique name, birth date, PHIN) from each client with whom you have had a significant interaction. Identify who the primary PHN is. Contact that service provider to advise them of the contact.

The nurse should document in a progress note if it is a current client regardless of whether status is open or closed. If the client is in another community area the receiving PHN should include it in the client record. If it is new client, register them to the database. Determine if this qualifies as a single issues or whether a full paper record should be opened.

Unless they are already open, all clients should have cases opened. Depending on whether follow-up is expected, the case may then be closed.

Relationships should be noted, where relevant.

Nurses providing once-only services should assign themselves as providers but mark themselves historical.

Visits should be tracked. 'Type of visit' will be 'Other Visit'.

Single Issue Forms

Demographics, service providers, relationships, referrals, visits, and forms (e.g., breastfeeding clinic) for all single issue forms that are HPECD related should be entered into the database. The routing note should also identify the location of the health record. Ensure that there are at least two unique identifiers in single issue forms and in the database to allow for future client identification.

Providers should ask for and register as many unique identifiers as possible. They need to have at least two unique identifiers so that the entries into the database are meaningful and the client can be found if they call back again.

Name Changes, Relationship Changes and 'Relationships'

When a name in the client record is changed, it does not change in the relationships section. Relationships is a snap-shot in time at original creation.

Situations where a change might need to occur in the relationships tab:

- When the Child given name or surname needs to be updated
- When there is a change in the name of adults
- When the 'relationship type' was inappropriately classified.

For all of these situations, both clients must have the original relationship removed and recreated manually.

Steps to correct;

1. Access Client #1 of the relationship and error out the relationship
2. Adjust the name of Client #1 if this was required.
3. Access Client #2 of the relationship and error out the relationship item.
4. Adjust the name of Client #2 if this was required.
5. Within Client #2 record manually recreate the correct relationship paying close attention to the format. (relationships must be manually created even if the original was created via the Birth Episode)
6. Save this relationship to Client #2 record
7. Search and load Client #1 and verify that the inverse relationship was populated.

Note: There is no need to update the Birth episode if the infant/child record is updated. Both the old name and new name will be searchable within the database.

Adoption/Fostering & Apprehension/Relinquishing

The easiest way to address situations of apprehension/relinquishment and fostering/adoption is to break them into discrete tasks: registration, case activity, birth episode, relationships, referral, and forms. There are a variety of issues that may affect these situations. Adoptions or foster situations can be voluntary or involuntary, open or closed. Foster placements may vary in length.

1. Registration We assume that any referral we receive was sent with consent. We will register every person to whom we provide a service and those whom we have made a reasonable effort to contact with or without success.
2. Case Activity Open case activity on any person to whom we are providing service or whom we are looking for to provide service.
3. Birth Episode The only person for whom a birth episode can be entered is the biological mother. In situations where the child was apprehended or relinquished at birth, we would not create the child record from within the birth episode. We would not do this is because we are not providing service to the infant associated with that mother.
4. Relationships It will be important to create and update all relationships that we know about. Sometimes we will be able to link biological mothers to their children where open adoptions have occurred and the biological mother has ongoing involvement with the child. It is acceptable to include the relationship of the biological mother and infant even

if the apprehension is permanent. The relationship information between a biological parent and infant can be errored out if we learn about a new relationship between the apprehended infant and a new parent in a closed adoption. This information would not be errored out in an open adoption. It is understood that errored our relationship information still shows up as crossed out text if you view 'historical relationships'. It is also acceptable to add the MFRN of the biological mother to the infant's record. If we become aware of a new relationship between the infant and a new parent, we can change the MFRN to that of the new parent. The formal health record is the paper record, not the electronic database. Any potential future requests for access to health information would consider what information needs to be severed from the health record.

5. **Referral** – The referral is associated with the parent that consented to the referral.
6. **Forms** The Families First Screen should be completed to the extent possible for all birth parents. Completing the Families First Screen for temporary foster situations is based on the PHN's discretion. Any new permanent family situations will likely have a Families First Screen associated with it. The person taking most responsibility for parenting will be Parent 1.

Changes in Family Composition

Family composition may change over time. Parents or children may move away or into the family, or die.

1. Make historical, and close to care those relationships that are no longer current. If there are new members of the family you are providing service to, register them as clients, open them to care, create relationships, and add providers.
2. There are variations in how to enter the screening number.
 - a. If Parent 1 is no longer in the family, consider if the original screen is still relevant to the remaining parent (e.g., biological mother and father were living together and co-parenting but now mother is not parenting and no longer in the home). If so, re-enter the 'Families First Screening Form' and the 'Parent Survey and Summary' (if relevant) to the new Parent 1 file.
 - b. If a change in parents happens before 3 months have passed and there are new parents for this infant a new Families First screen may be needed. Add the new screening number to the child health record. The second screening number should be entered into the 'Other' field as FF#(and then the number without any spaces after FF#). For example FF#2014469700.
 - c. If the change in parents happens after 3 months have passed and this is an entirely new set of parents and a Families First parent survey was completed. Add screening number from the 'Program Tracking II Form' to the child health record.

Do not change the relationship status between the child and a parent who no longer has custody. Both persons are still in that relationship.

Mother declines service and we receive infant referral later

We assume that any referral we receive was sent with consent. An infant is not normally discharged before the mother. If the mother is discharged first, she would usually be registered and case activity would be open on her. If the mother declined service when she was discharged we may have no pre-existing information about her. But now that we have an infant referral we will have some information about the infant and the parent, and open case activity for both. If the infant was discharged a little later than the mother, the case would be registered and case activity would be opened at that time. The referral is associated with the parent that consented to the referral.

If we receive an Infant Referral without a mother or mother is still in hospital

If the information about mom is not on the referral we should not enter or open it. If mom is in hospital, there is no point in opening it (it can be entered as 'preliminary') until she is discharged, at which point we will hopefully get a referral.

Deleting Duplicate Clients

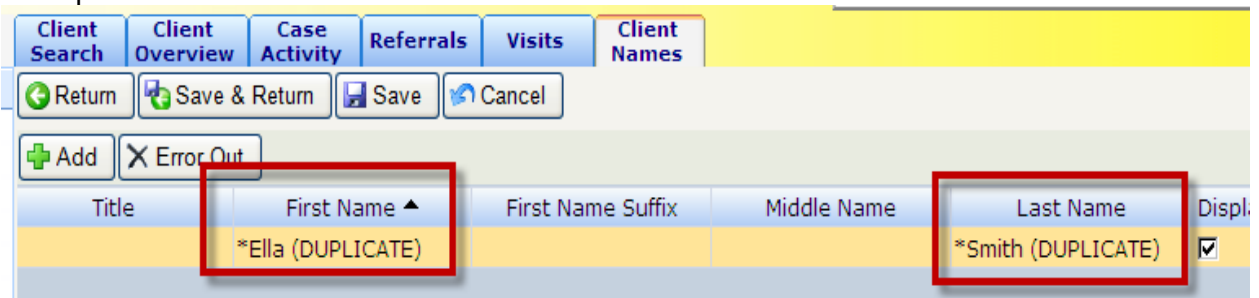
Caution: *Once a client record has been deleted from the database, all information will be lost and cannot be retrieved. Careful attention must be utilized to ensure client information is not lost from the reporting system.*

There is no merge function currently available in the HPECD to merge duplicate records; therefore, the process of dealing with duplicate chart records entered into the system will be a manual process.

When a duplicate record is discovered:

1. Validate that the record is a true duplicate by verifying, client name, PHIN, MFRN, DOB, gender, and relationships.
2. Once verified that the chart entry is a true duplicate, proceed with deleting the duplicate chart entry as follows:
 - a. The original (first) client chart entry should not be deleted and should be the entry that is retained in the database. EXCEPTION: If this is a child's record ensure that the record you want to delete is not the entry associated with a perinatal episode. If it is associated with a perinatal record then it CANNOT be deleted as this would delete the original perinatal episode. In these cases it may not be possible to retain the original chart entry.
 - b. Open the "Client Names" tab in the duplicate chart entry.
 - c. Insert an asterisk symbol (*) at the beginning of both the client's **First Name and Last Name** ensuring not to leave any spaces between the asterisk and name.
 - d. Insert a space and then word "DUPLICATE" in all uppercase letters within parentheses at the end of both the client's **First Name and Last Name**.

Example:



3. Send e-mail communication to the Administrative staff to complete the manual merge process. Provided in the e-mail is the file number for the client record that will be deleted and the file number that will be retained to ensure the correct record is deleted.

Admin ONLY Manual Merge Process:

1. **For Child Records Only** - Check to see if the labeled "(DUPLICATE)" record is associated with a perinatal episode. For further direction on how to proceed see the 'Yes' or 'No' instructions below. *By deleting a child associated with a perinatal episode you will also delete the original perinatal episode; this is not something that we want to do.*

Yes (the child record is associated with a prenatal episode and is the record that **MUST** be kept). The person sending this to you made an error in identifying this record as the duplicate;

- I. Ensure that all:
 - visits
 - relationships
 - referrals
 - perinatal episodes
 - forms
 in the duplicate record have been re-created/entered (as applicable) into the appropriate record associated with the Perinatal Episode that will be retained in the database.
- II. Remove "(DUPLICATE)" and the asterisk (*) from the client record that has been incorrectly identified and ensure that "(DUPLICATE)" and asterisk (*) have been transferred to the record that should be deleted.

No (the child record is **NOT** associated with a prenatal episode)

- I. Ensure that all
 - visits
 - relationships
 - referrals

- perinatal episodes
 - forms
- in the duplicate record have been re-created/entered (as applicable) into the appropriate record that will be retained in the database.

II. Proceed with step 2 below.

2. Ensure that all identifiers are entered into the record that is being retained
3. Add a Routing Note to the chart that will be retained with the following comment:
 - *Manual Merge completed from duplicate record; including transcription of visits, relationship, referral, perinatal episodes and forms as required - (add your name).*
4. Send an email to your Manager including the File number of the chart that will be deleted.

Manager ONLY request for Deletions

Compile the requests that have come from admin at minimum weekly. Submit a Service Desk email including the File number of the clients that will be deleted.

*Note: eHealth will only delete records that are correctly identified following the above guidelines, i.e. *FirstName (DUPLICATE), *LastName (DUPLICATE). The deleted record must also be associated with a retained record that contains the validation manual merge routing note.*

Central Intake (CI) Referral Management and Distribution Process

Role of CI

Most, but not all, referrals are sent to CI by fax and mail and routed from there to the appropriate Province, Territory, RHA or office.

CI records all referrals they receive in the database.

CI distributes all referrals to the appropriate Province, Territory, CA and RHA in a timely manner

Process for Referrals Received at CI

During the weekdays Central Intake will once again fax out the Winnipeg referrals by 8:30 so offices receive them by approximately 8:45 a.m. All referrals will be entered by 9 a.m.

CI Admin searches the database for a pre-existing client. For infant referrals it may be necessary to check the MFRN because the infant last name may differ from the parent's last name.

If a client's case activity was closed or had never been opened, enter the relevant demographic elements or correct them before referring the client to a CA or an RHA. If it is a family that is being referred or the referral is for a prenatal or postnatal client, CI usually only enters the woman's relevant demographics. If a child's main caregiver identified on the referral is someone other than the mother, their relevant demographics are entered. Entry of any additional family members, including infants who may be identified on the referral (e.g., Postpartum Referral) is the responsibility of the CA. However, if it is an Infant Referral, CI enters infant demographics when necessary.

Relevant demographic information for existing clients is always updated from the 'Client Overview' page. Always check for a client record in the Client Search prior to creating a new account, otherwise this can result in duplicate files.

New clients are added using the 'Register a New Client page'. Relevant demographic information to enter or update is noted below:

- *Required* in the 'Register a New Client' page (Last Name, First Name, Preferred Language, Preferred Official Language, Address Type). Enter 'English' as the preferred language if no other preferred language is noted. Enter 'Unknown' if Preferred Official Language' is unknown.
- Postal Code

- Gender
- Date of Birth
- PHIN
- MFRN
- Federal Service Number
- Insurance number for other provinces or territories or other relevant identifying numbers
- Phone number
- Address, both permanent and temporary. Ensure that the RHA field is identified and, for Winnipeg region addresses, that a CA is identified.

Typically referrals should be sent to the Province, Territory, CA or RHA of permanent residence unless a temporary residence is noted. In situations where there is a temporary address, the referral is sent to the Province, Territory, RHA or CA of temporary residence and permanent residence if rural.

We assume that any referral we receive was sent with the consent of the parent. Hospitals should always confirm consent before sending referrals our way.

An infant is rarely discharged before the mother. If the situation is that the mother is discharged first – she would usually be registered and case activity would be open on her. If the mother declined service when she was discharged we may have no pre-existing information about her. But now that we have an infant referral we will have some information about the infant and the mother, assuming she consented to service, and open case activity on both. If the infant was discharged a little later than the mother, the case would be registered and case activity would be opened at that time.

Prenatal referrals from Nunavut are sent to the Prenatal Connections team. Any referral already followed postpartum where a connection was made by a Prenatal Connections staff member would also be routed to the Prenatal Connections team. Any Nunavut postpartum referral where contact was not made prenatally by the Prenatal Connections nurse would be sent to that team to determine who will follow up, Prenatal Connections or a community area team. All referrals for the Prenatal Connections team have a PC prefix.

Opening the Case (WRHA Clients Only)

For clients receiving services in the WRHA, before searching or entering the referral information, note if the case is open or closed in the 'Case Activity' page.

If it is currently an open client, nothing more needs to be done.

If a client is currently closed or was never opened, open the client by selecting the 'Open Case' page and press 'Save and Return'.

Clients who never receive services in the WRHA are never opened and are only visible within the Inactive Record Status when performing a Client Search.

Searching and Entering Referral Information

CI Admin reviews the referral summary to determine if this referral has already been entered. If it has been entered, send a note on a fax accompanying the referral stating this referral appears to be a duplicate and request that the CA staff confirm that it is before destroying it.

If it is a client receiving services in WRHA and not already open, document the new referral entering data in these fields

- Referral Status – If it was already an open case, then select 'Current Episode'. If it originally was a closed or never opened client, select 'New Episode'.
- Date and Time of Discharge - Is entered if it is a postpartum referral. Only date is entered if it is an infant referral.
- Date and Time Received at Central Intake – Note the date and time of receipt in Central Intake.
- Date and Time Referred to Community Area - Is system generated when you press save and return. It is meant to identify when Central Intake sent the referral to the CA or when the CA generated the referral if it was not routed through Central Intake.
- Referral Received By - Is location to whom the referral is sent.

- Date and Time Referred to PHN – Is the time that the referral was assigned to a PHN. In 'Prenatal Connections team' this also serves as a proxy indicator for the date the client arrived in Winnipeg.
- Referral Type - Select the appropriate type of referral.
 - ⚠ **Important:** Any 'Referral Type' starting with PC is being sent to Prenatal Connections to manage, and any 'Referral Type' starting with HSHR is being sent to the Healthy Sexuality and Harm Reduction Team to manage.
- Referral Source - Select the appropriate source of the referral. If we are receiving the referral from a hospital, we can assume that the referral is coming from a nurse unless otherwise noted.
- Referring Discipline - Select the appropriate referring discipline of the person making the referral. 'Referring discipline' from hospitals is always a nurse unless explicitly stated otherwise. The hospital nurse offers a PHN visit and makes the referral to WRHA.
- Referral Note - This is a practical place to enter additional information. You have to enter a referral and save it first, after which you can access the 'Referral Note'. Use this for referrals for multiple births. For example "Infant A Doe" or if you have the name: "John Doe Infant A". There should be a second referral for Infant B entered the same way just with Infant's B information.

The only difference to the process noted above is for clients who receive services outside of the WRHA. They always are entered as a 'New Episode' in the referral status field.

We track all referrals in the system except those are identical and have obviously been resent in error. The purpose for doing so is to allow us to improve referral process, especially for prenatal referrals.

For twins who are sent to us as infant referrals we would track them as two referrals. For twins in a postpartum referral we would treat them as one referral, even though it was on two pages.

Faxing the Referral

Once the data has been entered and the case activity updated as required, referrals are faxed to the CA or RHA with a cover sheet identifying the number of pages. All paper referrals are filed by date and kept for the current year plus one year.

CI may batch referrals to a CA but delays in sending these referrals *should not exceed 30 minutes* from the automatic time stamp when they enter the referral information.

Community Area (CA) Referral Management and Distribution Process

The day's referrals routed through CI to a CA should be determined by using the 'Referral Summary' report. Although faxed referrals can be received earlier, run the Referral Summary Report at 9 am. This report should be run by CA Admin at least twice daily, at 9 a.m. and at the end of the afternoon. The report should include the relevant CA and time frame being queried. The faxes received should be compared to the outputs of that report. If faxes are missing, contact CI Admin.

CAs distribute all referrals to the appropriate PHN or FFHV.

CAs record all referrals that have been generated by them or that were sent directly to them and without being routed through CI. Some referrals are generated in or sent to CAs and routed from there to the appropriate PHN, FFHV, RHA or office.

CAs transfer all records to providers external to WRHA as necessary.

Community Area Entering and Confirming Demographics

CA Admin do most of this data entry. If this has not already been done by CI, they search the database for a pre-existing client. Ensure the relevant demographic elements are entered or corrected before referring the client to a PHN, CA or to another RHA. If it is a family that is being referred or the referral is for a prenatal client, usually only the woman's relevant demographics are entered by CI Admin.

If the referral clearly notes other persons who need to be included in the assessment or intervention, also register them as clients.

- An example of a number of people who need to be registered is a referral from Bridge Care for a family with many children.
- Another example is a postpartum referral including a woman her husband and newborn infant

If the main caregiver identified on the referral is someone other than the mother, that person's relevant demographic information is entered. Other family members not noted on the referral and who have received an assessment or an intervention should be added to the database. This data entry is the responsibility of the CA.

New clients may be added using the 'Register a New Client' page. Relevant demographic information for current clients is updated navigating from the 'Client Search' view. Do not forget to add the postal code to have the system generate a CA or RHA. If the system does not generate a postal code, use the table found in 'The Process for Incorrect or Absent Postal Codes' to assign a generic postal code that will assist the database to correctly attribute the correct CA and RHA.

Infants can be added using the 'Birth Episode' section of the 'Perinatal Episode' page. After saving the information about the infant, you will be presented with a button to allow you to 'Create a Child Record' and include the address. Only 'Create a Child Record' for live births. Do not create a child record for referrals stating that there was a stillbirth or neonatal death. If selected, the address of the person in context will then be added to child's record. Enter information from postpartum referrals into the 'Birth Episode' but do not register (create a client) for any referral on a 'stillborn' or 'neonatal death'.

'Client Relationships' information should be entered.


*FFS – The Families First screening number is added to the client record at the CA level. The FFS is added to the mother's record for all prenatal referrals. The FFS number is added to the infant record if there is going to be a Families First screen and:

- If there was no contact with the mother prenatally
- When there is more than one birth and there was prenatal contact with the mother, the pre-existing FFS number is associated with the mother for the first live-born infant only.

HSR can use the address at which a client is currently staying. It is a temporary address. These clients don't often have a permanent address.

Opening a WRHA Case

When searching for WRHA clients note if the case is open or closed in the 'Case Activity' page.

 **Important:** All members of the family served need to be opened, including infants noted in Postpartum referrals.

If it is currently an open client, nothing more needs to be done.

If it is a client who is currently closed or was never opened, open the client by selecting the 'Open Case' page and press 'Save and Return'.

Searching and Entering Referral Information

Central Intake or Community Area Admin reviews the 'referral summary' to determine if this referral has already been entered. .

We are tracking time of discharge through to the time of first contact to evaluate how we are meeting our contact after postpartum discharge standard. We have had a number of standard-related occurrences. Sometimes we are unable to meet the standard due to the delays of others, and sometimes the delays are due to our own delays. The purpose of most of the fields is to identify delays in one of the handoffs. We track time of client discharge, time of receipt at central intake, time referred to the community area, time referred to a PHN and then time of first contact with client.

If the client was not currently open, document the new referral entering data in these fields

- Referral Status – If it was already an open case, then select 'Current episode'. If it originally was a closed or never opened client, select 'New episode'.
- Date Referral Received – . The 'Date Referral Received' field cannot be left blank. It refers to the time that Central Intake sent the referral to the CA and the CA received the referral. However it is not relevant when a CA generates a referral. In this situation the 'Date Referral Received' field should be and will be ignored. The date may be disregarded. This should be left empty if the referral was directed to the CA without being routed through CI. For CA-generated referrals it should be left empty.
- Date and Time Referred to Community Area - Is system generated when you press save and return. It applies to those referrals generated in a CA as well as those sent to a CA from Central Intake.
- Referral Received by - Is the location in another RHA or the WRHA service or CA managing the referral.
- Date and Time Referred to PHN – Is entered by the person that assigned the work, at the time the assignment was made. The person responsible for ensuring that the 'time the referral is assigned to a PHN' is entered is the person assigning the client to a PHN. If the person making this assignment is a PHN, she/he may negotiate that Admin make this entry depending on the number of entries required. The time of assignment to a PHN includes having a paper file available.
- Permanent Address – Select the permanent address at the time of referral from the drop down list. The following applies when we get referrals with a permanent Winnipeg Health Region address but the person or family is currently at a temporary address, because there is no current need for our services at the permanent address, and the person may never move back to Winnipeg even though they say they have a permanent address here, do not enter this information into the database as we then have information that we may not need. Entering this data may create opportunities for missing data when we do our quality assurance reports.
- Temporary Address - Select the Temporary address at the time of referral from the drop down list.
- Referral Type - Select the appropriate type of referral.
- Referral Source - Select the appropriate source of the referral.
- Referring Discipline - Select the appropriate referring discipline of the person making the referral.

The remainder of this tab is not used.

Register a New Client

Generally we register only those people that we actively provide service to.

We wouldn't register or open case activity for a child that was never a client (e.g., stillbirth or dead before they left the hospital). However we would create a birth event (postnatal episode) for them. If the referral was made while the child was still alive, we would treat it like any other person. The nurse would mark them as closed and deceased.

People to whom we never provide service or who are never opened may be added to the system. A situation where this may be appropriate is to document complex family relationships or where family relationship status of those receiving intensive support varies very significantly from child to child (e.g., various biological parents, blended families).

Clients can be easily added using the 'Register a New Client' page.

Any live births will eventually have a Families First Screen completed on them. It is the role of Administrative Staff to add the FF Screening number to the 'identifiers' section in the 'client overview' of the infant. The FF Screening number should never be entered in the Parent's 'identifier' section. Before adding in a new screening number, confirm that no screen for that live birth was initiated in Parent 1's file (e.g., screen was initiated prenatally). If a screen was initiated prenatally, add that number into the 'identifiers' section of the infant.

Creating a Paper Health Record

After searching for and selecting a client. Open 'Client Record Label Reports'. Ensure that the appropriate label sheets are available in your printer. Press print. Add labels to each sheet of the health record.

Assigning a Service Provider

The person who assigns the work assigns the service provider and updates the 'Date and Time Assigned to PHN' field in the referral tab for all clients who are opened to service.

Visit Tracking

All PHN and FF Home Visitor HPECD direct services to individuals or families will be tracked in the database. Any visits related to preschool children or their parents are tracked (e.g., immunization, head lice issues). Only enter visits that are in person or on the phone with a client that actually resulted in an assessment, intervention, plan or evaluation.

Do not enter visits that resulted in no contact or that were primarily to set up a future contact. Do not enter anything about mail, email or text contacts with clients. Email and texts should never include personal health information. Mail rarely has personal health information.

PHNs enter visits in the health record of Parent 1. PHNs include the following elements in tracking each direct service:

- Date of Visit
- Time of Visit only for the first postpartum visit
- Provider Role
- Type of Visit
 - Office Visit includes any visit at the CA office or any other CA office except Breastfeeding Clinics,
 - Other Visit includes any visit on the street, in a coffee shop, in a neighbor's home, a Healthy Baby site, etc.
 - Home Visit includes any visit in the home or in places like Villa Rosa which is semi-permanent accommodation
- Visit Length (in minutes) If for some extremely unusual reason, such as the sudden departure of a PHN, the length of the visit is unknown indicate 999.

There are exceptions to the rule of always tracking visits in the record of Parent 1. For children in hotels or temporary shelters there may be no Parent 1 so visits in this exception only can be tracked in the infant's record. There should be no screen or survey in these situations.

FF Home Visitors enter visits in the health record of Parent 1. FF Home Visitors include the following elements in tracking each direct service:

- Date of Visit
- Provider Role
- Type of Visit
- Visit Length (in minutes) If for some extremely unusual reason, such as the sudden departure of a Home Visitor, the length of the visit is unknown indicate 999.
 - Service Level
 - The HPECD database currently has no option to place families on Creative Engagement because all other levels of service are associated with a visit of some sort. Creative Engagement does not involve a client visit so we have been unable to record it to date. However, we have a solution. Please find details below.
 - When a family enrolls in the FF program the FFHV inputs the home visit(s) into the database as either a Level One or Prenatal using the date that the home visit(s) were made.
 - When a family goes 30 days without home visits the FFHV will change the level status in the HPECD database by going to the visits tab.

- The FFHV will insert the date that the family was placed on Creative Engagement.
 - In the 'Level of Service' box they will choose Creative Engagement.
 - In the 'Type of Visit' box they will choose Office Visit.
 - The 'Length of Visit' will be 1 for 1 minute.
 - As the FFHV works with the family to re-engage them and a home visit is made, the FFHV will then enter the date that the visit was made; the 'Level of Service' will remain as Creative Engagement; the 'Type of Visit' becomes a Home Visit and the 'Length of Visit' would be the time that the FFHV spent in the home doing the visit.
 - The family will continue on Creative Engagement until they are making regular home visits and at that time, the FFHV would change the level back to the previous level that they were receiving services at prior to being placed on Creative Engagement.
 - After 60 days without visits, the family is then discharged from the program. (This could be sooner depending on the family situation.)
 - In order to ensure that this information gets into the HPECD database, it is necessary that FFHVs back enter any families that they have placed on Creative Engagement since June 9th.
 - For discharged families, they will need to re-opened in the HPECD database and the date that they were moved to Creative Engagement added. In the 'Level of Service' box choose Creative Engagement. In the 'Type of Visit' box choose Office Visit. The 'Length of Visit' will be 1 for 1 minute. The discharge date has already been inputted, so close the file as per the usual instructions.
- And note if any of the following were part of that direct service: Goal Setting Plan, GGK & SSBF, GGF, TF, Triple P, Family Issues

Families First

Parent 1: This is usually the mother but it could also be the person who provides the majority of the infant's care. Use the mother if care is provided equally between a biological mother and someone else. The FF Screening Form and the Parent Survey and Summary are normally attached to this person's record. Visits are tracked against Parent 1 where the forms are located.

Parent 2: This is the second most important person who is involved in parenting the child

FF Screening Number

The FF Screening number itself should only be associated with live infants, so it should never be registered in the identifiers section of the parent's health record, but only in the live-born child's health record. All live births will have their own screening numbers. The 'FF Screening' number is entered as an identifier for all live born children, and for all late entry children where the original screening number can be found. The screening number can be taken from the 'Program Tracking II Form' if there is no original screening number. If the number on the 'Program Tracking II Form' is being used, the form should be kept in the paper record but not faxed to HCM.

The FFS number is added to the 'Client Identifiers' infant or child's identifiers area at the CA level, usually by Admin when they open the client. A FF Screening form is added to and retained in the paper record as a permanent record of all screen information.

In the event of multiple births (e.g., twins, triplets) or sequential births (e.g., someone who had another birth 10 months later) generate additional Families First Screening numbers in Parent 1's record. There are two ways to do this.

- (1) After entering the 'Identifiers' tab select 'Other' in the 'Identifier Value' column and replace it with the letters 'FFS'. It is important that this label is accurately typed because if it is not it will interfere with searching by FFS and also interfere with reporting. Then type in the FFS number in the 'Value' column.
- (2) After entering the 'Identifiers' tab press the add button then type the letters 'FFS' in the new row in the 'Identifier Value' column. It is important that this label is accurately typed

because if it is not it will interfere with searching by FFS and also interfere with reporting. Then type in the FFS number in the 'Value' column.

FF Screening Form

PHNs complete the paper screening form, keeping the original in the client record, and enter the data into the database. All data for the Families First Screen must be entered within a week of completing it.

A screen may have been started with a birth mother before an apprehension or adoption. The FF number is entered into the infant record identifiers section if it should be linked such as in an open adoption. An infant with an open adoption may have more than one screening number associated with them.

Save the form using the 'Save as Draft' button until the final closure of the case or until you know that the form (possibly minus the PHIN) has been fully completed. 'Completed By' and 'Completed Date' are only generated when the 'Save and Mark Complete' button is pressed.

If the client is clinically positive or if no screen was completed, then PHNs enter the data into the 'Clinical Positive' or 'No Screen' fields.

Instructions:

- a. These fields are mandatory and must be completed before saving.
 - For this Baby is this a foster or adoptive parent?
 - Families First screening number
 - Screened prenatally
 - Parent 1 postal code
- b. 'Completed By' and 'Completed Date' - are populated once the Save and Mark Complete button is pressed. This enters the name of the person who 'pressed the save and mark complete' button. This information is not used to report to Healthy Child Manitoba.
- c. 'Assessment Date' refers to the date the FF Screen was completed.
- d. 'Assessed By' - is the name of the person completing the assessment once the Save and Mark Complete button is pressed
- e. 'Age' for Parent 1 or Parent 2: If the parent's age is unknown, enter it as 99.
- f. 'Parent Survey Completed Date' is the date the Parent Survey was completed, not the date the data was entered.
- g. 'Parent Survey Completed By' - is the name of the person who actually completed the Parent Survey, not necessarily the person who saved and marked complete.
- h. 'Family First Screen Completion Date' - is the date the Families First Screen was completed, not necessarily when it was entered.
- i. 'Community Area' is the community area of the permanent address. If the person does not live in the Winnipeg Region, then choose the blank option.
- j. Parent 1 is typically, but not always, the biological mother. If the child is living with a parent or guardian other than the biological mother, list the most significant guardian
- k. Parent 2 is another significant person, if any, involved in parenting the child.
- l. Ensure that every item that has been screened is noted as 'no' or 'yes'. Do not check items that have not been screened.
- m. 'Clinical Positive' - Check only for those that are clinically positive and where the screen is not numerically positive.
- n. 'No screen' - Check only if it has not been possible to do a screen. And provide the reason why screen was not completed.

Entry of the **PHIN** is an anomaly in that it must be completed on all Manitoba FF Screens but the form can be saved and marked complete, and the entire record can be closed to service before the number is entered. **However, a very accurate tracking system needs to be implemented in each office so that the PHIN will be entered in a timely manner.**

PHNs may task Administrative staff with adding the PHIN number to the infant identifiers in the client overview and to the FF Screening Form, usually in the health record of Parent 1.

For multiple births, PPH staff may contact Hospital directly to assist in assigning the correct PHIN in the HPECD database. Staff should contact the Hospital where the birth occurred.

HSC: Denise Felbel – 204.787.2984
Geraldine Berania – 204.787.2985

SBH: 204.237.2278 - press "0" to avoid listening to the telephone message.

If there are any issues that arise pertaining to this process, please contact
Crystal Letain, CHIM
Manager, Health Information Services, Community
Winnipeg Regional Health Authority
234 - 1155 Concordia Avenue, Winnipeg, MB R2K 2M9
Ph: 204.926.7838 Cell: 204.479.4396 Fax: 204.947.9970
E-mail: cletain@wrha.mb.ca

If completing the Families First screen with a temporary foster parent or guardian at an emergency shelter, you can fill in the PHIN section of the screen with 9 nines (i.e., 999 999 999) which indicates the PHIN is unknown.

The PHIN of parent 2 should not be included on the screening form unless the information is gathered directly from that parent. If the PHN is providing service to parent 2, the PHIN should be noted in the database and ideally in the screening form.

If you have been unable to complete the screen, indicate the reason for no screen and 'Save and Mark Complete'. 'Save and Mark Complete' is a function in the database and does not indicate that all fields in the form were completed.

The screenshot shows the 'Families First Screening Form' interface. At the top, there is a navigation bar with tabs for 'Client Search', 'Client Overview', 'Case Activity', 'Referrals', 'Visits', and 'Fill out a Form'. Below this is a 'Section Navigation' bar with buttons for 'Return', 'Save as Draft', 'Check For Errors', and 'Save and Mark Complete'. A 'Print' button is also visible. The main form area is titled 'Families First Screening Form' and contains a question: 'For this baby is this a Foster or adoptive parent?' with radio buttons for 'No' and 'Yes'. Below this is a 'Signatures' section with fields for 'Completed By' and 'Completed Date'. At the bottom, there is a 'Families First Screening Assessment' section with a 'Section Help' link and a table with columns for 'Assessment Details' and 'a. Assessment Date'.

If the 'Families First Screening' form is initiated with a prenatal woman, the form will already be in her file. The form will be dated with the year the screen was initiated. If an infant is fostered after a screen was completed with the biological mother, more than one 'Families First Screening' form will be generated for the same infant. In this situation add a new FFS identifier to the infant record.

The FF Screening information is added to the Screening Form in the Parent 1 record by the assigned PHN. If there was no screen, the reason for this is noted by the PHN. Before pressing 'Save and Mark Complete', the information must be confirmed by the PHN.

What should be done in the event that a screening form needs to be revised with updated information? If the form has been 'Saved and Marked Complete' it will need to be re-opened and the appropriate changes should be made. Include these changes in the Parent Survey and Summary. If the family is now eligible for a Parent Survey a new 'Parent Survey and Summary Worksheet' will need to be initiated in the Parent 1 record.

Parent Survey and Summary Worksheet

The 'Parent Survey Summary Worksheet' in the HPECD Database is completed by the assigned PHN. The Parent Survey documentation is retained in the Parent 1 record. One 'Parent Survey and Summary Worksheet' is associated with each child where its parents are eligible for the Parent Survey (e.g., for twins or triplets each would have a Parent Survey and Summary Worksheet).

When a family is discharged from the FF program and then is re-enrolled for the same target child: If the 'Parent Survey and Summary Worksheet' has been saved and marked complete because they were discharged, reopen the form and delete all information associated with the previous discharge and continue using the form as if the original discharge did not happen.

When a family is transferred to another RHA to continue receiving FF services: Discharge them from the program and note the 'Reason for Discharge' as 'Other Reason'. In 'Other Reason Notes' write exactly "Transfer to another RHA". The 'Discharge/Transfer Summary' form is used to transferring a client to another RHA for their benefit only. It is not faxed to HCM. All transfers within the WRHA do not require use of this form.

The Survey and Summary Worksheet replaces the 'Program Tracking II Form' for all children. Please note that due to a design flaw 'total visits' counts only Home Visits, not Other Visits. We will be reporting all FFHV visits to HCM directly from the Visit Tracking Summary.

The database will replace all faxed forms to HCM and all reports with the following exceptions:

- Monthly Supervision Summary (continue to Telefax this form)
- Home Safety Form (continue to Telefax this form)
- Case Management Worksheet
- Towards Flourishing Monthly Summary
- The 'Family First Screen form' is retained in the client health record, but not faxed to HCM.
- The 'Discharge/Transfer Summary' form is used to transferring a client to another RHA for their benefit only. It is not faxed to HCM.

When a family is already receiving home visiting services and has another child:

Complete the parent survey form for the additional child. Indicate that the child is enrolled. Keep both Parent Survey and Summary forms open until the family is discharged from the program.

Breastfeeding Clinics

PHNs collect this information on a paper form at the breastfeeding clinics only and provide it to Admin to enter unique client information into the database. The visit summary should not be placed in nor does it replace documentation in the client's paper health record. If there is no paper health record, documenting on a single issue form may be appropriate.

Keep breastfeeding clinic forms for quality assurance purposes for three months in a secure location. Forms can be discarded thereafter.

It is possible that people from out of region may make use of the Breastfeeding Clinic and that they have not been registered as clients yet. They will need to be registered and opened to enter their breastfeeding consultation information. Remember to close their case activity thereafter.

Admin enters client specific data on this form after the breastfeeding clinic. Data entry of breastfeeding clinic appointments is the responsibility of the community area administrative staff upon receipt of the paper form. These visits do not need to be added in Visit Tracking,

If the client is not currently open, open and close the record. If a breastfeeding clinic client is already associated with the PHN who saw them at the clinic, then nothing needs to be done. If the client is not already registered in the database, the PHN should be added and the relationship should be made historical.

Aggregate information about the clinic that is not client specific continues to be sent to the person noted on the form. Do not send personal health information when sending the top half of the form. The aggregate information includes:

- Clinic Date
- Community Area of Clinic
- Number Attending Group
- Issues Discussed in Group

Closing a File

Introduction

Very importantly, **closure is the time of the final quality check for data entered into the database. The PHN closes the file.** This quality check replaces many other forms and processes we used to use in the program. If this final quality check is not completed well, then the data entry efforts of the entire program and staff are called into question.

A case will be closed in the database at the same time the paper file would be closed, and using the same rationale. We would close a record to WRHA if we are transferring the file to another RHA or province.

Any clients who is receiving ongoing service (e.g., those enrolled in Families First), who are anticipated to receive service (e.g., prenatal clients) or who are receiving ongoing services for clinical reasons related to HPECD (e.g., assessments or interventions) should never have their case closed.

When a decision has been made to close a case on the database a decision needs to be made about whether to close the case of other members or all members of the family. This may vary depending on the family situation (e.g., infant death in the first weeks after discharge from hospital).

If a **FF Home Visitor** has been serving a family they need to review their paper documentation and entries into the database are complete before closing their portion of the paper health record. They provide their portion of the health record to the case managing PHN.

Case Managing PHN reviews the Home Visitor HPECD Database records ensuring information is correctly entered, current and complete.

PHN searches for and reviews all clients in a family they are closing. This is intended to be the final quality check to ensure all data is

- (1) correctly entered,
- (2) current and
- (3) complete.

All demographics, service providers, relationships, perinatal episodes, forms, referrals and visits should be reviewed. All forms should be 'Saved and Marked Complete'.

Assigned PHN Closure Checklist

1. *Demographics* (use 'Client Overview').
 - a. Confirm demographics are current (i.e., names, gender, identifiers, addresses, phone number)
 - b. Ensure only the child has Families First screening numbers noted as an identifier. In situations of apprehension or relinquishment or with multiple foster parents, it is acceptable for a child to have multiple FF Screening Numbers noted in their identifiers section.
 - c. Parents should not have a FF Screening number in their identifiers area.
 - d. Mark all service providers as Historical. (*To ensure inactive cases are not displayed as part of the referral summary report*)
 - e. Relationships are accurate and up to date.
2. *Perinatal Episode* - Review all prenatal and birth episodes
3. *Referrals* (All referrals in the client record should be noted and complete in the database, do not forget to include 'self-referrals' and 'community generated' referrals.)
4. *Visits* (All visits by PHNs, Outreach Workers and FFHVs have been entered and are completely entered.)
5. *Families First Screening Form*

- a. Only Parent 1 should have the form or forms (in the event of multiple births or previous children) in their record. If the form has been associated with any other parent, it needs to be errored out and entered into Parent 1's record.
 - b. Should be reviewed in detail, 'checked for errors', and should have been 'saved and marked complete'.
 - c. If the form has errors and has been 'saved and marked complete', you will need to reopen the form to avoid having to transcribe it again.
6. *Parent Survey Summary Worksheet*
- a. Only Parent 1 should have the form or forms (in the event of multiple births or previous children) in their record. If the form has been associated with any other parent, it needs to be errored out and entered into Parent 1's record.
 - b. Should be reviewed in detail, 'checked for errors', and should have been 'saved and marked complete'.
 - c. If the form has errors and has been 'saved and marked complete', you will need to reopen the form to avoid having to transcribe it again.
7. *Breastfeeding Clinic*
- a. *Appointment Summary(s)*
 - b. Only Parent 1 should have the form or forms (in the event of multiple births or previous children) in their record. If the form has been associated with any other parent, it needs to be errored out and entered into Parent 1's record.
 - c. Should be reviewed in detail, 'checked for errors', and should have been 'saved and marked complete'.
 - d. If the form has errors and has been 'saved and marked complete', you will need to reopen the form to avoid having to transcribe it again. Remember to look for and close the case of all other family members who are no longer being served.

PHN 'Closes Case' for all family members. Then press 'Save'.

PHN writes closure note in the paper health record.

PHN provides paper record to admin.

Admin confirms case activity is closed in HPECD Database.

Admin returns the chart to the PHN if the PHN has not closed the activity in HPECD.

Admin adds a routing note to identify chart location

Entering a PHIN on a Closed Record

We do want the PHIN entered for all children born in Manitoba. It may take a number of months to find this number. When available the child's PHIN should be entered into the 'Identifiers' section as well as the 'Families First Screening Form'.

Nurses may close a file without a child PHIN. But they need to advise admin staff about which closed files still need child PHIN number. Admin will enter the PHIN number in a timely manner when it becomes available.

Admin will need to keep a MANUAL list of the closed files that require back entry of the PHIN when it becomes available. This list should be accessible to anyone who may cover. Any names on the manual list of files where the PHIN has been added should be clearly marked or deleted.

Transferring Clients

Transferring clients to another office within the WRHA

1. Sending nurse closes case activity in database, makes previous staff assignment historical, makes previous address historical, adds new address in the new community area (if not already entered) – for all members of the family.
2. Sending nurse advises the receiving office administrative staff of the transfer. Follow the 'December 2010 (Updated July 2012) Guidelines for Transferring Families Enrolled in the Families First Program within the WRHA' where appropriate. Do not complete the discharge transfer summary form.
3. Sending nurse completes a quality check of paper health record and all database entries to ensure that all entries are complete, accurate and current.
4. Sending administrative staff sends the original paper file to the receiving office. PHN may send relevant information by fax if there is high urgency to the transfer,.
5. Receiving administrative staff creates a desk note that a file will be received and when it was sent. This note should be available to any other covering administrative staff.
6. Sending administrative staff inserts routing note that the "File in transit to (new community area)" – for all members of the family.
7. When the file is received, receiving administrative staff deletes or removes the desk note that the file will be received.
8. Admin ensures that a new PHN has been assigned to the client files– for all members of the family.
9. Whoever assigns PHN adds the new 'provider' (providers – in the event of a Families First family) to the client files, add 'routing note' regarding new location of the file and opens case activity – for all members of the family.

Transferring client to other RHAs

1. Sending nurse closes case activity in database, makes previous staff assignment historical, makes previous address historical, adds new address (if not already entered) – for all members of the family.
2. Sending nurse advises the receiving office administrative staff of the transfer. Follow the 'Guidelines for Transferring of Families First Families between Regional Health Authorities' where relevant.
3. Sending nurse completes the Screening Form and Parent Survey and Summary Worksheet form and marks it 'Save and Mark Complete' (where appropriate).
4. Sending nurse completes a quality check of paper health record and all database entries to ensure that all entries are complete, accurate and current.
5. Sending nurse contacts receiving RHA with summary letter and includes families first screen, parent survey (if any), discharge transfer summary form (if active in the Families First program), and any copies of relevant documentation to the receiving RHA.
6. Sending administrative staff inserts routing note that the "File in transit to (new RHA)" – for all members of the family.

Transferring clients to other Provinces/Territories/Countries

1. Sending nurse closes case activity in database, makes previous staff assignment historical, makes previous address historical, adds new address (if not already entered) – for all members of the family.
2. Sending nurse completes the Screening Form and Parent Survey and Summary Worksheet form and marks it 'Save and Mark Complete' (where appropriate).
3. Sending nurse completes a quality check of paper health record and database entries to ensure that all entries are complete, accurate and current.
4. Sending nurse contacts receiving Province/Territory/Country and sends summary letter with copies of relevant documentation to the receiving Province/Territory/Country.
5. Sending administrative staff inserts routing note that the "File in transit to (receiving Province/Territory/Country)" – for all members of the family.

Receiving transferred clients from outside of the WRHA

1. Admin opens the family and registers them as necessary. A PHN is assigned and a FF Home Visitor, if eligible for the FF program.
2. If there is a pre-existing FF Screen it is entered by the PHN. If the screen was positive, a Parent Survey and Summary document is entered or completed.

Add a New Staff Person or Change Information about a Staff Person

Only eHealth staff has access to this functionality. When new staff (including PHNs, Home Visitors, Outreach Workers or Managers) need to be added, use the ACMT form. You can add new personnel or delete them from your office using this form.

Change Password

To change passwords use the 'Change Passwords' page found under 'User Preferences' in the side bar.

Weekend Services Process

On weekends or holidays, the role of admin and of PHNs is somewhat modified. Some data entry needs to be prioritized by admin so that PHNs are able to enter 'visits tracking' information into the database before they leave for morning visits. Because Admin are not there at the end of the day, PHNs will need to enter some data as well.

Based on the premise of fair distribution of work, it is recommended that any referrals that are not already assigned to a PHN are assigned to the weekend services PHN normally working in the CA or CA pairing corresponding to the client's address. It is recommended that, where possible, this weekend services PHN would be that client's primary nurse in the CA and that this client not be handed off unless that did not conform with local area distribution systems (e.g., neighbourhood cluster distribution).

As a priority, first thing in the morning, Admin will:

- Search for, update or enter registration and referral information for Parent 1 (typically the mother).
- Open these parents to service.
- Run a referral summary report and enter the content into the template in the memory stick.
- Print the report and provide it to PHN#1 who uses this report to track work assignment.
- Review routing notes to determine if there is a safety plan. If there is they will write "See safety plan" on the referral.
- Note on referrals if this is a "New client". That is, this note is added to any referral where they need to register a new client.

Later that day Admin will:

- Enter any new referrals in 'Add new referral'.
- Enter information from postpartum referrals into the 'Birth Episode' and register (create a client) for any live births associated with the referrals. Enter information from postpartum referrals into the 'Birth Episode' but do not register (create a client) for any referral on a 'stillborn' or 'neonatal death'.
- Assign the right PHN to cases using 'Service Providers'.

At the end of the day Admin adds the referral summary report to the memory stick.

PHN #1 is responsible for assigning work but can request that the PHNs working that weekend assign themselves as providers when they do triage or visit the family.

PHNs will:

- Review the safety plan in the binder if "See safety plan" is written on the referral.

- Check the database of those without the "New client" note to review any screening reports that may already be partially complete, or that are complete for previous children.
- If PHNs have participated in triage or in a face to face assessment or intervention of some kind, they should note their visit in the visit tracking tab.

Later that day PHNs will:

- Note any contact with Parent 1 using 'Visit Tracking'.
- Search for, update or enter registration information for any other family members who have been served.
- Search for and open any additional family members who have received service.
- Link any additional family members using 'Client Relationships'.
- Enter or complete the FF screening form for every live born child in Parent 1's file.
- Enter FF parent survey form, where relevant and to the extent possible, in Parent 1's file.
- If the weekend PHN is no longer going to be providing service to the family, they should make themselves the historical providers to the family members.

Transferring Files to and from Weekend Services

Before the weekend The CA faxes relevant portions of records to Central Intake for weekend service. The CA should keep track of the records that have been faxed as these are the same records they should expect to have returned to them from CI after the weekend.

After the weekend the CA admin can run a report to determine what new referrals were received over the weekend to determine what records to expect to receive from central intake.

HSHR & Prenatal Connections Processes

HSHR staff is involved with women in the prenatal period and, from time to time, with other HPECD families. Any pregnant woman and her family members who are being served and who are receiving pregnancy support by our staff will be registered in the database.

The case activity of family members who are served will be open, and family relationships will be established.

Visits will be tracked.

Where relevant, services will be transferred to community area Public Health or services will be closed upon completion of service.

The referral summary can be sorted by referral type to help identify your clients and your referrals.

Infant Feeding Class Letters

CAs may be able to identify which clients should be sent an infant feeding class invitation using the following process.

1. Run a referral summary report selecting the PHN, CA and the appropriate time interval.
2. As not all postpartum referrals result in live births, and some infants are apprehended after birth, ask the PHN to identify which individuals should be sent an invitation.
3. Admin can generate the invitations to the identified individuals.

Distribution of Work

Please consider these suggestions for how to use the database for distribution. The following are tools potentially available for use in distributing referrals.

- A client search can identify historical providers for that client.
- The 'Referral Summary Report' can be used to identify which providers were assigned recent referrals within a defined (recent) period of time. Referral Summary Reports are displayed as a PDF unless another option is selected. If you intend to manipulate data, select 'Excel 2007 or later'. To sort information in the report:

- Highlight the rows in the report
- Right click and select 'Format Cells'
- Ensure that 'Merge cells' is not selected
- Go to the 'Data' ribbon and select 'Sort'
- Select the column you wish to sort by (typically this will be by provider)
- Press 'OK'
- Shared calendars can be used to identify who is away or whose time is already spoken for.
- A list of ongoing commitments by provider that reduce available provider time such as FF Lead Role and Healthy Baby site Lead Role.
- Previous client to provider logs can be used until they are no longer useful. **These logs should no longer be updated regardless of whether they are manual or electronic!**

There are a number of principles you may consider for distribution. In order of priority they are:

- Continuity of care means that one PHN provides services over time to a family whenever possible. Continuity of care is a foundation for trusting and effective relationships, as well as improved efficiency as the relationship and knowledge of the family already exists.
- Geographic assignment implies that one PHN takes on the majority of work in a specific neighbourhood. The benefit of concentrating geographic assignments of families to a nurse is that the nurse more fully understands the neighbourhood resources and challenges. Geographic assignment may also significantly reduce travel time.
- Timeliness of service is based on the ability to provide service. The distribution of work should take into account the nurse's planned and unplanned time away from work, and other ongoing work assignments such as 'Healthy Baby' groups.

Training New Staff

As soon as possible Managers should request access and submit the relevant documentation to the eHealth HelpDesk. Get the form at <http://services.manitoba-ehealth.ca/acctManagement.html>

Use of the database is an integral part of the work of all staff. Untrained staff will eventually need formal training from CSIS in use of the database. Monthly training will be posted on the Orientation web page <http://www.wrha.mb.ca/extranet/publichealth/orientation.php> and registration requests can be emailed to CSIS_support@wrha.mb.ca.

In the meantime, untrained staff should pair up with experienced staff to learn how to use the database to do their work. They should also attend any scheduled training opportunities because we want to ensure that all staff knows how to enter data that is current, accurate and complete.

In the event the new staff member does not have their HPECD database access yet- another staff person can enter data on their behalf. This individual must sign and date an entry describing what they added, deleted or changed in the database within the client's paper chart. It is a requirement of all electronic information systems that the person making all additions, deletions or changes are tracked as well as the time these occurred.

New staff will not be able to select themselves as a Service provider until they have been given access to the database. This will make it impossible to select their name in visit tracking or in any other tab that requires this functionality. ***The staff person is responsible for keeping a list of the items they are unable to complete. They must back-enter it when they receive access to the database.***

8. Plan In the Event of an HPECD Database Outage: Business Continuity Plan

Scheduled Outages

The database will be shut down every Tuesday morning from 0300 hours to 0700 hours.

File System and Data Disaster Recovery

This plan is developed to address issues such as:

- planned or unplanned outages of the HPECD Database (The HPECD Database is part of the Collaborative Health Record [CHR])
- severed data cables, or
- other unforeseen disruptions caused by humans or the environment

All Population and Public Health (PPH) teams in:

- Community Area (CA),
- Prenatal Connections (PC),
- Healthy Sexuality and Harm Reduction (HSHR), and
- PPH Central Intake (CI)
- Weekend Services

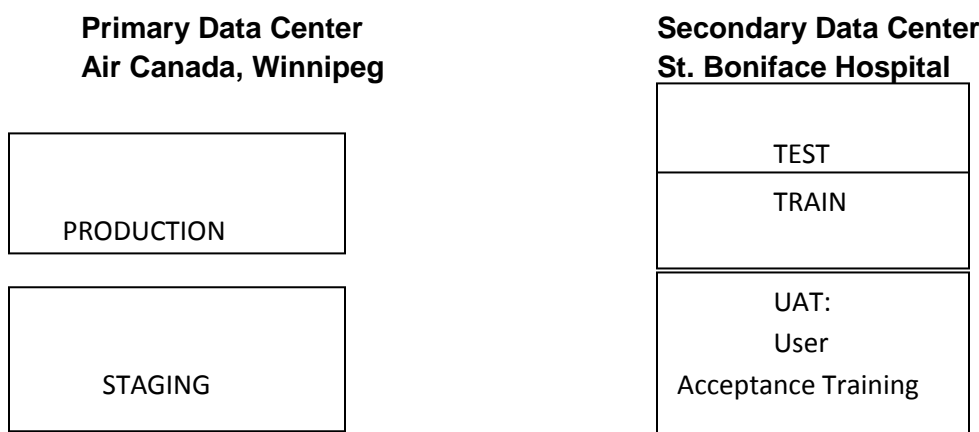
will be using the CHR. For the purposes of this plan there will be one protocol for PPH CI, and another for all other services.

Overview of System Design

The CHR is housed at the Air Canada building on Portage Ave. Winnipeg, with a backup system on a second power grid at St. Boniface Hospital, Winnipeg.

The system is designed to create redundancy by deploying both a production and staging environment that mirrors production. In the event of a prolonged Production outage the current production data would be copied to the Staging environment and the business redirected to Staging. This could take 30 minutes. If the problem can be fixed in an hour then the outage could take an hour.

Within each environment additional redundancy is provided with multiple web app servers.



Back up of all data is handled by eHealth. There is a full back up of the production environment database every 24 hours. Production Transaction logs are backed up every 2 hours.

Routine Preparation

In the event of a disruption of the systems either for planned upgrades or due to an unforeseen disaster staff may be unable to view the latest stored version of the CHR.

The following procedure is routinely carried out to prepare for the event where the CHR is not available.

- For CI including Weekend Services:
 - In the late afternoon of the first Thursday of every week a complete Referral Summary Report (to the beginning of the entries in the database) to date is run for all RHAs and another for each CA and saved as an Excel file on an encrypted memory stick
 - Late afternoon of every day of the week (except Thursday) the Referral Summary Report is run for the referrals for each RHA and CA from the previous Thursday to the current date and saved as an Excel file on an encrypted memory stick
- For all CAs, HSHR, and PC
 - In the afternoon of the first Thursday of every week a complete Referral Summary Report to date is run for your CA and saved as an Excel file on an encrypted memory stick
 - Late afternoon of every day of the week (except Thursday) the Referral Summary Report is run for the referrals for your CA from previous Thursday to the current date and saved as an Excel file on an encrypted memory stick.

This information can be sorted and used to help in the determination of who should be assigned cases in the event of a CHR outage.

Notification

For planned disruptions Manitoba eHealth will coordinate with the Population Health Initiatives Leader (PHIL) or designate. Notice will be given at least 48 hours in advance. The PHIL or designate has authority to activate the business continuity plan for CHR outage.

For unplanned disruptions of the CHR, authority for activation of the business continuity plan will come from the Centralized Manager of Facility and Support Services or designate for Centralized Intake, and from Team Managers or their designate for all other users, The PHIL or their designate should be notified.

In communication with eHealth within the first half hour of the unplanned disruption it will be determined if the problem can be fixed within another 60 minutes. If it is determined that the disruption will be longer than 60 minutes then a plan will be activated to move the business to the “unbroken” environment to allow staff to document in that environment.

Activation

The individual that takes responsibility for activating the business continuity plan will instruct all staff on shift by e mail, voice mail or in person to activate the business continuity plan for the CHR and to change from electronic processes to paper until further notice.

If the CHR is not available to CI, then CI will notify all CAs, PC and HSHR by email or fax.

If CHR is not available to CAs, PC or HSHR; these sites will inform CI by email, or fax.

Standard Procedures in the Event of a Disruption of Service

PPH CI and Weekend Services

1. Referrals will be assigned to a site by first looking at the backed up excel files (see Phase 1) and the postal code conversion file on Insite to determine CA of assignment.
2. On regular work days referrals will be faxed to CAs, HSHR and PC using a fax cover sheet to summarize the referrals sent.
3. Paper copies of the following forms will be maintained by the Admin staff for entry at a time when the database is up and running
 - Referrals sent to CAs, PC and HSHR.
 - Fax cover sheets that summarize referrals sent to CAs, HSHR and PC.

CAs, PC and HSHR

1. Referrals will be assigned to PHNs and Home Visitors by first reviewing information in the backed up excel files (see ‘Routine Preparation’).

2. Paper copies of the following forms will be maintained by the Admin staff for entry at a time when the database is up and running
 - Referrals sent to CA, PC and HSHR.
 - Any other paper forms (Breast Feeding Clinic, Families Screening or Assessment) or other data (e.g., visit information, changes to demographic information) that needs to be entered will be created and maintained in written format.

Data Re-Entry

Upon notification that the CHR is reactivated, data entry for past referrals will begin. Typically this will occur within one work day. The priority is to enter data regarding referrals. It is the responsibility of the CA, PC or HSHR to initiate and complete all data entry that would normally have been done by CI, when CI has sent a referral to a service delivery site without entering data because the CHR was not available,

Wrap Up

Team Managers follow up to verify that all client records have been entered or updated.

Outage debrief will be scheduled by the Population Health Initiatives Leader.

Appendix A: Breastfeeding Clinic Visit Summary

Fax ONLY Group Information (top section only) to Carolyn Perchuk in the Transcona Office.

Clinic Date	PHN name	Community Area of Clinic	Number Attending Group
Issues discussed in group:	<input type="checkbox"/> Slow to gain <input type="checkbox"/> Decreased milk supply <input type="checkbox"/> Sore nipples <input type="checkbox"/> Difficulty/not latching <input type="checkbox"/> Hydration <input type="checkbox"/> Thrush <input type="checkbox"/> Plugged ducts/mastitis <input type="checkbox"/> Engorgement	<input type="checkbox"/> Oversupply <input type="checkbox"/> Prematurity <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Infant illness <input type="checkbox"/> Maternal illness <input type="checkbox"/> Medications	<input type="checkbox"/> Not confident <input type="checkbox"/> Reflux <input type="checkbox"/> Weaning <input type="checkbox"/> Weight check <input type="checkbox"/> Other - Details of other
Individual Information			
Given Name			
Surname			
Birth Date			
PHIN			
Permanent RHA	<input type="checkbox"/> Northern <input type="checkbox"/> Interlake-Eastern <input type="checkbox"/> Prairie Mountain <input type="checkbox"/> Southern <input type="checkbox"/> Winnipeg <input type="checkbox"/> Other	<input type="checkbox"/> Northern <input type="checkbox"/> Interlake-Eastern <input type="checkbox"/> Prairie Mountain <input type="checkbox"/> Southern <input type="checkbox"/> Winnipeg <input type="checkbox"/> Other	<input type="checkbox"/> Northern <input type="checkbox"/> Interlake-Eastern <input type="checkbox"/> Prairie Mountain <input type="checkbox"/> Southern <input type="checkbox"/> Winnipeg <input type="checkbox"/> Other
Support person attended	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
First visit	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes
Infant age	<input type="checkbox"/> Days if < month <input type="checkbox"/> Weeks if ≥ 1 month	<input type="checkbox"/> Days if < month <input type="checkbox"/> Weeks if ≥ 1 month	<input type="checkbox"/> Days if < month <input type="checkbox"/> Weeks if ≥ 1 month
Referred by	<input type="checkbox"/> PHN <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Self <input type="checkbox"/> Other	<input type="checkbox"/> PHN <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Self <input type="checkbox"/> Other	<input type="checkbox"/> PHN <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Self <input type="checkbox"/> Other
Issues	<input type="checkbox"/> Difficulty/not latching <input type="checkbox"/> Hydration <input type="checkbox"/> Slow to gain <input type="checkbox"/> Decreased milk supply <input type="checkbox"/> Sore nipples <input type="checkbox"/> Thrush <input type="checkbox"/> Plugged ducts/mastitis <input type="checkbox"/> Engorgement <input type="checkbox"/> Oversupply <input type="checkbox"/> Prematurity <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Infant illness <input type="checkbox"/> Maternal illness <input type="checkbox"/> Medications <input type="checkbox"/> Not confident <input type="checkbox"/> Reflux <input type="checkbox"/> Weaning <input type="checkbox"/> Weight check <input type="checkbox"/> Other Details of other	<input type="checkbox"/> Difficulty/not latching <input type="checkbox"/> Hydration <input type="checkbox"/> Slow to gain <input type="checkbox"/> Decreased milk supply <input type="checkbox"/> Sore nipples <input type="checkbox"/> Thrush <input type="checkbox"/> Plugged ducts/mastitis <input type="checkbox"/> Engorgement <input type="checkbox"/> Oversupply <input type="checkbox"/> Prematurity <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Infant illness <input type="checkbox"/> Maternal illness <input type="checkbox"/> Medications <input type="checkbox"/> Not confident <input type="checkbox"/> Reflux <input type="checkbox"/> Weaning <input type="checkbox"/> Weight check <input type="checkbox"/> Other Details of other	<input type="checkbox"/> Difficulty/not latching <input type="checkbox"/> Hydration <input type="checkbox"/> Slow to gain <input type="checkbox"/> Decreased milk supply <input type="checkbox"/> Sore nipples <input type="checkbox"/> Thrush <input type="checkbox"/> Plugged ducts/mastitis <input type="checkbox"/> Engorgement <input type="checkbox"/> Oversupply <input type="checkbox"/> Prematurity <input type="checkbox"/> Failure to thrive <input type="checkbox"/> Infant illness <input type="checkbox"/> Maternal illness <input type="checkbox"/> Medications <input type="checkbox"/> Not confident <input type="checkbox"/> Reflux <input type="checkbox"/> Weaning <input type="checkbox"/> Weight check <input type="checkbox"/> Other Details of other
Interventions	<input type="checkbox"/> Position/latch assist <input type="checkbox"/> Supplementation <input type="checkbox"/> Milk expression/pump <input type="checkbox"/> Nipple shield <input type="checkbox"/> Nipple care <input type="checkbox"/> Education <input type="checkbox"/> Discuss medications <input type="checkbox"/> Confidence building / reassurance <input type="checkbox"/> Refer to primary caregiver <input type="checkbox"/> Other Details of other	<input type="checkbox"/> Position/latch assist <input type="checkbox"/> Supplementation <input type="checkbox"/> Milk expression/pump <input type="checkbox"/> Nipple shield <input type="checkbox"/> Nipple care <input type="checkbox"/> Education <input type="checkbox"/> Discuss medications <input type="checkbox"/> Confidence building / reassurance <input type="checkbox"/> Refer to primary caregiver <input type="checkbox"/> Other Details of other	<input type="checkbox"/> Position/latch assist <input type="checkbox"/> Supplementation <input type="checkbox"/> Milk expression/pump <input type="checkbox"/> Nipple shield <input type="checkbox"/> Nipple care <input type="checkbox"/> Education <input type="checkbox"/> Discuss medications <input type="checkbox"/> Confidence building / reassurance <input type="checkbox"/> Refer to primary caregiver <input type="checkbox"/> Other Details of other
Minutes of Visit			

Note: The visit summary should not be placed in or replace documentation in the paper health record.