



Health – FSC Job Aid

The *Health* screen allows users to document Household Member's pregnancies, basic health information, and child/youth health information.

Health

Pregnancy Health Child/Youth Info

Father's Name	Approx Due Date	Receiving Prenatal Care?	Pregnancy Outcome	Single or Multiple Delivery	Attended 6 Week check-up?

Show 10 entries First Previous 1 Next Last

Father's Name *
-Select- First Name Last Name

Approximate Due Date *
-Select- Begun receiving prenatal care? *
-Select- Approximate Begin Date

Weeks pregnant at first visit
-Select- Did staff assist Member in getting prenatal care?
-Select- Name of health clinic, obstetrician or family physician who will provide prenatal care

Same as prenatal facility
☐ Facility where member plans to deliver the baby
Smoking during pregnancy?
-Select- Stopped smoking Prior to delivery
-Select-

Drinking during pregnancy?
-Select- Stopped drinking Prior to delivery
-Select- Pregnancy Outcome
-Select-

Single birth or multiple delivery?
-Select-

Length at birth (Inches) Gestational age at birth (Weeks) Mother attended 6 week check-up?
-Select- Date of 6 month check-up

New Save

Navigation

- From the **Dashboard**: Locate the desired Case and click on the *Case ID* to bring the Case into focus.
 - Click on the **Case Information** tile. Then click on the **Health** tile.



Pregnancy tab

1. Select an individual by clicking on that individual's name in the *Household Member List*. That individual's line in the grid will turn grey to show that it has been selected.

The screenshot shows a web application interface. At the top, there's a 'Household Member List' tab. Below it is a table with columns: Member Name, Legal Sex, Birth Date, Relationship to HOH, and Source. The table contains two rows: Sally Sunset (Female, 01/02/2001, Self, FSC) and Sam Sunset (Male, 02/03/1995, Brother, FSC). A mouse cursor is hovering over Sally Sunset's name. Below the table is a 'Show 10 entries' dropdown and pagination links: First, Previous, 1, Next, Last. Below this is a 'Pregnancy' tab. It has sub-tabs: Pregnancy, Health, and Child/Youth Info. The 'Pregnancy' sub-tab is active, showing a table with columns: Father's Name, Approx Due Date, Receiving Prenatal Care?, Pregnancy Outcome, Single or Multiple Delivery, and Attended 6 Week check-up?. The table contains one row: Joe Smith, 08/30/2017, No, (empty), (empty), (empty). A trash icon is to the right of the row. Below the table is a 'Show 10 entries' dropdown and pagination links: First, Previous, 1, Next, Last. At the bottom of the 'Pregnancy' tab are two buttons: 'New' and 'Save'.

2. In the **Pregnancy** tab below the *Household Member* grid, update or document the individual's pregnancy information:
 - a. To view or edit existing pregnancy information click on the record's line in the *Pregnancy* grid.
 - b. Click **New** to add a new pregnancy record.
 - c. Click **Save** to save any information that has been entered or updated.
 - d. To delete a pregnancy record, click the Delete Icon [] to the right of the record in the *Pregnancy* grid. A *Confirm Delete* pop-up will appear:

A modal dialog box titled 'Confirm Delete'. It contains the text 'Are you sure you want to delete this record?' and two buttons: 'Yes' and 'No'.

Clicking **Yes** will delete the record.

Clicking **No** will cancel the action and the record will not be deleted.



3. Completing the **Pregnancy** tab:

The screenshot shows the 'Pregnancy' tab of a web application. At the top, there are three tabs: 'Pregnancy', 'Health', and 'Child/Youth Info'. Below the tabs is a table with columns: 'Father's Name', 'Approx Due Date', 'Receiving Prenatal Care?', 'Pregnancy Outcome', 'Single or Multiple Delivery', 'Attended 6 Week check-up?', and an action column with a trash icon. The first row of the table contains the data: 'Joe Smith', '08/30/2017', 'No', an empty field, an empty field, an empty field, and the trash icon. Below the table, there is a 'Show' dropdown set to '10' and 'entries', and pagination links: 'First', 'Previous', '1', 'Next', 'Last'. The form below the table has several sections, each with a red callout letter:

- A**: Points to the 'Father's Name' dropdown menu.
- B**: Points to the 'Approximate Due Date' text input field.
- C**: Points to the 'Approximate Begin Date' text input field.
- D**: Points to the 'Weeks pregnant at first visit' text input field.
- E**: Points to the 'Did staff assist Member in getting prenatal care?' dropdown menu.
- F**: Points to the 'Name of health clinic, obstetrician or family physician who will provide prenatal care' text input field.
- G**: Points to the 'Facility where member plans to deliver the baby' text input field.
- H**: Points to the 'Stopped smoking Prior to delivery' dropdown menu.
- I**: Points to the 'Stopped drinking Prior to delivery' dropdown menu.
- J**: Points to the 'Pregnancy Outcome' dropdown menu.
- K**: Points to the 'Single birth or multiple delivery?' dropdown menu.
- L**: Points to the 'Length at birth (Inches)' text input field.
- M**: Points to the 'Gestational age at birth (Weeks)' text input field.
- N**: Points to the 'Date of 6 month check-up' text input field.

At the bottom of the form are two buttons: 'New' and 'Save'.

- Father's Name, First Name, Last Name:** Select the name of the father from the *Father's Name* drop-down. If the father's name is known, but it is not listed in the drop-down, select "Other" and type the father's name in the *First Name* and *Last Name* fields.
- Approximate Due Date:** Enter the approximate due date for this pregnancy.
- Begun receiving prenatal care? and Approximate Begin Date:** Indicate whether or not the Member has begun receiving prenatal care by selecting "Yes" or "No" from the drop-down. If the answer is "Yes" enter the approximate date that prenatal care began.
- Weeks pregnant at first visit:** If the Member has begun receiving prenatal care, enter approximately how many weeks pregnant the mother was at the time of the first prenatal care visit.
- Did staff assist Member in getting prenatal care?:** Indicate whether or not FSC staff assisted in getting prenatal care by selecting "Yes" or "No" from the drop-down.



- f. *Name of health clinic, obstetrician or family physician who will provide prenatal care:* Enter who is providing prenatal care.
- g. *Facility where member plans to deliver the baby:* If this is the same as the facility providing prenatal care check the ☐ *Same as prenatal facility* checkbox. Otherwise, enter the planned delivery facility here.
- h. *Smoking during pregnancy? / Stopped smoking prior to delivery:* Indicate whether or not the member was smoking during the pregnancy by selecting "Yes", "No" or "Declined to answer" from the drop-down. If the answer is "Yes" indicate whether or not the Member stopped smoking prior to delivery using the drop-down.
- i. *Drinking during pregnancy? / Stopped drinking prior to delivery:* Indicate whether or not the member was drinking during the pregnancy by selecting "Yes", "No" or "Declined to answer" from the drop-down. If the answer is "Yes" indicate whether or not the Member stopped drinking prior to delivery using the drop-down.
- j. *Pregnancy Outcome:* If known, select the outcome of this pregnancy from the drop-down.
- k. *Single birth or multiple delivery?:* Indicate whether this pregnancy resulted in a single birth or multiple delivery using the drop-down.
- l. *Length at birth (inches):* Enter the infant's length at birth in inches.
- m. *Gestational age at birth (weeks):* Enter the infants gestational age at birth in weeks.
- n. *Mother attended 6 week check-up?:* Indicate whether the Member attended the 6 week check-up by selecting "Yes", "No" or "Declined to answer" from the drop-down. If the answer is "Yes" enter the date or estimated date of the 6 month follow up appointment.

4. Once the Pregnancy tab has been completed:

- a. Click Save to save any information that has been entered or updated.
- b. Click New to add a new pregnancy record.



Health tab

1. Select an individual by clicking on that individual's name in the *Household Member List*. That individual's line in the grid will turn grey to show that it has been selected.

Household Member List

Member Name	Legal Sex	Birth Date	Relationship to HOH	Source
Sally Sunset	Female	01/02/2001	Self	FSC
Sam Sunset	Male	02/03/1995	Brother	FSC

Show 10 entries First Previous 1 Next Last

Pregnancy Health Child/Youth Info

Diagnosis

Appointment Date	Diagnosis System	Priority Group	Source System
05/01/2017	ICD-10-CM	Adult target population 1	FSC

Show 10 entries First Previous 1 Next Last

New Assessment

Diagnosis System *
ICD-10-CM

Appointment Date
05/01/2017

Priority Group
Adult target population 1

Axis/Category	Sub-Category	Type	Diagnosis Code	Diagnosis
Mental, Behavioral and Neurodevelopmental disorders (F01-F99)	F40-F48 Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	Primary	F41.9	Anxiety disorder, unspecified

Save Diagnosis

Hospitalization/Treatment

Type	Hospital/Facility	Entry Date	End Date	System	Notes
Physical Health	Allegheny General Hospital	04/03/2017	04/05/2017	FSC	Broken wrist.

Show 10 entries First Previous 1 Next Last

Save Hospitalization

Medication

Medication	Start Date	End Date	Prescribed by	Dosage	Frequency
Singulair Tablets	01/02/2017		Dr. Jones	10 mg	1x/day

Show 10 entries First Previous 1 Next Last

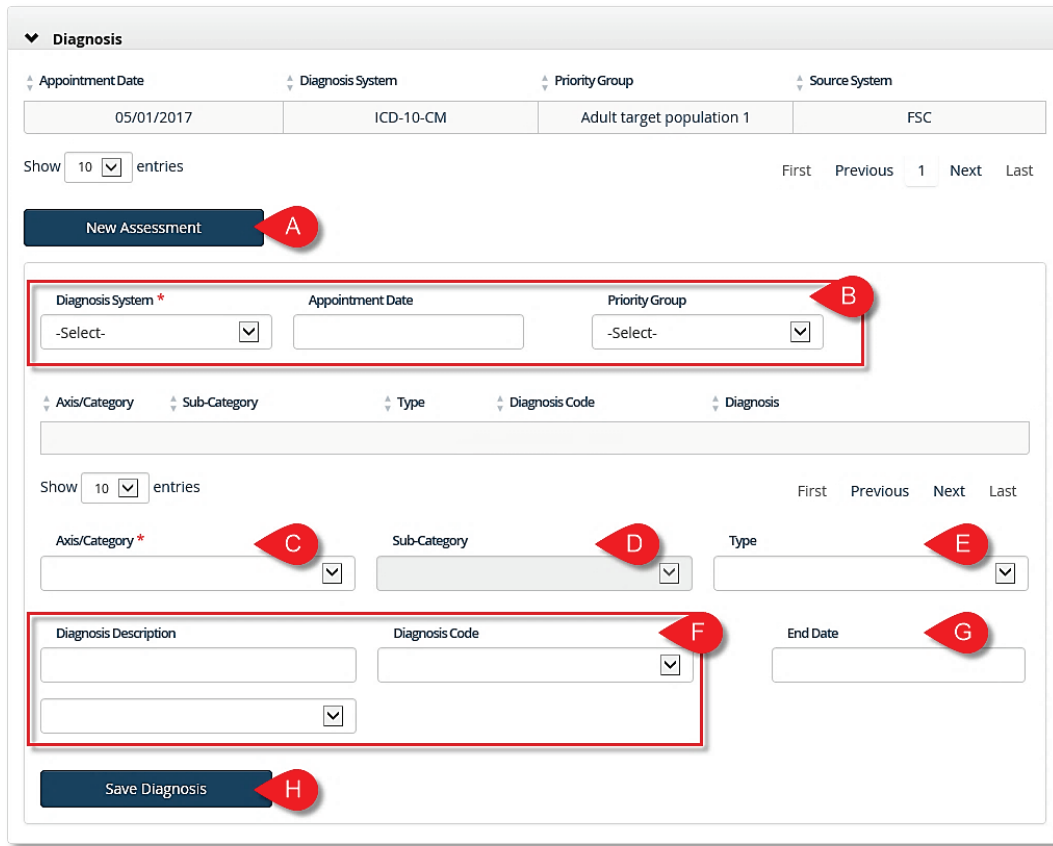
Save Medication



2. **▼ Diagnosis**: Update or document the individual's diagnosis information. Note: Diagnoses can be physical health or mental health diagnoses.
 - a. To view or edit existing diagnosis information click on the record's line in the *Diagnosis* grid.
 - b. Click **New Assessment** to add a new diagnosis.
 - c. Click **Save Diagnosis** to save any information that has been entered or updated.
 - d. To delete a diagnosis record, click the Delete Icon [] to the right of the record in the *Diagnosis* grid.
 - i. A *Confirm Delete* pop-up will appear: Clicking **Yes** will delete the record.
Clicking **No** will cancel the action and the record will not be deleted.
3. **▼ Hospitalization/Treatment**: Update or document the individual's hospitalization/treatment information. Note: Hospitalizations can be physical health and/or mental health hospitalizations.
 - a. To view or edit existing hospitalization/treatment information click on the record's line in the *Hospitalization/Treatment* grid.
 - b. Enter or update hospitalization/treatment information.
 - c. Click **Save Hospitalization** to save any information that has been entered or updated.
 - d. To delete a hospitalization/treatment record, click the Delete Icon [] to the right of the record in the *Hospitalization/Treatment* grid.
 - i. A *Confirm Delete* pop-up will appear: Clicking **Yes** will delete the record.
Clicking **No** will cancel the action and the record will not be deleted.
4. **▼ Medication**: Update or document the individual's medication information.
 - a. To view or edit existing medication information click on the record's line in the *Medication* grid.
 - b. Enter or update medication information.
 - c. Click **Save Medication** to save any information that has been entered or updated.
 - d. To delete a medication record, click the Delete Icon [] to the right of the record in the *Medication* grid.
 - i. A *Confirm Delete* pop-up will appear: Clicking **Yes** will delete the record.
Clicking **No** will cancel the action and the record will not be deleted.

Completing the Health – Diagnosis section

1. **Diagnosis**: Enter the Member's diagnosis information. Diagnoses can be physical or mental health diagnoses.



- To document a new diagnosis click **New Assessment** below the *Diagnosis* grid. This will open up the *Diagnosis* details section.
- Diagnosis System**: Select the diagnostic system associated with the diagnosis from the drop-down. Note that "Self-Reported" is also an option.
Appointment Date: If known, enter the appointment date when the diagnosis was made.
Priority Group: Select the associated Priority Group from the drop-down. If the Priority Group is unknown select "Unknown" from the drop-down.
- Axis/Category**: Select the Axis or Category for the diagnosis from the drop-down.
- Sub-Category**: Select the Sub-Category for the diagnosis from the drop-down. Note that the Sub-Category cannot be selected until an Axis/Category has been selected. These options will change based on which Axis/Category is selected.
- Type**: Select whether the diagnosis is Primary or Secondary.



- f. Select either the *Diagnosis Description* or the *Diagnosis Code*. When one is selected the other will automatically update.

EXAMPLE:

Choosing *Mild persistent asthma* in the *Diagnosis Description* drop-down will cause the associated diagnosis code (*J45.3*) to be automatically selected in the *Diagnosis Code* drop-down.

Selecting *J45.3* from the *Diagnosis Code* drop-down will cause the diagnosis of *Mild persistent asthma* to be automatically selected in the *Diagnosis Description* drop-down.

If this is a self-reported diagnosis, type the diagnosis in the *Diagnosis Description* text field and leave the drop-down and *Diagnosis Code* drop-down blank.

Example:

Diagnosis System * Appointment Date Priority Group

Self Reported 05/01/2017 -Select-

Axis/Category Sub-Category Type Diagnosis Code Diagnosis

Show 10 entries First Previous Next Last

Axis/Category * Sub-Category Type

Mental, Behavioral and Neurodevelopmental -Select- -Select-

Diagnosis Description Diagnosis Code End Date

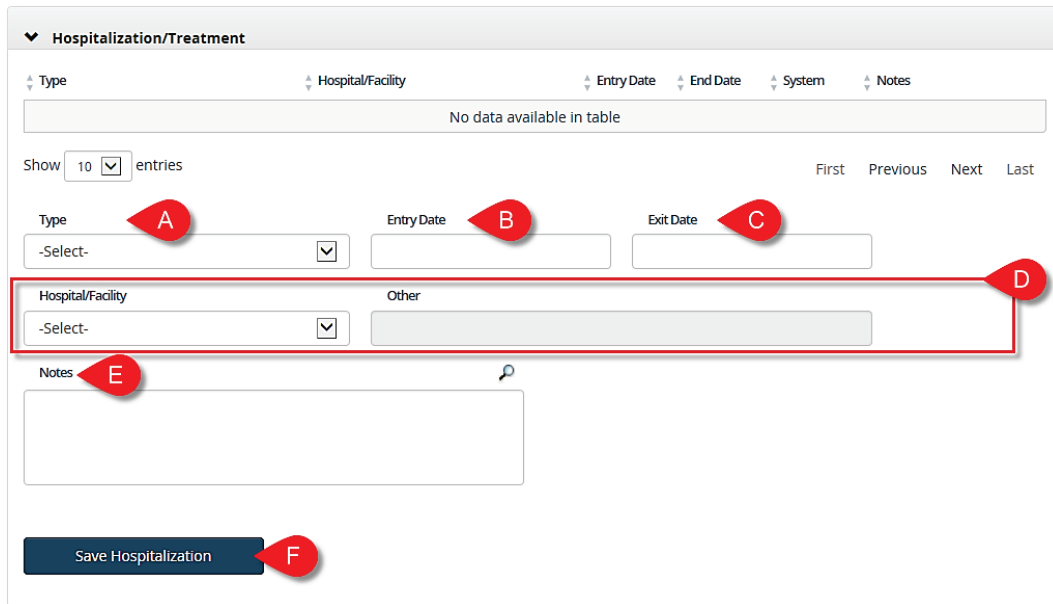
Depression -Select-

Save Diagnosis

- g. *End Date*: If applicable, enter an end date for the diagnosis.
- h. Click **Save Diagnosis** to add the diagnosis to the grid below the *Diagnosis System/Appointment Date/Priority Group*. Multiple diagnoses can be documented under a single *Appointment Date*.

Completing the Health – Hospitalization/Treatment section

1. **Hospitalization/Treatment**: Document hospitalizations/treatments for the Member.



The screenshot shows the 'Hospitalization/Treatment' form. At the top, there is a table header with columns: Type, Hospital/Facility, Entry Date, End Date, System, and Notes. Below the header, a message states 'No data available in table'. Below this, there is a 'Show 10 entries' dropdown and navigation links: First, Previous, Next, Last. The form fields are labeled with red circles and letters: A points to the 'Type' dropdown, B points to the 'Entry Date' field, C points to the 'Exit Date' field, D points to the 'Hospital/Facility' dropdown and the 'Other' text field, E points to the 'Notes' text area, and F points to the 'Save Hospitalization' button.

- a. *Type*: Select the type of Hospitalization or Treatment from the drop-down.
- b. *Entry Date*: Enter the date that the Hospitalization or Treatment began.
- c. *Exit Date*: If applicable, enter the date that the Hospitalization or Treatment ended.
- d. *Hospital/Facility*: Select the Hospital or Facility providing treatment from the drop-down. If the Hospital or Facility is not in the drop-down list, select "Other" from the drop-down and enter the name of the Hospital/Facility in the *Other* field.
- e. *Notes*: Use the *Notes* narrative field to include information on the Hospitalization or Treatment.
- f. Click **Save Hospitalization** to save the Hospitalization or Treatment to the *Hospitalization/Treatment* grid.

Completing the Health – Medication section

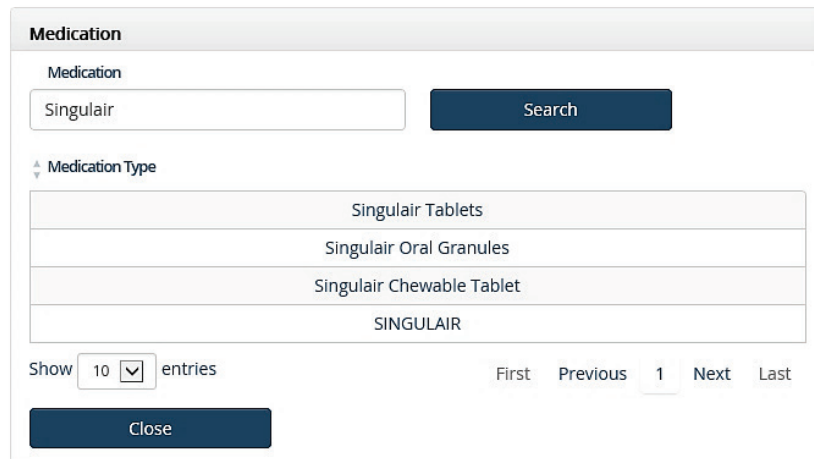
1. **Medication**: Medications for the Member can be documented here.



The screenshot shows the 'Medication' form with the following fields and callouts:

- A**: Search icon (three dots) next to the Medication field.
- B**: Start Date field.
- C**: End Date field.
- D**: Strength/Unit dropdown menu.
- E**: Prescribed by field.
- F**: Contact phone field.
- G**: Dosage field.
- H**: Frequency field.
- I**: Special Instructions field.
- J**: Verified checkbox.
- K**: Save Medication button.

- a. Click **...** to the right of the Medication field to search for a medication. The *Medication* pop-up will appear.



The screenshot shows the 'Medication' pop-up window with the following fields and buttons:

- Medication**: Text input field containing 'Singulair'.
- Search**: Button to search for the medication.
- Medication Type**: Grid showing a list of medication types: Singulair Tablets, Singulair Oral Granules, Singulair Chewable Tablet, and SINGULAIR.
- Show**: 10 entries (dropdown menu).
- First**, **Previous**, **1**, **Next**, **Last**: Navigation buttons.
- Close**: Button to close the pop-up.

- i. Type the name of the Medication in the *Medication* field and click **Search**.
- ii. Review the list to locate the correct medication. Once the correct medication is located, click on the name of the medication in the *Medication Type* grid.
- iii. If the medication cannot be located type "other" in the Medication field and click **Search**. Then select "Other" from the *Medication Type* grid.
- iv. After selecting the medication click **Close** to close the *Medication* pop-up.



- b. *Start Date* and *End Date*: If known, enter the date the client began using the medication. If applicable, enter the date the client stopped using the medication.
- c. *Type*: Select the type of medication, Over-the-counter or Prescription.
- d. *Strength/Unit*: Select the strength/unit from the drop-down. The options in this drop-down will include the available strength or unit options for the selected medication. If the medication is "Other" the Strength/Unit options will be "Other" or "Unknown".
- e. *Prescribed By* and *Contact Phone*: If known, enter the name of the prescribing professional and their contact phone number.
- f. *Purpose*: If known, enter the purpose of the medication.
- g. *Dosage*: Enter the medication dosage here.
- h. *Frequency*: Enter the medication frequency.
- i. *Special Instructions*: If applicable, enter any special instructions here.
- j. *Verified*: If this medication information has been verified check the *Verified* ☒ checkbox.
- k. Click  to save the medication to the *Medication* grid.



Child/Youth Info tab

1. Select a child/youth by clicking on that individual's name in the *Household Member List*. That individual's line in the grid will turn grey to show that it has been selected.

The screenshot shows the 'Household Member List' grid with two entries: Sally Sunset and Sam Sunset. Sally Sunset is selected, indicated by a grey background and a hand cursor. Below the grid is a 'Show 10 entries' dropdown and pagination controls. Below the grid is a tabbed interface with 'Pregnancy', 'Health', and 'Child/Youth Info' tabs. The 'Child/Youth Info' tab is active, showing a grid with columns: Immunizations Up-to-Date, Lead Screening, Well-Child Care, Sees Dentist?, Under 5 Pound 8 Ounces, and Single or Multiple Delivery?. The grid contains one row with values: Yes, Yes, Did Not Report, Did Not Report, Did Not Report, and Single Birth. Below the grid is a 'Show 10 entries' dropdown and pagination controls. At the bottom are 'New' and 'Save' buttons.

Member Name	Legal Sex	Birth Date	Relationship to HOH	Source
Sally Sunset	Female	01/02/2001	Self	FSC
Sam Sunset	Male	02/03/1995	Brother	FSC

Show 10 entries First Previous 1 Next Last

Pregnancy Health **Child/Youth Info**

Immunizations Up-to-Date	Lead Screening	Well-Child Care	Sees Dentist?	Under 5 Pound 8 Ounces	Single or Multiple Delivery?
Yes	Yes	Did Not Report	Did Not Report	Did Not Report	Single Birth

Show 10 entries First Previous 1 Next Last

New Save

2. In the **Child/Youth Info** tab below the *Household Member* grid, update or document the individual's child/youth health information:
 - a. To view or edit existing child/youth health information click on the record's line in the *Child/Youth Info* grid.
 - b. Click **New** to add a new child/youth health information record.
 - c. Click **Save** to save any information that has been entered or updated.



- d. To delete a child/youth health information record, click the Delete Icon [] to the right of the record in the *Child/Youth Info* grid. A *Confirm Delete* pop-up will appear:

Confirm Delete

Are you sure you want to delete this record?

Clicking will delete the record.

Clicking will cancel the action and the record will not be deleted.

3. The History Icon [] in the grid, when clicked, will open the *Child Youth History* pop-up. This pop-up contains a limited history of changes to this specific Child/Youth Info record including the *Start Date* and *End Date* of each update.

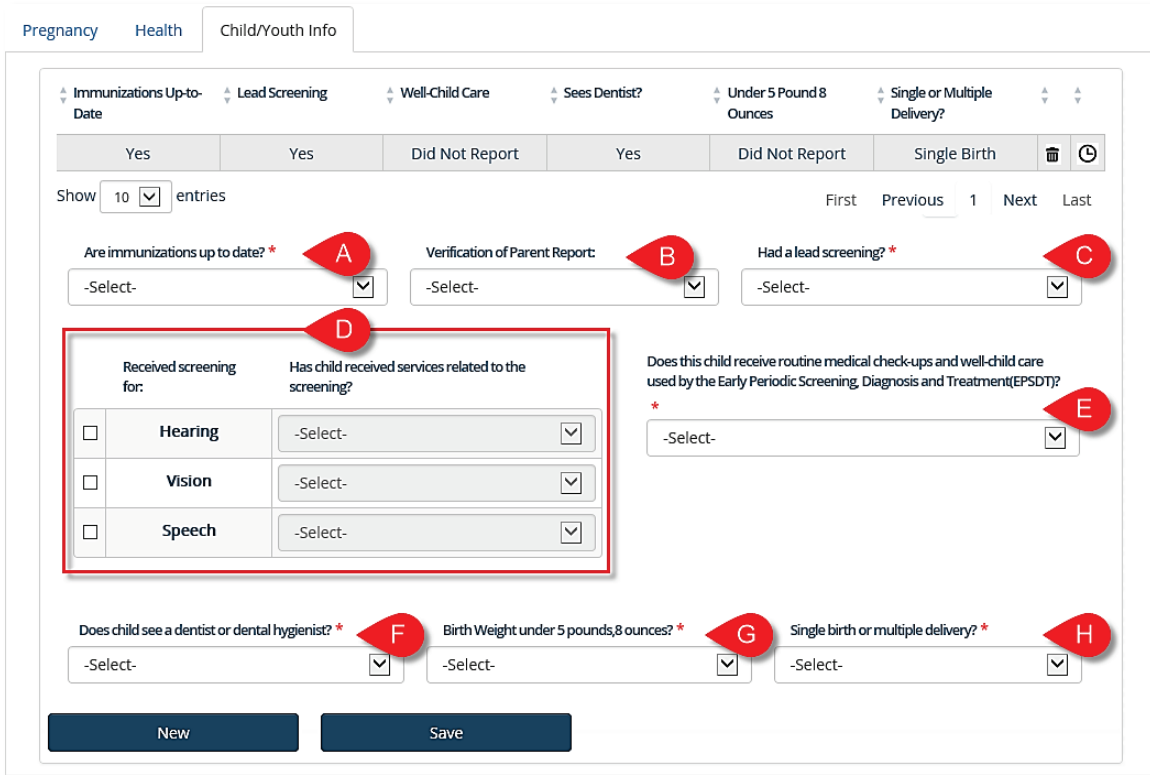
Child Youth History								
Immunizations Up-to-Date	Lead Screening	Well-Child Care	Sees Dentist?	Under 5 Pound 8 Ounces	Single or Multiple Delivery?	Start Date	End Date	UpdatedBy
No	Did Not Report	No	No	No	Multiple Delivery	4/24/2017 2:33:33 P M		Chimes, Dan
Yes	No	No	No	No	Single Birth	4/24/2017 2:31:42 P M	4/24/2017 2:33:33 P M	Davis, Amber

Show entries First Previous 1 Next Last

To close the *Child Youth History* pop-up, click .

Completing the Child/Youth Info tab

1. **Child/Youth Info** : Click **New** to add a new child/youth health information record.



The screenshot shows the 'Child/Youth Info' tab in a software interface. At the top, there are tabs for 'Pregnancy', 'Health', and 'Child/Youth Info'. Below the tabs is a table with columns for various health metrics: Immunizations Up-to-Date, Lead Screening, Well-Child Care, Sees Dentist?, Under 5 Pound 8 Ounces, and Single or Multiple Delivery. The table has a 'Yes' row and a 'Did Not Report' row. Below the table, there is a 'Show' dropdown set to '10' and a 'First' button. The form contains several dropdown menus and checkboxes, each labeled with a red callout letter: A (Are immunizations up to date?), B (Verification of Parent Report), C (Had a lead screening?), D (Received screening for: Hearing, Vision, Speech), E (Does this child receive routine medical check-ups and well-child care used by the Early Periodic Screening, Diagnosis and Treatment (EPSDT)?), F (Does child see a dentist or dental hygienist?), G (Birth Weight under 5 pounds, 8 ounces?), and H (Single birth or multiple delivery?). At the bottom, there are 'New' and 'Save' buttons.

- a. *Are immunizations up to date?*: Indicate whether or not the immunizations are up to date by selecting "Yes", "No" or "Did not report" from the drop-down.
- b. *Verification of Parent Report*: Indicate whether or not the parent's immunization report has been verified by selecting "Yes", "No" or "Did not report" from the drop-down.
- c. *Had a lead screening?*: Indicate whether or not the child/youth has had a lead screening by selecting "Yes", "No" or "Did not report" from the drop-down.
- d. *Received Screening for and Has child received services related to the screening?*: Check the checkbox next to each screening the child has received and indicate whether or not the Child is receiving services related to that screening by selecting "Yes" or "No" from the drop-down.
- e. *Does this child receive routine medical check-ups and well-child care used by the Early Periodic Screening, Diagnosis and Treatment (EPSDT)?*: Indicate whether or not the child/youth receives EPSDT check-ups/care by selecting "Yes", "No" or "Did not report" from the drop-down.



- f. *Does the child see a dentist or dental hygienist?*: Indicate whether or not the child/youth has seen a dentist/dental hygienist by selecting "Yes", "No" or "Did not report" from the drop-down.
- g. *Birth Weight under 5 pounds, 8 ounces?*: Indicate whether or not the child/youth's birth weight was under 5 lb., 8 oz. by selecting "Yes", "No" or "Did not report" from the drop-down.
- h. *Single birth or multiple delivery?*: Indicate whether this child was born as a single birth or part of a multiple delivery using the drop-down.
- i. Click  to save any information that has been entered or updated.

For more information...

For assistance, please contact the Allegheny County Service Desk at ServiceDesk@AlleghenyCounty.US or call 412-350-HELP (4357). Select Option 2 for the DHS Service Desk.

To access I-Service, go to: <https://servicedesk.alleghenycounty.us>

This and other Job Aids can be found at: <http://s3.amazonaws.com/dhs-application-support/index.htm>