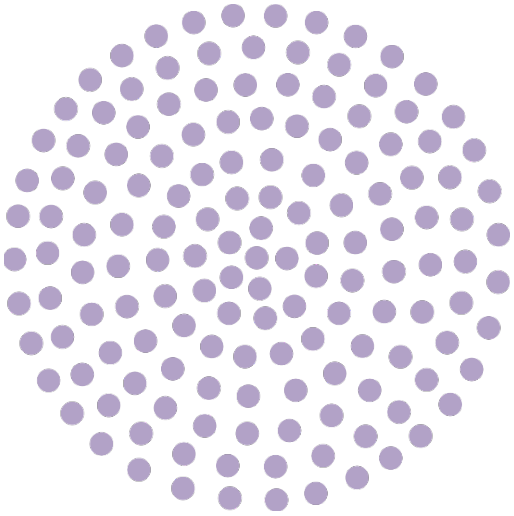
Guide to PRA|SPECT



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Guide #	Mini Guides by Topic	Community Home Visiting Staff	Community Home Visiting Supervisor	Community Health Worker Staff	Community Health Worker Supervisor	HUB Admin / Central Intake Specialist
1	PRA|SPECT Onboarding	x	x	x	x	x
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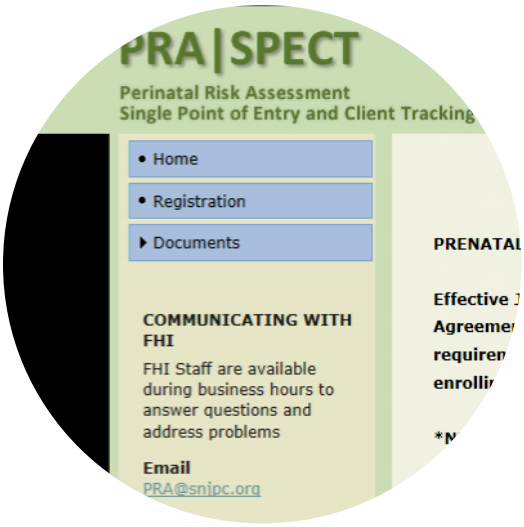
PRA|SPECT Onboarding

Getting Started

Registration and training are required to become a user of the PRA|SPECT www.praspect.org web portal. All new users or users requesting a different access type/level must do the following:

- ☐ Complete and submit the Database User Registration form
- ☐ Attend orientation training



Click Documents to view resource materials

To access the Database User Registration form:
Visit www.praspect.org > Click Documents > Click Community Based Services – Forms & Charts > Click Database User Registration Form

To register for orientation training:
Visit www.praspect.org > Click Documents > Click Community Based Services – Training Schedules > Click training schedule > Click desired date/time link to access event registration page > enter registration information > Click Register > User will receive an email with instructions and webinar link

Resource Materials

Educational materials are available on PRA|SPECT for print, download, or reference. The publication and version date will guide you in determining if updated information is available.

To access resource materials:
Visit www.praspect.org > Click Documents > Click Community Based Services – FAQs & User Guides

Post Training

Once you have completed orientation training, you will receive an email from PRA@snjpc.org with your account information. If you do not receive your login within (2) business days of training completion, email SPECT@snjpc.org

After training, we expect all users to stay current with updates made to the Community Based Services (CBS) referral and PRA/SPECT portal. Not sure you need details about the timing of the trainings. Regularly scheduled trainings are available. Repeat attendees are encouraged and live sessions enable users to ask questions in a training forum.

To register for supplemental trainings:
Visit www.praspect.org > Click Documents > Click Community Based Services – Training Schedules > Click training schedule > Click desired date/time link to access event registration page > enter registration information > Click Register > User will receive an email with instructions and webinar link

Post Training Recommendations:

- ☐ Add www.praspect.org to your browser favorites
- ☐ Review all user-specific guides and additional resource materials on www.praspect.org
- ☐ Print the List of Service Programs for RRAs for easy navigation of the linked type, program, and provider RRA dropdown menus
- ☐ Attend mini supplemental trainings
- ☐ Send all inquiries (questions, policy clarification, technical assistance, etc.) to SPECT@snjpc.org

Click Logoff prior to leaving computer

User Responsibility

Once you become a PRA|SPECT user, it is your responsibility to protect the sensitive information with which you work. You should not be logged into www.praspect.org unless you are physically in front of your device. Passwords should not be saved in browsers, and should be reentered each time the user logins to the web portal.

Protecting Sensitive Information:

- ☐ Always click the Logoff prior to stepping away from your device
- ☐ Do not include any personally identifiable information (PII) in the email subject line
- ☐ Only include client's first name and first letter of last name in the body of your email
- ☐ Get into the habit of viewing your referral forms online. If you print out referral forms, always ensure that this information is stored in a secure location.

Account Login

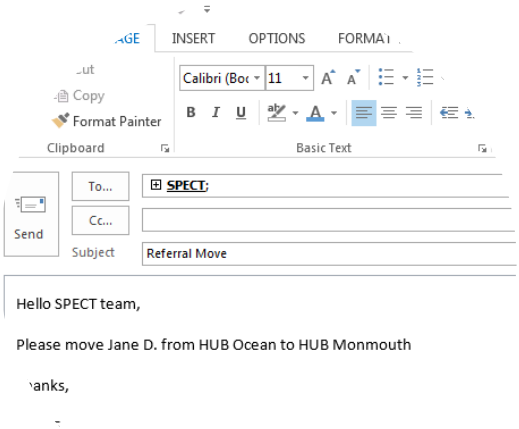
Access is intended for the named individual only and login credentials should never be shared. Should you forget your username or password, you can click the Forgot Password link to receive an email with your account login.

To change your password:
Login > Click User Administration > Click Account Update Options > Click Change Password > Enter current password > Enter new password (passwords should be at least 8 characters and contain at least one number and special character) > Enter confirmation of password > Enter security questions answer > Click Update Account

SPECT Inquiries

Consult PRA|SPECT FAQs documents prior emailing the SPECT team. The distribution list includes state leadership and FHI staff. All inquiries should be emailed to SPECT@snjpc.org

Be sure to include an inquiry-specific screenshot in the body of your email or attachment. Expect a reply from the SPECT triage team within (24) hours receipt of your inquiry.



Send all inquiries to SPECT@snjpc.org

- If referring to client from a PRA, use the number located in the bottom right corner of the form to address your inquiry (i.e. move referral w12345 to HUB Camden or cannot change record status for f54321)
- If referring to a client from a CHS, use the referral date and client's first name and first letter of the last name (i.e. move referral 05/23/16 Jane D. to HUB Hudson or cannot change record status on 05/23/16 Jane D.)

Account Deactivation

Agencies must email SPECT@snjpc.org as soon as possible if a registered user leaves the organization or goes out on extended leave of absence. The email should include the employee's full name and termination date or date of extended leave. Upon return of employee, reactivation requests should be emailed to SPECT@snjpc.org

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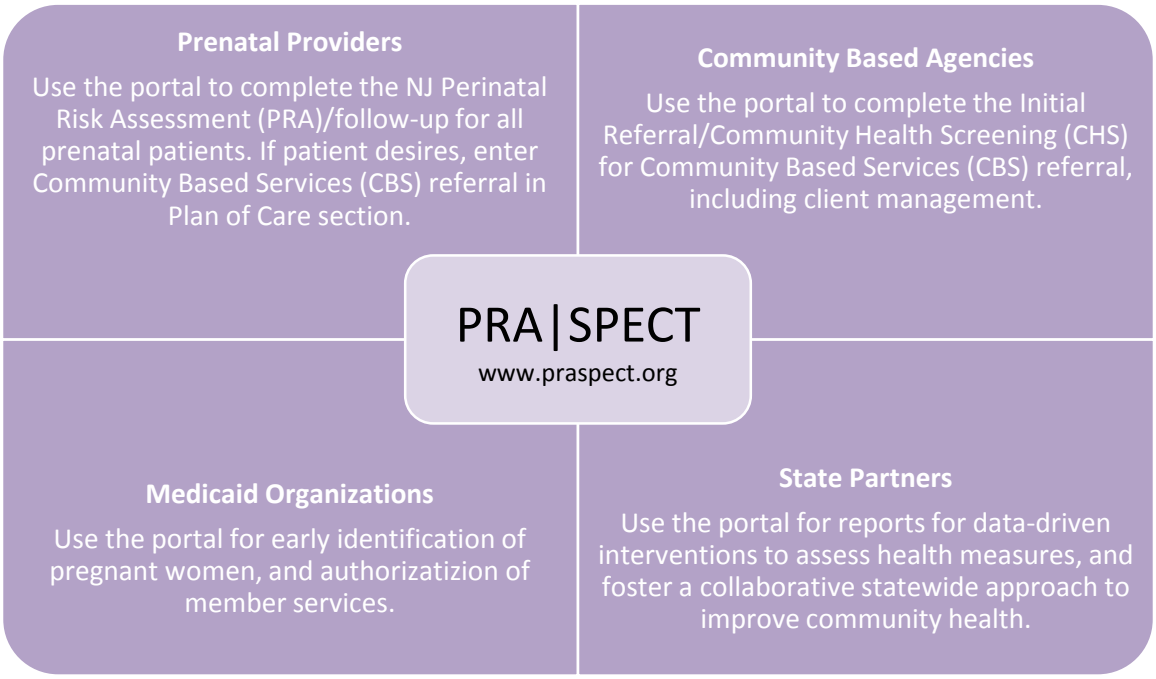
PRA|SPECT Overview

What is PRA|SPECT?

Perinatal Risk Assessment & Single Point Entry Client Tracking (PRA|SPECT) is New Jersey's online web portal www.praspect.org that serves as secure and integral system of care to streamline community health navigation. The portal affords the state's only uniform source of prenatal information for data driven efforts to improve maternal health and birth outcomes. Additionally, PRA|SPECT is the gateway for Community Based Services (CBS) referral to increase the health and wellbeing of New Jersey men, women, and children.

Who Uses PRA|SPECT?

Prenatal providers, community based agencies, Medicaid organizations, and state partners:



What is the Community Based Services (CBS) Referral?

The CBS referral links men, women, and children to local programs and services based upon individual needs. All CBS referrals get entered on PRA|SPECT, and triage to a Central Intake (CI HUB) based upon the county listed on the original referral form. The CI HUB determines individual eligibility, and hand selects an agency to work with the client. The community focus and duration of services varies per program. CBS agencies are classified in (3) general categories:

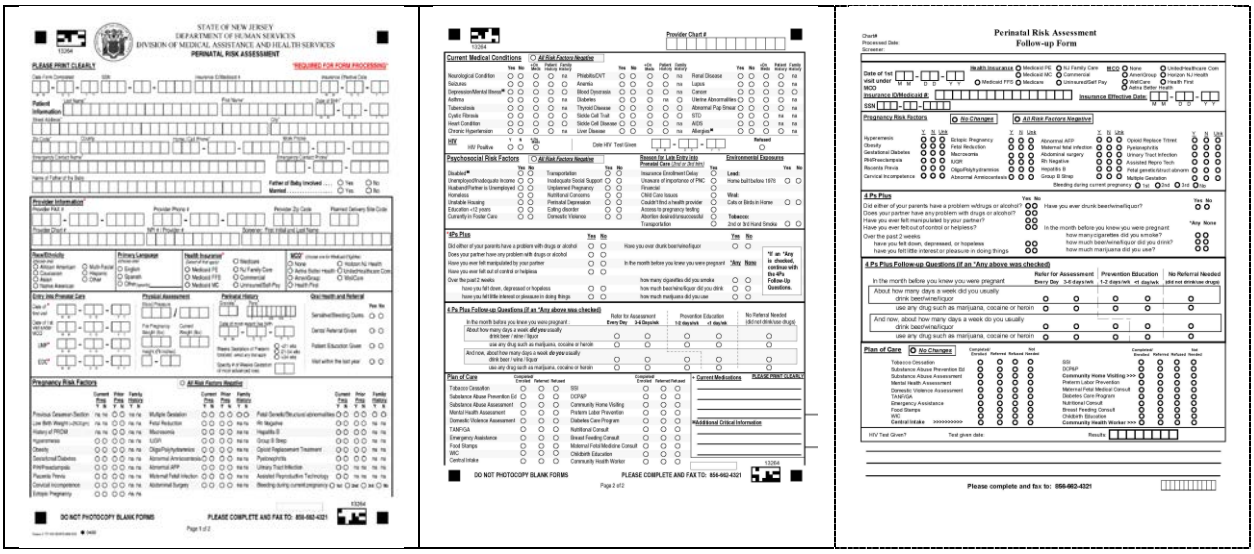
- Evidence-based Community Home Visiting (EBCHV), Community Home Visiting (CHV), and other core programs such as Healthy Families, Nurse Family Partnership, Parents as Teachers, and HIPPY
- Community Health Worker (CHW) and Healthy Start programs
- Central Intake (CI HUB) Managed services

How does the CBS referral get entered on PRA|SPECT?

The one-page Initial Referral Form (IRF) in conjunction with the two-page Community Health Screening (CHS) or the two-page Perinatal Risk Assessment (PRA) are the CBS referral forms.

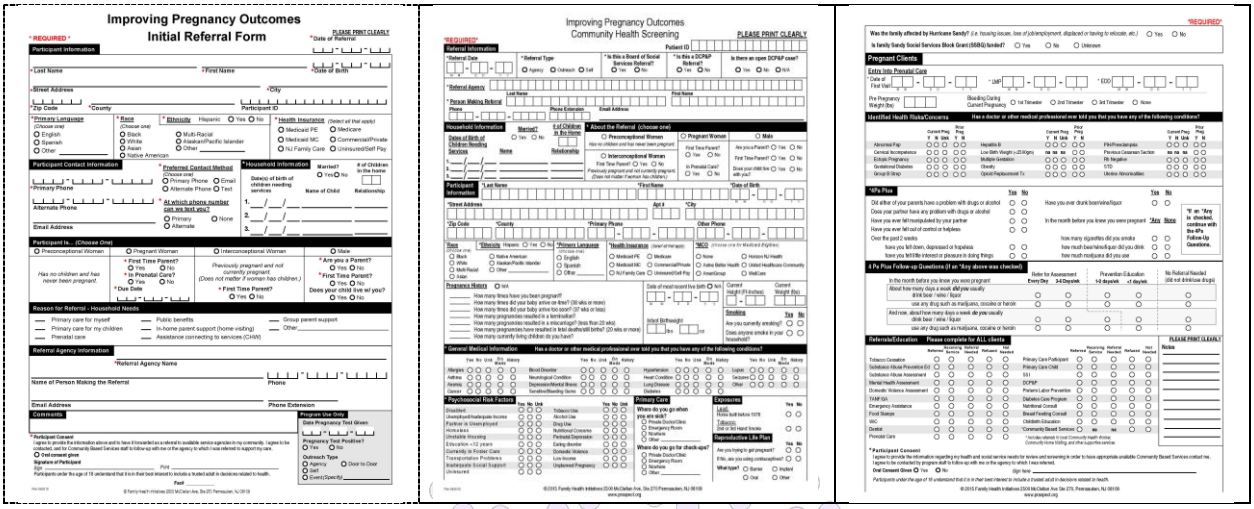
The PRA is completed at the first prenatal care visit for pregnant women. If not desired at the first visit, CBS referral can be entered at any point in time during the pregnancy through the postpartum visit via the one-page PRA Follow-up form. OB provider can view CBS referral Program Status/History on PRA record once client's record status is updated to Pending Enrolled.

Figure 1 Perinatal Risk Assessment & Follow-up forms



The IRF & CHS are completed for pregnant women not in prenatal care, non-pregnant women, men, and children. Children in need of referral get entered with their caregiver listed as the participant.

Figure 2 Initial Referral & Community Health Screening forms



How does the CBS referral get assigned to an agency?

All referrals triage to a county-specific Central Intake HUB based upon the county entered on the referral form. The HUB receives the referral and assigns it to a partner agency based upon the defined business rules. The supervisor at the partner agency receives the client from the HUB, and determines if the program/service will accept the client. If accepted, the supervisor assigns the client to a staff member for outreach and management. If not accepted, the referral is returned to the HUB for reassignment to a different program/service.

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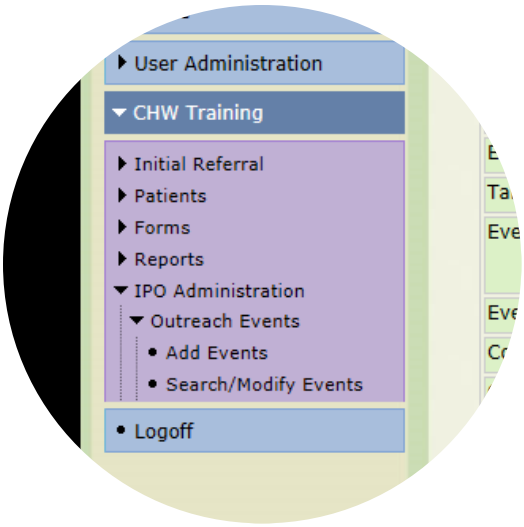
PRA|SPECT IPO Administration

What is IPO Administration?

Improving Pregnancy Outcomes (IPO) Administration is a Community Health Worker (CHW) exclusive function that enables agencies to document outreach events and showcase program accomplishments.

CHWs should use IPO Administration as an online address book and resource tool to enhance future outreach efforts. All registered users at an agency feed into the same IPO Administration. Therefore, it is important to ensure that users always conduct an Outreach Event Search prior to creating a new entry. Once entered, outreach events cannot be deleted.



Search prior to entering a new outreach event

Outreach Event Modification Tracking

Once a new outreach event is created, it is date-stamped with the entry person's ID. As the outreach event is updated, the tracker displays the last edit made to the entry by user ID and date. Outreach Events can be updated at any point in time.

CHWs are required to link all Initial Referral (IR) forms to an outreach event. Outreach events get classified in (3) categories:

Education	Meetings	Outreach
Health Education	Advisory Board Meeting	Community Event
Workshop	2 Week Joint CI/CHW Meeting	Daily Street Outreach
Fatherhood	Networking	Door-to-Door
Other Group Event	Professional Education	General Public Event
	Professional/Peer Meeting	Health Fair
		Healthcare Setting
		Public Setting
		Self-Referral
		Other

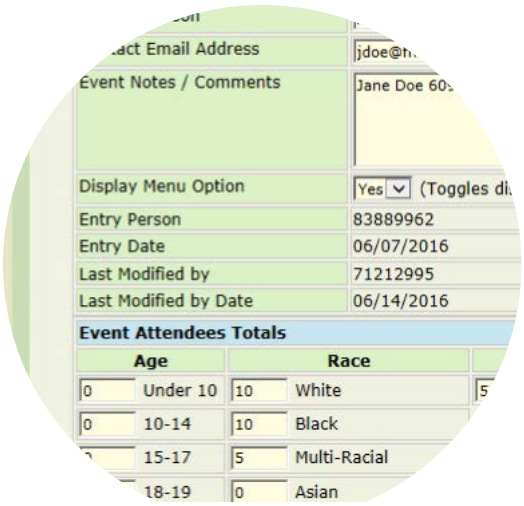
IPO Report data is extracted directly from IPO Administration. Staff must ensure the timeliness and accuracy of information entered in order for the program to receive proper credit for its outreach efforts. Supervisors should monitor staff documentation in IPO Administration to ensure program requirements are met and outreach goals are accomplished.

To search prior to entering a new outreach event:
Login > Click Program/Service > Click IPO Administration > Click Outreach Events > Click Search/Modify Events > Click Advanced Search > Enter Event Date in Begin and End Range > Click Search Events > If results appear, further refine search by adding Event Name > Click Search Events > If event appears, click Event Date to enter existing outreach event > If no search results appear, enter a new outreach event.

To enter a new outreach event:
Login > Click Program/Service > Click IPO Administration > Click Outreach Events > Click Add Events > Enter Name, Date, Type > Click Submit > Outreach event now appears on Basic Search as top entry based upon Event Type

Outreach Event Field Guidance	
Event Name	Should be detailed and meaningful, as well always include City/Town. Example: Diaper Derby, Newark Door-to-Door: Camden S. 3rd – S. 4th St, Cherry - Chestnut Daily Street Outreach: Trenton, Franklin St Self-Referrals Week of MM/DD/YY
Event Date	Day event occurs. For multiday events, use the first day.
Event Type	Specific classification based upon the (3) categories of events
Target Audience	Particular group of people event is aimed at
Event Topic(s)	Specific focus areas of event
Event Location	Include full address
Contact Person	Event organizer or main individual affiliated with event
Contact Email Address	Contact Person's email address. If available, include contact person's phone number in Event Notes/Comments
Event Notes/Comments	Use to record any meaningful information regarding the event, attendee totals, and overall outreach efforts. Also record new community contacts, services, or resources from event Example: Low turnout due to inclement weather Left flyers in # mailboxes Spoke to contact person prior to event and she made formal announcement about CHW program Made new contact Jane Doe ###-###-#### that holds local breastfeeding support group
Display Menu Option	Defaults to Yes and controls whether outreach appears on Initial Referral Outreach Event dropdown menu. Set older events that no longer require initial referral linking to No.
Total Attend	Number of people CHW interacted with at event (not the total number of attendees at the event).
Initial/Screen	Number of completed Initial Referrals (IRFs) from the event. Total Attend will often be higher than Initial/Screen, as not all individuals interacted with are willing to complete the IRF.
Age	Breakdown of people CHW interacted with by age bracket, and should equal Total Attend.
Race	Breakdown of people CHW interacted with by age bracket, and should equal Total Attend.
Ethnicity	Breakdown of people CHW interacted with by how individual self identifies, and does not need to add up to Total Attend.
Gender	Breakdown of people CHW interacted with by how individual self identifies, and should equal Total Attend.

To access an existing outreach event:
Login > Click Program/Service > Click IPO Administration > Click Outreach Events > Click Search/Modify Events > Basic Search displays (25) most recent outreach events > Click Event Date > If desired event is not on Basic Search, click Advanced Search > Enter search fields > Click Search Events > Click Date to access outreach event



Outreach event modification tracking

To cleanup Initial Referral Outreach Event dropdown menu:
Login > Click Program/Service > Click IPO Administration > Click Outreach Events > Click Search/Modify > Click Advanced Search > Select Yes from Menu Display Status > Click Search Events > Click Event Date > Select No from Display Menu Option dropdown menu > Click Submit > Event no longer appears on Initial Referral Outreach Event dropdown menu > Repeat until search only displays desired selections to display on Initial Referral Outreach Event dropdown menu

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PRA|SPECT Entering Referrals

Entering Community Based Services (CBS) Referrals

Search prior to entering a new Initial Referral

The CBS referral is entered on PRA|SPECT by partner agencies via the one-page Initial Referral (IRF) and the two-page Community Health Screening (CHS). The IRF and CHS are used to enter referrals for pregnant women not in prenatal care, non-pregnant women, men, and children. Children in need of services are entered under their caregiver as the participant. The child's information is recorded in the Household Information section.

The IRF and CHS are designed to be used as scripts to collect as much information as possible from the participant. Understanding that not all people are comfortable disclosing information upon introductory contact, the IRF and CHS can be entered with minimal information. However, screeners should always attempt to collect as much information as possible to ensure participants get linked to the most appropriate program/service based upon their individual needs. Referrals entered by an agency may or may not be returned to the program/service for client management.

Participant Consent

Consent is the choice of the client only. Screeners should read entire consent statement to the participant. Consent is required on both the IR and CHS form, and may be given orally or in writing. If in-person, the participant's wet signature should be collected on the paper form. If the participant refuses consent, agencies should still enter forms to receive program credit. IRF and CHS data is used for recordkeeping, and is reflected on SPECT Reports.

Initial Referral (IRF)

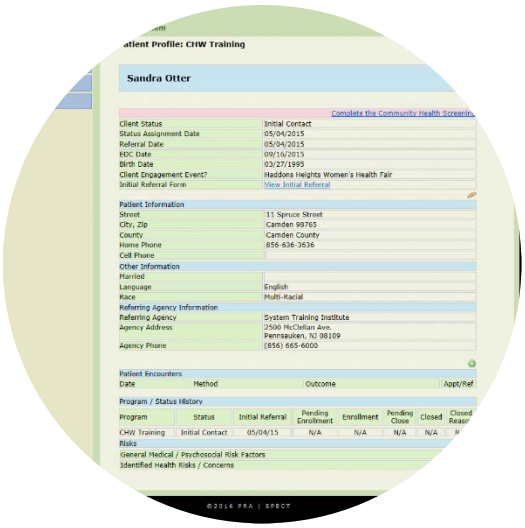
The IRF is the one-page standardized form used by partner agencies to link pregnant women not in prenatal care, non-pregnant women, men, and children to the Community Health Screening (CHS) for CBS referral. The IRF highlights the introductory encounter with the participant, and collects Basic Demographic Background, General Household Information, and Reason(s) for Referral. Screeners should coordinate with OB providers to ensure referrals for pregnant women in prenatal care are entered on the two-page Perinatal Risk Assessment (PRA) or the one-page PRA Follow-up.

All registered users at an agency feed into the same Initial Referral Administration. Therefore, it is important to ensure that users always conduct a Client Search prior to creating a new entry. Additionally, users should always review and check data entered prior to submission. Once entered, IRFs cannot be edited or removed from the system.

To search prior to entering a new Initial Referral (IRF):
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Advanced Search > Enter client's first name > Click Search Patients > If records display, enter client's date of birth > Click Search Patients > If records display, further refine search with client's last name > Click Search Patients > If record match appears, Click Contact Date to enter client profile > If no records appear, enter new IRF

To enter a new Initial Referral (IRF):
Login > Click Program/Service > Click Initial Referral > Click Add New Referral > Enter all information collected > Click Save to submit and create client profile > Once submitted, the IRF cannot be modified

To view a completed Initial Referral (IRF):
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Contact Date to enter client profile. If record does not appear on Basic Search, click Advanced Search > Enter search fields > Click Search > Click Contact date > Click View Initial Referral > Click floppy disk icon to get a digital copy of form or Right-click on form window > Click Print to generate a paper form



Entering the Initial Referral creates the client profile

To access a client profile:
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Con tact Date to enter client profile > If record does not appear on Basic Search, click Advanced Search > Enter search fields > Click Search > Click Contact Date

Initial Referral (IRF) Guidance			
Field	**Required Field**	**Specifics**	
Date of Referral		Day referral completed	
Last Name, First Name, DOB		Full name and birth date	
Street Address, City, Zip Code, County		Include apartment, unit, floor, etc.	
Participant ID		If applicable, agency-specific ID associated with person	
Primary Language		If other, include language spoken	
Race		If other, include race	
Ethnicity		Y or N required	
Health Insurance		*Medicaid PE*	Presumptive Eligibility allows children and pregnant women to get access to Medicaid or CHIP services without having to wait for their application to be fully processed
		Medicaid MC	Managed Care (MC) are health care organizations that contract with a network of providers to provide covered services to their enrollees. Managed Care Organizations (MCOs) are responsible for providing or arranging for the full range of healthcare services
		NJ Family Care	New Jersey's publicly-funded health insurance program - includes CHIP, Medicaid and Medicaid expansion
		Medicare	Provides health insurance for Americans aged 65 and older who have worked and

		paid into the system. It also provides health insurance to younger people with disabilities, end stage renal disease, and amyotrophic lateral sclerosis.
	Commercial/Private	Non-Medicaid health insurance
	Uninsured/Self Pay	Includes charity pay, persons with no health insurance, and persons who pay cash for their healthcare
Primary Phone	Best phone number to reach person	
Preferred Contact Method	Choose only one option	
Alternate Phone	Secondary number to reach person	
At which number can we text?	If willing to receive, select primary or alternate	
Married	Current marital status	
# of children in home	Current number of children in home	
Date(s) of birth of children	Include for all children in household	
Participant Type	Select one and fill in field specific requirements	
Reason for Referral	Select all that apply	
Referral Agency Information	Agency, referrer name and phone, and outreach type required	
Comments	Special instructions or referral details	
Participant Consent	Written signature if in person	

Community Health Screening (CHS) Form

The CHS is the two-page standardized tool used by partner agencies to complete comprehensive screening to link non-pregnant women, men, and children to Community Based Services (CBS) referral. The CHS is modeled after the Perinatal Risk Assessment (PRA) tool to collect information and outline a need-based wellness profile for non-pregnant persons. The CHS tool collects detailed Demographic Background, General Medical Information, Psychosocial Risk Factors, Environmental Exposures, and Personal Care Plan to capture overall health and wellbeing.

A Referred, Refused, or Not Need selection is required for Community Based Services (CBS) in the Referrals/Education section on page two of the CHS. Select REFERRED if the participant desires to get linked up with a program/service. Select REFUSED or NOT NEEDED if the participant declines or does not need CBS referral. Only CHS forms with CBS Referred forward to a Central Intake HUB for distribution to a program/service.

Information from the participant's Initial Referral (IRF) prepopulates on the CHS. Staff should always verify this data to ensure accuracy, and can update these fields if need be.

CHS Review | Submit| Exit Options	
Save	Saves the form for further completion
Submit	Enters the referral into the system. If CBS Referred selected, referral moves to Central Intake HUB for distribution. If CBS Refused or Not Needed selected referral is archived for tracking and reporting purposes.
Remove	Form is removed from the system, and cannot be retrieved. Client profile and Initial Referral do not remove from the system.

To enter a Community Health Screening (CHS) form:
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Contact Date to enter client profile > If record does not appear on Basic Search, click Advanced Search > Enter search fields > Click Search > Click Contact Date > Click Complete the Community Health Screening

To save a Community Health Screening (CHS) form:
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Contact Date to enter client profile > If record does not appear on Basic Search, click Advanced Search > Enter search fields > Click Search > Click Contact Date > Click Complete the Community Health Screening > Click Review|Save|Submit > Select Save > Click Enter Selection

CHS sections can be completed in any order

Community Health Screening (CHS) Form Guidance			
Field	**Required Field**	**Specifics**	
Date of Referral		Day referral completed	
Referral Type		Select one	
Board of Social Services		New Jersey individual and family needs assistance and service agencies within the Department of Human Services Division of Family Development	
DCP&P		Division of Child Protection and Permanency is New Jersey's child protection and welfare agency within the Department of Children and Families	
Open DCP&P case?		Active investigation involving person	
MCO		Select None if person does not have Medicaid MCO assignment	
Pregnancy History, Date of most recent live birth & birth weight		Complete for pregnant participants	
Current Height, Current Weight		Used to calculate BMI	
Smoking		Select Y or N	
General Medical Information		Select Y, N, or Unknown	
Psychosocial Risk Factors		Select Y, N, or Unknown	
Primary Care		If other, include source	
Exposures		Select Y or N	
Reproductive Life Plan		Select Y or N. If applicable select primary contraceptive used, If other, indicate type.	
Hurricane Sandy		If pregnant participant, select Y or N	
Pregnant Client		*Pregnant Clients*	Select Y, N, or Unknown
		Health Risks/Concerns	Select Y, N, or Unknown

	4Ps Plus	Algorithmic screen for substance use and referral for pregnant participants. Questioning is designed to be nonjudgmental and nonthreatening, and should be read exactly as written. A positive screen occurs if Any is selected for cigarettes, beer/wine/liquor, and/or marijuana. Positive screen prompts screener to proceed to Follow-up questions to assess need for Prevention Education and/or Referral for Substance Abuse Assessment. When applicable, Screeners should document Referred, Referral Needed, or Refused for Substance Abuse Prevention Education and Substance Abuse Assessment in Referrals/Education.
	4Ps Plus Follow-up	
Referrals/Education	*Referred*	Select if made during CHS completion
	Receiving Services	Select if participant already enrolled
	Referral Needed	Select if need notated during CHS completion. Referral to be made by agency that manages client.
Referrals/Education (continued)	*Refused*	Select if declined during CHS completion
	Not Needed	Select if not necessary/not applicable
Participant Notes - Internal	Only viewable by other staff at CHS enterer's agency	
Participant Notes - External	Viewable by any agency that accesses referral	
Participant Consent	Written signature if in person	

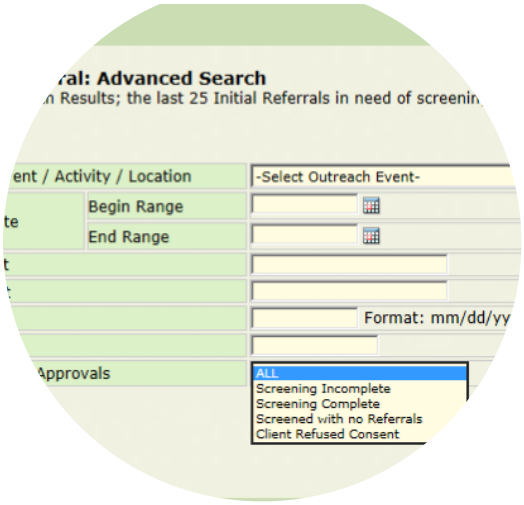
To submit a Community Health Screening (CHS) form:
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Contact Date to enter client profile > If record does not appear on Basic Search, click Advanced Search > Enter search fields > Click Search > Click Contact Date > Click Complete the CHS > Click Review|Save|Submit > Select Submit > Click Enter Selection

To remove a Community Health Screening (CHS) form:
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Contact Date to enter client profile > If record does not appear on Basic Search, click Advanced Search > Enter search fields > Click Search > Click Contact Date > Click Complete the CHS > Click Review|Save|Submit > Select Remove

Incomplete Initial Referral Monitoring

Once outreach time expires, Initial Referrals that do not progress to status Screening Completed (two-page Community Health Screening submitted) should be closed.

To change the record status from Initial Referral to Closed (Patient Option):
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Advanced Search > Enter search fields > Click Search Patients > Click Contact Date to left of client's name > Click top pencil icon on client profile > Select Closed from Client Status > Select Patient Close Option > Click Update Information > Closed record remains retrievable on Initial Referrals Search



Search options on Initial Referrals Advanced Search

Additional Initial Referral Search Options		
Outreach Event	CHW Exclusive Function search by outreach event	
Contact Date	Search by Initial Referral submission date	
Patient City	Search client's city/town	
Status Types/Approval	Screening Incomplete	IRF submitted, CHS not yet submitted
	Screening Complete	IRF and CHS submitted with CBS Referred
	Screened with no Referrals	IRF and CHS submitted with CBS Not Needed
	Client Refused Consent	IRF and CHS submitted with CBS Refused

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PRA|SPECT Updating CHS

The CHS Update is used to make additions to referral details, especially in scenarios where the client has supplied little information during the introductory phase. Often clients decline to answer some of the personal questions or do not yet feel comfortable disclosing certain behaviors or risk factors. The CHS Update is geared toward these types of situations where more information is collected as trust is gained, usually early on in the enrollment process. Updates are more common in the beginning of the client's service. However, CHS Updates can be made at any point in time until the client's record is assigned with a Patient Close Option.

Click Update to enter new or updated Community Health Screening information

CHS updates should be made within (48) hours of notification of new information. Once submitted, CHS updates cannot be removed. Users should always review and check work prior to submitting forms. There is no limit on the number of CHS updates that can be entered. Prenatal fields for pregnant clients are only updateable for a specific time period based upon the client's due date. Therefore, it is important to ensure prenatal updates are entered as soon as new information becomes available. CHS Updates cannot be saved for future submission. Therefore users will need to gather all update details to enter in one sitting.

Core referral details such as referral agency, participant consent, and Referrals/Education items are not updateable. Additional Referrals/Education items should be documented via Encounter/Engagement Resource, Referral, or Appointment (RRA). In most instances, YES selections are not updateable.

Updateable CHS Sections	
Participant Information	Yes, No, or Unknown fields
General Medical Conditions	No or Unknown fields
Psychosocial Risk Factors	No or Unknown fields
Pregnant Client	No or Unknown fields
4Ps Plus & 4Ps Plus Follow-up Questions	All fields

CHS Update Access

Access to the CHS update varies based upon user type and level.

Access to the CHS Update by User Type & Level	
Program/Service Supervisor	Access CHS update on client profile via Search on Referrals tab when record status is New, Pending Enrolled, or Enrolled. Once referral is assigned to a staff person, supervisors can also view CHS update via Patients tab on Newly Assigned or Enrolled Patients lists
Program/Service Staff	Access CHS update on client profile via Newly Assigned or Enrolled Lists on Patient tab when record status is Pending Enrolled or Enrolled
CHW Exclusive	If referral entered by CHW, access CHS update via Search/Modify on Initial Referral tab up to the point of CHW Program Close or (if assigned to CHV or CI Managed) Enrollment in a partner program

For supervisor access to CHS update:

www.praspect.org

Login > Click Program/Service > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name > Click Update

CHS Update history is viewable on record

For staff access to CHS update via Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Clients List > Click Client Name > Click Update

For staff access to CHS update via Enrolled Patients List:
Login > Click Program/Service > Click Patients > Click Enrolled Clients List > Click Client Name > Click Update

For referrals entered by CHW access to CHS updates:
Login > Click Program > Click Initial Referral > Click Search/Modify > Click Advanced Search > Enter search fields > Click Search Patients > Click Contact Date > Click Update

For HUB access to CHS update:
Login > Click HUB > Click Referrals > Click Unassigned, Returned, or Ineligible Referrals List > Select CI Managed from Program Option to left of client's name > Click Assign Patients > Click CI Managed > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name > Click Update

To enter the CHS update:
Access the record as outlined above > Enter all new information prior to submitting CHS Update > Click Review|Submit > Select Submit > Click Enter Selection > CHS Update is viewable

To remove the CHS update:

Prior to submission the CHS update can be removed if need be. Click Review|Submit > Select Remove > Click Enter Selection

CHS Update History

All CHS Updates are available on the client profile, and are displayed from Newest to Oldest submission. The core CHS referral form is labeled as the original. Each CHS Update is marked by a PDF file with the updated variables. Allow up to (30) minutes after CHS update submission for the new variable(s) to reflect in the PDF file.

To access the original CHS form:
Click View CHS to left of Original: MM/DD/YY

To access the CHS Update form:
Click View CHS to left of Updated: MM/DD/YY

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PRA|SPECT Assigning Referrals

New Referrals

Supervisor level sees all referrals that are assigned to the agency. Staff level sees only their individual referrals. Supervisors have exclusive access to the Referrals tab that is used for staff assignment and ease of client lookup. The Referrals tab should be monitored on a daily basis for new referrals. A system-generated email is sent at midnight for referrals received on the preceding day (previous 24 hours).

Referrals tab is only available to supervisors

Staff Assignment

Supervisors should fully review the original referral forms prior to assigning clients to staff for outreach and management. Important information is often logged in the Additional Critical Information and Notes sections on the Perinatal Risk Assessment/PRA Follow-up or the Comments and Notes fields on the Initial Referral/Community Health Screening.

New Record Status Updates

The Referrals tab should only be used to make record status updates from New to Pending Enrolled to assign the client to a staff person or from New to Closed to return the referral to the HUB for reassignment to a different program/service. All other record status updates must be made via the client profile on the Newly Assigned (Pending Enrolled) or Enrolled Patients Lists on the Patients tab. Only one referral should be assigned at a time if more than 10 referrals appear.

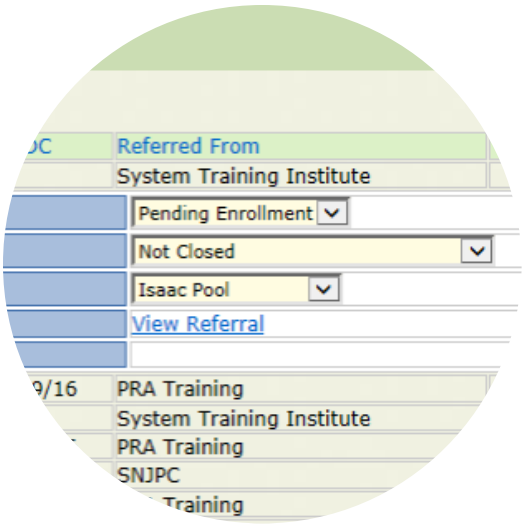
Client Record Status Options	
Initial Referral	Two-page Community Health Screening (CHS) has not yet been submitted
New	Client is new to agency and has not yet been assigned to a staff person
Pending Enrolled	Client is assigned to a staff person and is on Newly Assigned Patients List
Enrolled	Client is assigned to a staff person and is on Enrolled Patients List
Closed	Client is assigned to a staff person and is on Closed Patients List

To view the original referral for a new client via Newly Referred Clients List:
Login > Click Program/Service > Click Referrals > Click Newly Referred Clients > Click View to far right of client name > Click View Referral

To view the original referral for a client via Referrals Search:
Login > Click Program/Service > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click View Referral to far right of client name

To assign a new referral to a staff person:
Login > Click Program/Service > Click Referrals > Click Newly Referred Clients > Click View to far right of client name > Select Pending Enrolled from Patient Program Status > Select Not Closed for Patient Close Reason > Select Staff Person from Assign Staff > Click Assign Patients > Referral moves from Newly Referred Clients to Newly Assigned Patients List on Patient tab

To search for a client profile:
Login > Click Program/Service > Click Referrals > Click Search Referrals > enter search fields > Click Search Patients > Click Client Name > Note: Record status updates should not be made via Referrals Search. *See Managing Clients User Guide for further record status update guidance.*



Status must be changed from New to Pending Enrolled to assign referral to staff

Returning Referrals

Referrals that are unable to be accepted by an agency should immediately be returned to the HUB for reassignment to a different program/service. Referrals on the Closed Patients List cannot be returned to the HUB. Only one referral should be assigned at a time if more than 10 referrals appear.

Return to HUB Options	
Client Refused	Client declined program/service
Not Eligible	Client does not met program or service eligibility
Outreach Time Expired	Unable to reach client by outreach deadline
Outreach Unsuccessful	Unable to reach client
Program at Capacity	Program or service full and unable to accept new clients
Not available during the day	Client unable to participate in daytime activities
MIHOPE	Client selected for Mother & Infant Home Visiting Program Evaluation
Other Reason	Returned to HUB for reason not listed
Returned for Reassignment	Returned to HUB for assignment to a different program/service

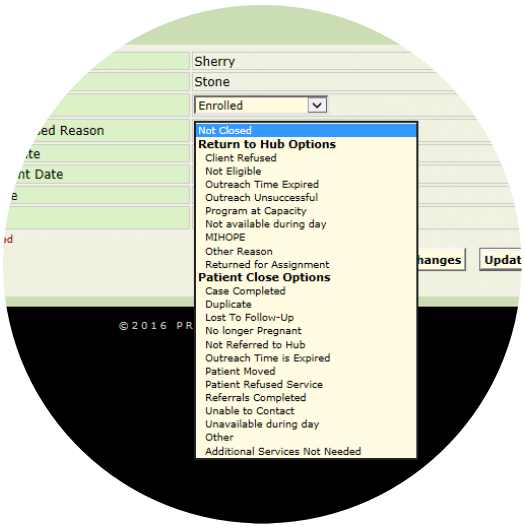
To return a referral to the HUB from Newly Referred Clients:
Login > Click Program/Service > Click Referrals > Click Newly Referred Clients > Click View to far right of client name > Select Closed from Patient Program Status > Select Return to HUB Option from Patient Close Reason > Select Staff Not Assigned from Assign Staff > Click Assign Patients > Referral moves from Newly Referred Clients to HUB Returned Referrals

To return a referral to the HUB from Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click top pencil icon > Select Closed from Client Status > Select Return to HUB Option from Program Close Reason > Click Update Information > Referral moves from Newly Assigned Patients List to HUB Returned Referrals

To return a referral to the HUB from Enrolled Patients List:
Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click top pencil icon > Select Closed from Program Status > Select Return to HUB reason from Program Close Reason > Select Case Not Assigned from Assign Staff > Click Update Information > Referral moves from Enrolled Patients List to HUB Returned Referrals

Reassigning Clients

Clients should immediately be reassigned if the managing staff person is out on an extended absence. Supervisors can view all clients assigned to a staff person by sorting via Staff column on the Newly Assigned and Enrolled Patients List.



Select Return to HUB Options to send referral back for reassignment

To view staff person's clients on Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Staff to sort records by person's last name

To view staff person's clients on Enrolled List:

Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Staff to sort records by person's last name

To reassign a client to a different staff person from Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click top pencil icon > Select staff person from Assign Staff > Click Update Information

To reassign a client to a different staff person from Enrolled Patients List:
Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click top pencil icon > Select staff person from Assign Staff > Click Update Information

To reassign a client to a different staff person from Referrals Search:
Login > Click Program/Service > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name > Click top pencil icon > Select staff person from Assign Staff > Click Update Information

Review Submitted Referrals

Displays status of referrals submitted by your agency.

To view submitted referral status:
Login > Click Program/Service > Click Referrals > Click Review Submitted Referrals > Click column header to sort by desired field

Referrals Search

The Referrals Search allows supervisors to search through all referrals sent to the agency regardless of whether client enrolls in program or service. Returned referrals are retrievable via Referrals Search. The best search results are obtained by using one or two search fields.

Referrals Search Options	
Referral Date	Referral date entered on client's original referral form
Patient Last	Can use full name or first few letters of name
Patient First	Can use full name or first few letters of name
Patient DOB	Format ##/##/####
Patient City	Must be exact match
Type: Search All Referrals	Referrals entered by your agency and outside agencies
Type: Search HUB Referrals	Referrals entered by your agency only

Patient Information Update

Select fields can be updated on the client profile via the Patient Information Update. Updatable fields include address, phone, primary language, and date of birth. If a change has been made via the Patient Information Update, the This patient has multiple address entries link will appear to summarize the modification history. Community Health Screening (CHS) referral fields can be updated via CHS Update. *See Updating the CHS guide for further details.* Email SPECT@snjpc.org to request a change to any other Perinatal Risk Assessment/PRA Follow-up fields.

To modify client details via the Patient Information Update via Referrals Search:
Login > Click Program/Service > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name > Click pencil icon to left of Patient Information > Enter fields to be modified > Click Save > Updated variables display on client profile and This patient has multiple address entries link appears

This patient has multiple addresses will appear if patient update has been completed

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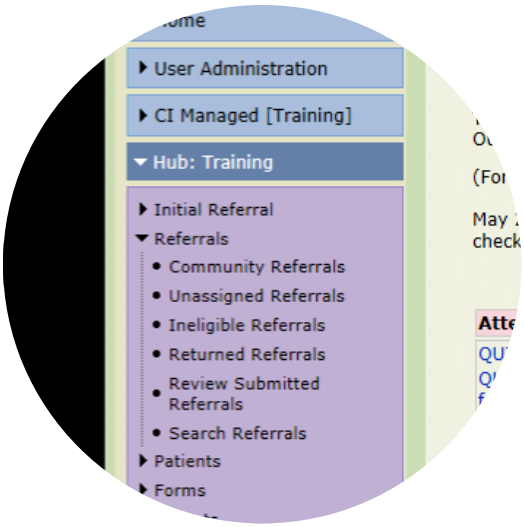
PRA|SPECT HUB Assigning Referrals

HUB Assigning Referrals

New Jersey has (21) county-specific Central Intake HUBs. The HUB serves as the single point of entry for incoming referrals to streamline and expedite client linkage to Community Based Services (CBS). Referrals are assigned to programs and services based upon the eligibility criteria, business rules, and agreements per county-specific Decision Trees and Process Maps. The HUB works in conjunction with community partners to oversee a collective and unified approach to linking New Jersey men, women, and children to local resources. HUB staff are well-versed in their county's broad range of programs and services. HUBs monitor referrals on at least a bi-daily basis for timely triage to a program or service.



Referrals tab should be checked bi-daily

Encounters/Engagements

All contact with the client is logged on the referral as an Encounter/Engagement.

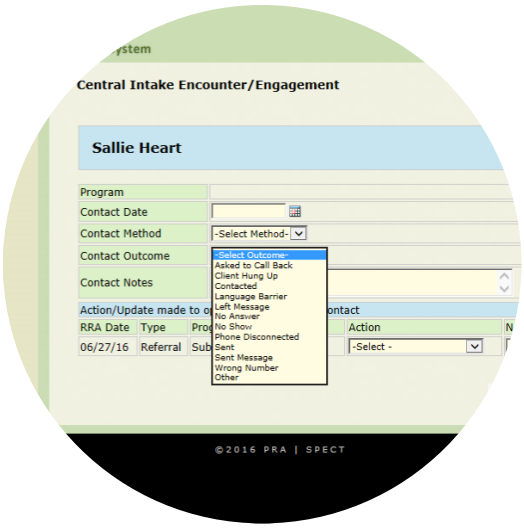
To add an Encounter/Engagement to a record on Unassigned Referrals:
Login > Click HUB > Click Referrals > Click Unassigned Referrals > Click Client Name > Click Add New > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact

Contact Method	
Home Phone	Client's landline
Cell Voice	Client's cell phone
Cell Text	Text via client's cellphone
Email	Client's email address
Met in Person	Physically met client
Mail	Client's mailing address

Contact Outcome Options	
Asked to Call Back	Answerer of phone advised staff to call at another time
Client Hung Up	Answerer of phone disconnected the line
Contacted	Use for any type of successful connection with client
Language Barrier	Client issue with communication
Left Message	A verbal or recorded message is left for the client
No Answer	Phone rings and there is no voicemail activated
No Show	Client does not show for a scheduled appointment
Phone Disconnected	Receive recording that phone number has been disconnected
Sent	Mail sent to client
Sent Message	Email or text sent to client
Wrong Number	Client is not reachable at phone number listed on referral
Other	Include Other Specifics in Contact Notes

Resources, Referrals, & Appointments (RRAs)

All Resources, Referrals, and Appointments (RRAs) made during client contacts are logged on Encounter/Engagements. The Encounter/Engagement must be saved before the RRA can be added.



Select contacted for successful connection with client

To add an Encounter/Engagement and RRA via Unassigned Referrals:
Login > Click HUB > Click Referrals > Click Unassigned Referrals > Click Client Name > Click Add New > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Add New Referral, Appointment, or Resource > Enter Date > Select Type > Select RRA Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

To add an RRA to an existing Encounter/Engagement via Unassigned Referrals:
Login > Click HUB > Click Referrals > Click Unassigned Referrals > Click Client Name > Click Encounter/Engagement date > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

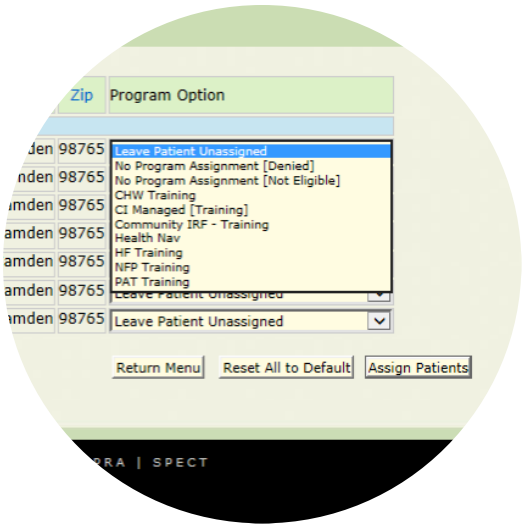
To add an Encounter/Engagement and RRA via Ineligible Referrals:
Login > Click HUB > Click Referrals > Click Ineligible Referrals > Click View > Click Add New > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

To add an RRA to an existing Encounter/Engagement via Ineligible Referrals:
Login > Click HUB > Click Referrals > Click Ineligible Referrals > Click View > Click Encounter/Engagement date > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

To add an Encounter/Engagement and RRA via Returned Referrals:
Login > Click HUB > Click Referrals > Click Returned Referrals > Click View > Click Add New > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

To add an RRA to an existing Encounter/Engagement via Returned Referrals:
Login > Click HUB > Click Referrals > Click Returned Referrals > Click View > Click Encounter/Engagement date > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

To add an Encounter/Engagement and RRA via Referrals Search:
Login > Click HUB > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name > Click green circle icon > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save



Assign one referral at a time if grid displays more than 10 referrals

To add an RRA to an existing Encounter/Engagement via Referrals Search:
Login > Click HUB > Click Referrals > Click Search Referrals > Click View > Click Encounter/Engagement date > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

Assigning New Referrals

New referrals from the Perinatal Risk Assessment/PRA Follow-up or Initial Referral/Community Health Screening appear on Unassigned Referrals. HUBs should always review the original referral prior to assigning to an agency. Only one referral should be assigned at a time if more than 10 referrals appear.

Program Option Note: Program and service selections vary per HUB	
Leave Patient Unassigned	Referral remains on Unassigned Referrals for future assignment
No Program Assignment [Denied]	Locks referral down so it can no longer be assigned
No Program Assignment [Not Eligible]	Moves referral to Ineligible Referrals for future assignment

To view a new referral from the Unassigned Referrals:
Login > Click HUB > Click Referrals > Click Unassigned Referrals > Click Client Name > Click View Referral

To assign a new referral from the Unassigned Referrals:
Login > Click HUB > Click Referrals > Click Unassigned Referrals > Click Client Name > Select Program Option > Click Assign Patients > Referral moves from Unassigned Referrals to agency's Newly Referred Clients

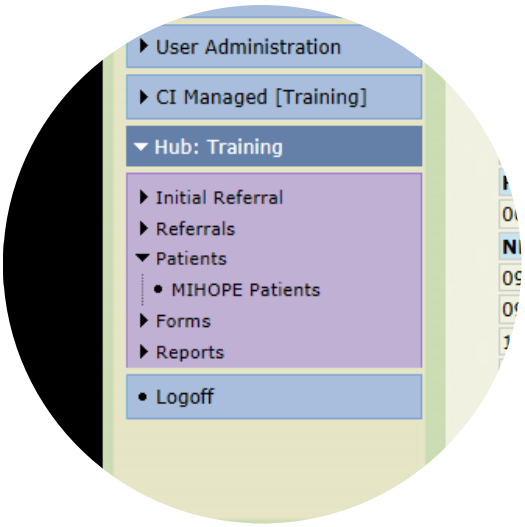
To view a referral from the Ineligible Referrals:
Login > Click HUB > Click Referrals > Click Ineligible Referrals > Click View > Click View Referral

To assign a referral from the Ineligible Referrals:
Login > Click HUB > Click Referrals > Click Ineligible Referrals > Click View > Select Program Option > Click Assign Patients > Referral moves from Unassigned Referrals to agency's Newly Referred

To view a referral from the Returned Referrals:

Login > Click HUB > Click Referrals > Click Returned Referrals > Click View > Click View Referral

To assign a referral from the Returned Referrals:
Login > Click HUB > Click Referrals > Click Returned Referrals > Click View > Select Program Option > Click Assign Patients > Referral moves from Returned Referrals to agency's Newly Referred



MIHOPE clients appear on Patients tab

MIHOPE Referrals

MIHOPE (Mother & Infant Home Visiting Program Evaluation) is a large-scale random assignment study of home visiting programs funded by MIECHV. Some measurements include the effect of early childhood HV programs on child and parent outcomes, how effects vary for different programs and populations, and the cost of operating the programs. Not all HV programs in New Jersey are part of MIHOPE. HUBs must confirm client status in study, as well as avoid assigning an enrolled MIHOPE client to another program if an additional referral is received. Encounters/Engagements and RRAs must be documented for MIHOPE clients. Record status should be updated to Closed - Return to HUB: MIHOPE regardless of the agency providing resources to the client.

To view MIHOPE participants:
Login > Click HUB > Click Patients > Click MIHOPE Patients

To add an Encounter/Engagement to a MIHOPE client:
Login > Click HUB > Click Patients > Click MIHOPE Patients > Click Client Name > Click green circle icon > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact

To add an Encounter/Engagement and RRA to a MIHOPE client:
Login > Click HUB > Click Patients > Click MIHOPE Patients > Click Client Name > Click green circle icon > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

To add an RRA to an existing Encounter/Engagement for a MIHOPE client:
Login > Click HUB > Click Patients > Click MIHOPE Patients > Click Client Name > Click Encounter/Engagement date > Click Add New Referral, Appointment, or Resource > Enter Date > Select RRA Type > Select Type > Select Program > Select Provider > Select Open from Status > Enter Notes/Comments > Click Save

Referrals Search

The Referrals Search allows HUBs to search client records. The best search results are obtained by using one or two fields.

To access a client profile via Referrals Search:
Login > Click HUB > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name

To generate a list of referrals for a specific time period via Referrals Search:
Login > Click HUB > Click Referrals > Click Search Referrals > Enter begin and end dates for Referral Date > Click Search Patients > Click Referral Date to sort list by date of referral > Click Patient to alphabetically sort list by client's last name

Use Referrals Search to quickly locate client record

Referrals Search Options	
Referral Date	Referral date as entered on client's original referral form
Patient Last	Can use full name or first few letters of name
Patient First	Can use full name or first few letters of name
Patient DOB	Format ##/##/####
Patient City	Must be exact match
Type: Search All Referrals	Referrals entered by your agency and outside agencies
Type: Search HUB Referrals	Referrals entered by your agency only

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PRA|SPECT Managing Clients

Client Assignments

All Community Based Services (CBS) referrals contain a client profile that can be updated at any level of record status (New, Pending Enrolled, Enrolled, and Closed). The record status must be changed as updates occur, and is completely independent from the Resource, Referral, and Appointment (RRA) status. With the exception of Community Home Visiting (CHV) programs, staff must log all client contact via Encounter/Engagement.

Client profile can be updated any record status level

Community Home Visiting (CHV) Exclusive

CHV staff must log all contact with the client up to and including the point of enrollment in the program. Once the client enrolls in the program, staff log via their individual program software (i.e. ETO, FAMSYS, etc.) CHV staff are responsible for ensuring PRA|SPECT record status updates mirror status updates on individual program software. Additionally, CHV staff must enter outcomes all RRA items. *See RRA User Guide for further details.*

Encounters/Engagements

All contact with the participant is logged via Encounter/Engagement on the client profile. The Contact Method and Outcome are recorded for all client interactions. The Outcome 'Contacted' should be selected for any type of successful connection with the client. All other Contact Outcomes pertain to unsuccessful connections, such as the phone number is disconnected or the client hung up. Contact Notes should be used to record the specific details regarding the Encounter/Engagement (i.e. client is ready to enroll in program). *Supervisors see Assigning Referrals User Guide for details regarding adding Encounters/Engagements via Referrals tab.*

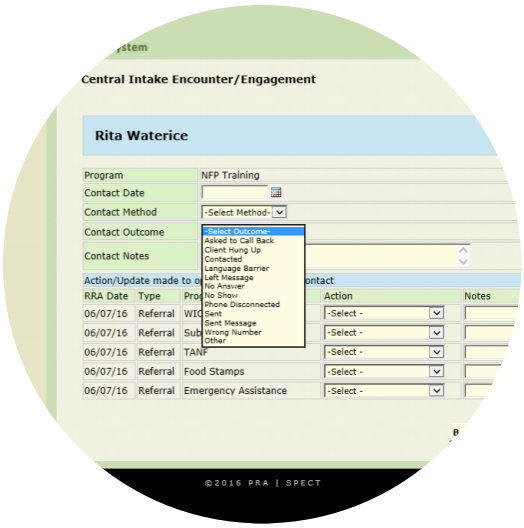
Encounter/Engagement Action/Update Open RRA Tracking

If a previous Encounters/Engagements contain open RRA items for the client, they will display on the Action Update Open RRAs List that appears at the bottom of the new Encounter/Engagement entry prior to clicking Save Contact. *See RRA User Guide for further details on recording outcomes for RRAs.*

To add an Encounter/Engagement via Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click green circle icon > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Back to List > Encounter/Engagement is now viewable under Patient Encounters

To add an Encounter/Engagement via Enrolled Patients List:

Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click green circle icon > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Back to List > Encounter/Engagement is now viewable under Patient Encounters



Select contacted for successful client connection

Resources, Referrals, & Appointments (RRAs)

All Resources, Referrals, and Appointments (RRAs) made during the contact are added to the Encounter/Engagement via the Add New RRA link. *All users See RRA User Guide.*

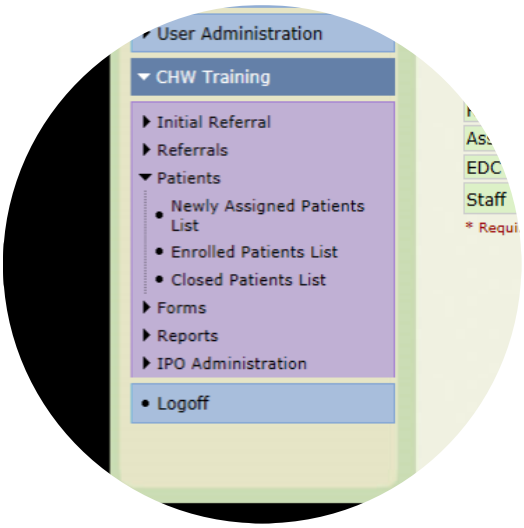
Contact Method	
Home Phone	Call to client's landline
Cell Voice	Call to client's cellphone
Cell Text	Text to client's cellphone
Email	Message to client's email address
Met in Person	In-person meeting with the client
Mail	Correspondence to client's mailing address
Screening	Contact to complete Community Health Screening (CHS)

Contact Outcome	
Asked to Call Back	Answerer of phone requested staff call again at a different point in time
Client Hung Up	Answerer of phone disconnected the line
Contacted	Any type of successful connection with the client
Language Barrier	Communication issue due to language
Left Message	Staff left verbal or recorded message for client
No Answer	Phone keeps ringing with no voicemail or answering machine
No Show	Client did not come to a scheduled meeting
Phone Disconnected	Phone number no longer in service
Sent	Mail to client
Sent Message	Text or email to client
Wrong Number	Client unreachable at given number
Other	Include specifics in the Contact Notes field

Documenting on Closed Client Records

A new Community Based Services (CBS) referral should be entered if the client's circumstances have changed and the client requires a new round of case management. If the client does not need a new round of case management, Encounters/Engagements and RRAs can be entered on closed client records. *See RRA User Guide for details on adding RRAs to Closed Records.*

To add an Encounter/Engagement via Closed Patients List:
Login > Click Program/Service > Click Patients > Click Closed Patients List > Click Client Name > Click green circle icon > Enter Contact Date > Select Contact Method > Select Contact Outcome > Enter Contact Notes > Click Save Contact > Click Back to List > Encounter/Engagement is now viewable under Patient Encounters



Encounters/Engagements and RRAs can be added to closed records

Record Status Updates

Agencies should have clear procedures outlining whether supervisor or staff are responsible for managing the record status throughout the client's time with the agency. Record status changes must be made on the same day the updates occur. PRA|SPECT will date stamp the record according to the day the record status is physically changed. This information updates in real-time on the record's Program/Status History.

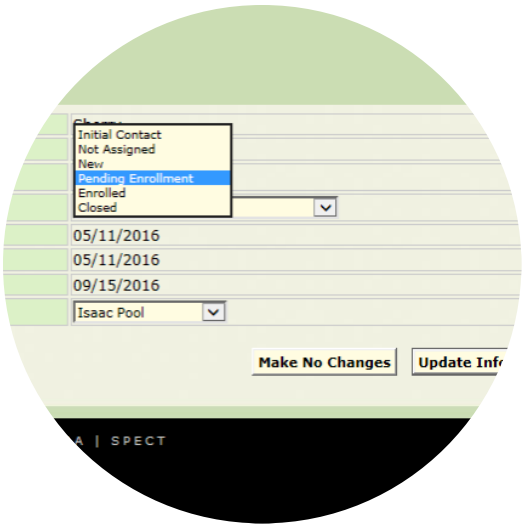
Only supervisor level has access to change the record status from New to Pending Enrolled via the Referrals tab to assign the client to a staff person for management. Once the record has reached Pending Enrolled, all subsequent record status updates must be made via the Patients tab. *Supervisors see Assigning Referrals User Guide for record status updates for New to Pending Enrolled.*

Client Record Status	
Initial Referral	Two-page Community Health Screening has not yet been submitted
New	Client is new to agency and has not yet been assigned to a staff person
Pending Enrolled	Client is assigned to a staff person and is on Newly Assigned Patients List
Enrolled	Client is assigned to a staff person and is on Enrolled Patients List
Closed	Client is assigned to a staff person and is on Closed Patients List

Status Updates & Record Location	
New to Pending Enrolled	Referrals tab: Moves record from Newly Referred Clients to Patients tab Newly Assigned Patients List
Pending Enrolled to Enrolled	Patients tab: Moves record from Newly Assigned Clients to Enrolled Patients List
Enrolled to Closed (Patient Option)	Patients tab: Moves record from Enrolled Patients List to Closed Patients List
New to Closed (Return to HUB)	Referrals tab: Moves record from Newly Referred Clients to HUB Returned Referrals
Pending Enrolled to Closed (Return to HUB)	Patients tab: Moves record from Newly Assigned Clients to HUB Returned Referrals
Enrolled to Closed (Return to HUB)	Patients tab: Moves record from Enrolled Patients List to HUB Returned Referrals

To change the record status from Pending Enrolled to Enrolled:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click top pencil icon > Select Enrolled from Client Status > Select Not Closed from Program Closed Reason > Click Update Information > Record moves from Newly Assigned Patients List to Enrolled Patients List

To change the record status from Enrolled to Closed (Patient Option):
Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click top pencil icon > Select Closed from Client Status > Select Patient Option from Program Closed Reason > Click Update Information > Record moves from Enrolled Patients List to Closed Patients List



Status must be changed on the same day record updates occur

To change the status from Pending Enrolled to Closed (Return to HUB):
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click top pencil icon > Select Closed from Client Status > Select Return to HUB from Program Closed Reason > Select Update Information > Referral moves from Newly Assigned Patients List to HUB Returned Referrals

To change the status from Enrolled to Closed (Return to HUB):
Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click top pencil icon > Select Closed from Client Status > Select Return to HUB from Program Closed Reason > Select Update Information > Referral moves from agency's Enrolled Patients List to HUB's Returned Referrals

Patient Information Update

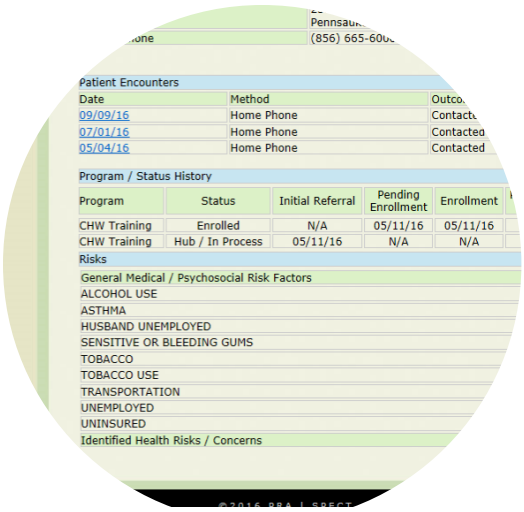
Select fields can be updated on the client profile via the Patient Information Update. Updatable fields include address, phone, primary language, and date of birth. If a change has been made via the Patient Information Update, the This patient has multiple address entries link will appear to summarize the modification history. Community Health Screening (CHS) referral fields can be updated via CHS Update. *See Updating the CHS User Guide for further details.* Email SPECT@snjpc.org to request a change to any other Perinatal Risk Assessment/PRA Follow-up fields. *Supervisors see Assigning Referrals for further details on Patient Information Update via Referrals tab.*

To modify client details via the Patient Information Update on Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click pencil icon to left of Patient Information > Enter fields to be modified > Click Save > Updated variables display on client profile and This patient has multiple address entries link appears

To modify client details via the Patient Information Update on Enrolled Patients List:

Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click pencil icon to left of Patient Information > Enter fields to be modified > Click Save > Updated variables display on client profile and This patient has multiple address entries link appears

To modify client details via the Patient Information Update on Closed Patients List:
Login > Click Program/Service > Click Patients > Click Closed Patients List > Click Client Name > Click pencil icon to left of Patient Information > Enter fields to be modified > Click Save > Updated variables display on client profile and This patient has multiple address entries link appears



Risks summary displays items recorded on original referral form

Incomplete Initial Referral Monitoring

Once outreach time expires, Initial Referrals that do not progress to status Screening Completed (two-page Community Health Screening form submitted) should be closed.

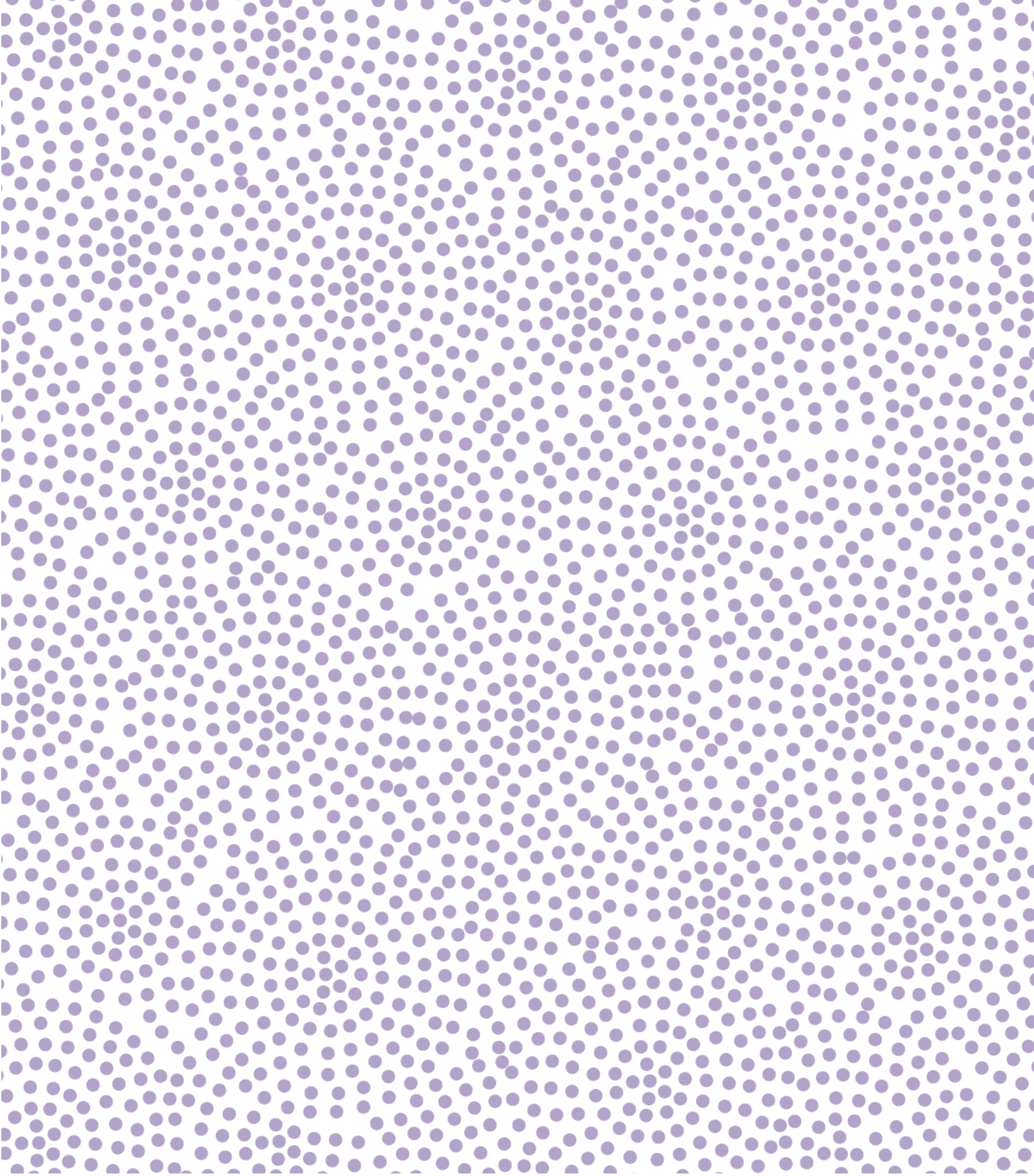
To change the record status from Initial Referral to Closed (Patient Option):
Login > Click Program/Service > Click Initial Referral > Click Search Modify > Click Advanced Search > Enter search fields > Click Search Patients > Click Contact Date to left of client name > Click top pencil icon on client profile > Select Closed from Client Status > Select Patient Close Option from Program Closed Reason > Click Update Information > Closed record remains retrievable on Initial Referrals Advanced Search

Program Status/History

The Program Status/History is viewable at the bottom of the client profile, and maps the journey the client record has taken through PRA|SPECT. Record status updates are viewable on the Program Status/History in real-time. Initial Referral is the date the one-page Initial Referral form is submitted. Perinatal Risk Assessment/PRA Follow-up referrals display an N/A for Initial Referral date. Pending Enrolled is the date the client was assigned to a staff person for management. Enrolled is the date the client enrolled in the program/service. Closed is the date the record was closed. The closed reason is required in order to close the record.

Risks Summary

The Risks Summary is viewable at the bottom of the client profile, and displays the key items outlined on the client's original referral forms. The summary affords a quick overview of the client's identified needs and risks. However, it should not replace doing an additional program evaluation.



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PRA|SPECT RRAs

Resources, Referrals, and Appointments (RRAs)

All Resources, Referrals, and appointments (RRAs) made for participants are entered on PRA|SPECT. New RRA items can be added at any point on time on the client profile via Encounter/Engagement Add New RRA link. Staff are responsible for recording, tracking, and updating outcomes for all RRAs.

Add resource, referral, appointment link appears once Encounter/Engagement is saved

Original Referral RRAs

Referred selections made in the Plan of Care section on the Perinatal Risk Assessment/PRA Follow-up or the Referrals/Education section on the Community Health Screening automatically populate as an Encounters/Engagement on the client profile. The staff person managing the client is responsible for following up and recording outcomes. System-generated items appear as Encounter/Engagements with "Screening" as the method, and contain "Ed/Referral from Screen" in the RRA notes field.

RRA Definitions	
Resource	Service or agency information given to client
Referral	Service or agency information given to client with a call to action
Appointment	Specific date/time made for client to meet with agency
Outcome	End result of resource, referral, or appointment that must be entered for agency to receive credit for outreach effort
Outcome Date	The day outcome action occurred per client, case manager, or referred-to agency

RRA Status

The status indicates whether an RRA outcome has been recorded.

RRA Status	
Open	Active RRA with outcome and outcome date not yet entered
Closed	Completed RRA with outcome and outcome date entered

RRA Outcomes

The Outcome is the end result of the RRA that can be entered at any level of record status (New, Pending Enrolled, Enrolled, and Closed). The RRA status is completely independent from the record status. Open client profiles can have open or closed RRAs and closed client profiles can have open or closed RRAs.

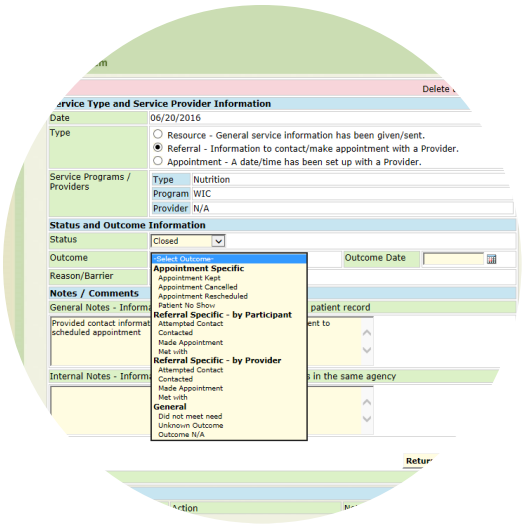
Recording the Outcome is a two-step process that involves changing the RRA status from open to closed, and entering the Outcome and Outcome Date. Outcomes are broken into four categories based upon the action of the client, case manager, or referred-to agency. A Reason/Barrier selection is required for all General category outcome selections.

RRA Outcome Categories		
Appointment Specific	Appointment Kept	By client
	Appointment Cancelled	By client or case manager
	Appointment Rescheduled	By client or case manager
	Patient No Show	Client did not attend or reschedule
Referral Specific – By Participant	Attempted Contact	By client
	Contacted	By client
	Made Appointment	By client
	Met with	By client
Referral Specific – By Provider	Attempted Contact	By referred-to agency
	Contacted	By referred-to agency
	Made Appointment	By referred-to agency
	Met with	By referred-to agency
General	Did not meet need	By client
	Unknown Outcome	Client unable to supply further details
	Outcome N/A	Client did not engage in RRA

RRA Reason/Barrier Options	
Agency did not return client calls	Referred-to agency did not contact client
Already receiving service	Client currently receiving service
Childcare unavailable	Client does not have care for child(ren)
Client did not follow-up	Client knowingly did not take action
Client forgot about referral	Client unknowingly did not take action
Client lost referral information	Client no longer has agency contact details
Client too busy	Client did not have time
Could not get appointment	Client unable to schedule time with agency
Could not miss work	Client unable to get time away from job
Felt was not important	Client did not see value in RRA
Financial barrier	Client financially unable to access RRA
Geographically inaccessible	Client physically unable to access RRA
Housing issue	Client living accommodations prevented access to RRA
Insufficient participant resources	Client unable to access RRA due to lack of resources
Lack of trust	Client did not feel comfortable with RRA
Language barrier	Communication issue due to language
No health insurance	Client unable to access RRA due to lack of health insurance
No phone	Client unable to access RRA due to lack of phone
No transportation available	Client unable to access RRA due to lack of transportation
Not eligible for service	Client does not meet service criteria
Office hours	Client unable to access RRA due to agency hours
Other (specify)	Any other option not listed on Reason/Barrier menu
Parent won't provide consent	Underage client's parent(s) unwilling to give consent
Perceived discrimination	Client perception of being treated differently due to race, creed, sexual orientation, socioeconomic status, etc.
Rejected for service	RRA not accepted by referred-to agency
Religious barrier	Client unable to engage in RRA due to personal life beliefs
Service not available	Referred-to agency unable to accommodate RRA
Was not referred	Case manager did not supply referral information

To enter RRA Outcome via Newly Assigned Patients List:
Login > Click Program/Service > Click Patients > Click Newly Assigned Patients List > Click Client Name > Click Encounter/Engagement > Click pencil icon to upper right of RRA item > Select Closed from Status > Select Outcome > If General Outcome, select Reason/Barrier > Enter Outcome Date > Click Save

To enter RRA Outcome via Enrolled Patients List:
Login > Click Program/Service > Click Patients > Click Enrolled Patients List > Click Client Name > Click Encounter/Engagement > Click pencil icon to upper right of RRA item > Select Closed from Status > Select Outcome > If General Outcome, select Reason/Barrier > Enter Outcome Date > Click Save



Outcomes must be entered for all resources, referrals, and appointments

To enter RRA Outcome via Closed Patients List:
Login > Click Program/Service > Click Patients > Click Closed Patients List > Click Client Name > Click Encounter/Engagement > Click pencil icon to upper right of RRA item > Select Closed from Status > Select Outcome > If General Outcome, select Reason/Barrier > Enter Outcome Date > Click Save

To enter RRA Outcome via Referrals Search (HUB and supervisor level only):
Login > Click Program/Service > Click Referrals > Click Search Referrals > Enter search fields > Click Search Patients > Click Client Name > Click Encounter/Engagement date > Click pencil icon to upper right of RRA item > Select Closed from Status > Select Outcome > If General Outcome, select Reason/Barrier > Enter Outcome Date > Click Save

Navigating RRAs

Once added, RRAs are viewable on the client profile via summary on the Encounter/Engagement. Encounters/Engagements with at least one RRA display with a VIEW option under the Appt/Ref column to the far right of the item. Clicking View presents a summary of the RRA items attached to the Encounter/Engagement. This option allows users to easily determine if an Outcome has been entered. Items without Outcomes entered will appear with blank Outcome and Outcome Date fields. Items with Outcomes entered will appear with populated Outcome and Outcome Date fields. However, a much more efficient way to manage items is to use the RRA Status Report.

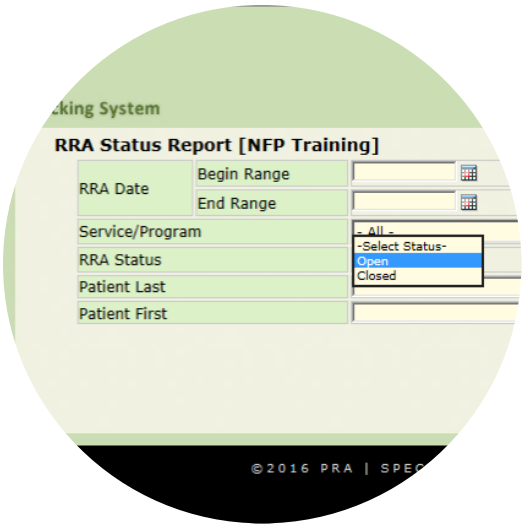
RRA Status Report

The RRA Status Report enables users to easily search their agency's RRA items. It can be run in a variety of ways to support staff and supervisors with RRA tracking and recordkeeping. The client profile can be accessed from the status report search results. Notate the RRA date prior to clicking the client name to quickly identify which Encounter/Engagement contains the open items. The RRA Status is completely independent from the Record Status. Open client records can have Open or Closed RRAs. Closed Records can have Open or Closed RRAs. The RRA Status Report captures RRA items regardless of record status Open or Closed.

To generate a list of a client's RRAs:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Enter client's name > Click Search RRAs

To generate a list of a client's incomplete RRAs:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Select Open from RRA Status > Enter client's name > Click Search RRAs

To generate a list of your agency's open RRA items:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Select Open from RRA Status > Click Search RRAs



Open status displays resources, referrals, and appointments without outcomes

To generate a list of your agency's incomplete RRA items for a specific time period:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Enter Begin Range Date and End Range Date > Select Open from RRA Status > Click Search RRAs

To generate a list of your agency's completed RRA items for a specific time period:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Enter Begin Range Date and End Range Date > Select Closed from RRA Status > Click Search RRAs

To generate a list of RRA items by service/program for a specific period of time:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Enter Begin Range Date and End Range Date > Select service/program > Click Search RRAs

To generate a list of completed RRA items by service/program for a specific period of time:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Enter Begin Range Date and End Range Date > Select service/program > Select Open from RRA Status > Click Search RRAs

To generate a list of incomplete RRA items by service/program for a specific period of time:
Login > Click Program/Service > Click Reports > Click RRA Status Report > Enter Begin Range Date and End Range Date > Select service/program > Select Open from RRA Status > Click Search RRAs

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PRA|SPECT Form Generation

Referral Forms

Blank Initial Referral (IRF) and Community Health Screening (CHS) are available for download or print via the Forms tab. Supervisor and staff users are able to generate agency-specific IRF forms in English or Spanish. HUBs users are able to generate agency-specific IRFs in English for their partner agencies.

Initial Referral populates agency-specific information

To print blank Initial Referrals (one-page):
Login > Click Program/Service or HUB > Click Forms > Click Initial Referral Form > Select Form Language > Right-click on form window > Select Print > Select desired copies > Click Print

To download a PDF file of blank Initial Referral (one-page):
Login > Click Program/Service or HUB > Click Forms > Click Initial Referral Form > Select Form Language > Click floppy disk icon > Select location to Save > Click Save

To print blank Community Health Screenings (two-pages):
Login > Click Program/Service or HUB > Click Forms > Click Community Health Screening Form > Right-click on top of form window > Select Print > Select desired copies > Click Print

To download a PDF file of Community Health Screening (two-pages):
Login > Click Program/Service or HUB > Click Forms > Click Community Health Screening Form > Click floppy disk icon > Select location to Save > Click Save

HUB exclusive: To print partner agency Initial Referrals:
Login > Click HUB > Click Forms > Click Initial Referral Form > Select agency from Provider > Click Generate Forms > Right-click on form window > Select Print > Select desired copies > Click Print

HUB exclusive: To download a PDF file of partner agency Initial Referral:
Login > Click HUB > Click Forms > Click Initial Referral Form > Select agency from Provider > Click Generate Forms > Click floppy disk icon > Select location to Save > Click Save

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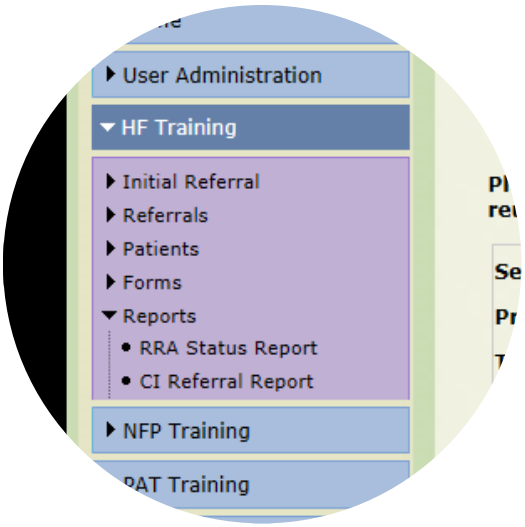
PRA|SPECT CI Referral Report

Central Intake (CI) Referral Report

The Central Intake (CI) Referral Report is available for HUBs, Central Intake Services, Community Home Visiting (CHV) programs, and Community Health Worker (CHW) programs to showcase and evaluate program accomplishments. In addition, the CI Referral Report serve as a tool to enable agencies to improve and expand their outreach, services, and number of clients served. Reports are also used for identifying trends and advocating as needed.



CI Referral Report is available to all users

Report Design

The CI Referral Report is designed to be run for a three-month date range, and does not matter if it starts on the first or any other day of the month (ex: 01/20/16 – 04/20/16 is acceptable). The CI Referral Report displays data for referrals originating from the agency. The data out is only as good as the data entered into the system. Therefore, supervision should work closely with staff to ensure the accuracy of documentation on PRA|SPECT.

To generate a CI Referral Report:
Click Program/Service or HUB > Click Reports > Click CI Referral Report > enter Begin and End Dates for three-month time period > Click Generate Report

CI Referral Report Fields		
Section 1	All Incoming Referrals	
	Initial Referrals (not Progressed to CHS)	
	Completed CHS not referred to CI (Refused)	
	Completed CHS referred to CI	
	Total CHS Screens referred to CI	
Section 1A	Referrals by Patient Type	
	Interconceptional	
	Pregnant	
Section 1B	Incoming Referrals Sent to Programs	
	Referred To	
	Enrolled In	
Section 2	Referrals – Pregnant Women	
	1st trimester	
	2nd trimester	
	3rd trimester	
	Unknown	
	Subset – Pregnant in Need of Link to PNC	
	CI referral to Pregnancy Testing	
	CI referral to Prenatal Care	

	Pregnant – Parity	
	First Time Mother	
	Subsequent Birth	
	Missing	
	Pregnant – DFD-TANF/GA	
	TANF/GA	
	Unknown	
Section 3	Referral - # of Parents w/ Infants/Young Children Needing Service	
	Parents with Newborns ≥ 30 days	
	Parents with infants 1-12 months	
	Parents with children 1-2 years of age	
	Parents with children 3-5 years of age	
	Parents with children 6-8 years of age	
	Parents with children 9-14 years of age	
	Parents with children 15-17 years of age	
	Parents with children 18-19 years of age	
	Subset: Interconceptional Women	
	Women with No Primary Care Provider (referred after birth)	
	Children with No Primary Care Provider	
Section 4	# of Individual referrals to community services	
	Healthcare	
	Behavioral Health	
	Breastfeeding Consult	
	Dental Services	
	Developmental Screening & Services	
	Diabetes Care Program	
	Eye Care	
	Family Health	
	Family Planning	
	HIV Testing	
	HIV/AID Care & Treatment	
	Hospitals	
	Immunizations	
	Lead Testing	
	Postpartum Care	
	Pregnancy Testing	
	Prenatal Care	
	Primary Medical Care Children	
	Primary Medical Care – Other	
	Primary Medical Care – Participant	
	Public Health Nursing	
	Smoking Cessation	
	STI Testing	

	Women's Health	
	Nutrition	
	Food Pantry	
	Jolin Food Box	
	Meals	
	Nutritional Consult	
	WIC	
	Family & Social Support	
	Baby Pantry	
	Basic Needs/General	
	Childcare	
	Childbirth Education	
	Community Centers	
	Disability Services	
	Early Head Start/ Head Start	
	Early Intervention (EIP)	
	Family Success Center	
	Fatherhood Services	
	Parent Aide Services	
	Parenting Education	
	Parenting Groups	
	Recreational Services	
	School Based Services	
	Youth Programs	
	Public Benefits	
	Emergency Assistance	
	Energy Assistance	
	Food Stamps	
	General Assistance (GA)	
	Medicaid	
	NJ Family Care	
	SSI	
	TANF	
	Concrete Services	
	Clothing, Furniture, Other Household Items	
	Emergency Shelter	
	Housing Assistance	
	In-Kind	
	Transportation	
	Counseling & Intensive Support	
	Crisis Intervention	
	DCP&P	
	Domestic Violence Services	
	Mediation	
	Mental Health Counseling	

	Psychiatric or Psychological Treatment	
	Special Child Healthcare	
	Substance Abuse Assessment	
	Substance Abuse Services	
	Support Groups	
	Employment, Training, Education	
	Adult Basic Education	
	College	
	Employment Services	
	ESL (English as a Second Language)	
	GED Preparation	
	Health Education	
	Job Training Program	
	Special Education	
	Vocational or Jobs Skills Training	
	Other Services	
	ACA Navigators	
	Health Related Case Management	
	Immigration Services	
	Insurance Services	
	IPO Outreach & Case Management	
	Legal Services	
	Money Management	
	Other social services	
	Out-of-service area	
	Translation Services	
Section 5	# of Completed Referrals through Central Intake per quarter	
	Healthcare	
	Behavioral Health	
	Breastfeeding Consult	
	Dental Services	
	Developmental Screening & Services	
	Diabetes Care Program	
	Eye Care	
	Family Health	
	Family Planning	
	HIV Testing	
	HIV/AID Care & Treatment	
	Hospitals	
	Immunizations	
	Lead Testing	
	Postpartum Care	
	Pregnancy Testing	
	Prenatal Care	
	Primary Medical Care Children	

	Primary Medical Care – Other	
	Primary Medical Care – Participant	
	Public Health Nursing	
	Smoking Cessation	
	STI Testing	
	Women's Health	
	Nutrition	
	Food Pantry	
	Jolin Food Box	
	Meals	
	Nutritional Consult	
	WIC	
	Family & Social Support	
	Baby Pantry	
	Basic Needs/General	
	Childcare	
	Childbirth Education	
	Community Centers	
	Disability Services	
	Early Head Start/ Head Start	
	Early Intervention (EIP)	
	Family Success Center	
	Fatherhood Services	
	Parent Aide Services	
	Parenting Education	
	Parenting Groups	
	Recreational Services	
	School Based Services	
	Youth Programs	
	Public Benefits	
	Emergency Assistance	
	Energy Assistance	
	Food Stamps	
	General Assistance (GA)	
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	TANF	
	Concrete Services	
	Clothing, Furniture, Other Household Items	
	Emergency Shelter	
	Housing Assistance	
	In-Kind	
	Transportation	
	Counseling & Intensive Support	

	Crisis Intervention	
	DCP&P	
	Domestic Violence Services	
	Mediation	
	Mental Health Counseling	
	Psychiatric or Psychological Treatment	
	Special Child Healthcare	
	Substance Abuse Assessment	
	Substance Abuse Services	
	Support Groups	
	Employment, Training, Education	
	Adult Basic Education	
	College	
	Employment Services	
	ESL (English as a Second Language)	
	GED Preparation	
	Health Education	
	Job Training Program	
	Special Education	
	Vocational or Jobs Skills Training	
	Other Services	
	ACA Navigators	
	Health Related Case Management	
	Immigration Services	
	Insurance Services	
	IPO Outreach & Case Management	
	Legal Services	
	Money Management	
	Other social services	
	Out-of-service area	
	Translation Services	
Section 6	Other Indicators – Profile Data for Women/Families (screens/referrals)	
Section 6A	Demographic Information	
Section 6A1	Municipality	
Section 6A2	Age	
	< 15	
	15-17	
	18-19	
	20-25	
	26-40	
	> 40	
Section 6A3	Ethnicity & Race	
	Ethnicity	
	Hispanic Origin	
	Not of Hispanic Origin	

	Hispanic origin not specified	
	Race	
	White	
	Black	
	Multiracial	
	Asian	
	Alaskan/Pacific Islander	
	Native American	
	Other	
	Unspecified	
Section 6A4	Gender	
	Male	
	Female	
Section 6A5	Referral Source/Prenatal Care Providers	
Section 6B	Economic Status	
Section 6B1	Uninsured	
Section 6B1A	Uninsured upon referral to CI	
Section 6B1B	CI referred & connected to Medicaid or Presumptive Eligibility (PE)	
Section 6B1C	CI referred & Connected to NJ Family Care	
Section 6B1D	Not Eligible (Reason)	
Section 6B2	Insured	
Section 6B2A	Medicaid Presumptive Eligibility (PE) application completed at PNC office	
Section 6B2B	Medicaid (had no coverage prior to pregnancy)	
Section 6B2C	NJ Family Care (had no coverage prior to pregnancy)	
Section 6B2D	Private Insurance (had coverage prior to pregnancy)	
Section 6B3	HMO (if applicable)	
Section 6B4	Other Economic Issues	
Section 6B4A	WIC Enrolled	
	Eligible and referred to CI	
Section 6B4B	TANF/GA enrolled	
	Eligible and referred to CI	
Section 6B4C	Food Stamps Enrolled	
	Eligible and referred to CI	
Section 6B4D	Other	
Section 6C	4P's Plus	
Section 6C1	Tobacco use	
	# of new referrals made by CI or partner	
Section 6C2	Alcohol or Other Drug use	
	# of new referrals made by CI or partner	
Section 6C3	Depression/Mental Health	

	# of new referrals made by CI or partner	
Section 6C4	Domestic Violence	
	# of new referrals made by CI or partner	
IR/CHS Stats	Total # of screens	
	CHS screens referred to CI	
IR/CHS Stats	CHS screens refusing referral to CI Initial Referrals completed during report period but not progressed to full CHS	
	Total # of above Initial Referrals progressed to full CHS after report period	

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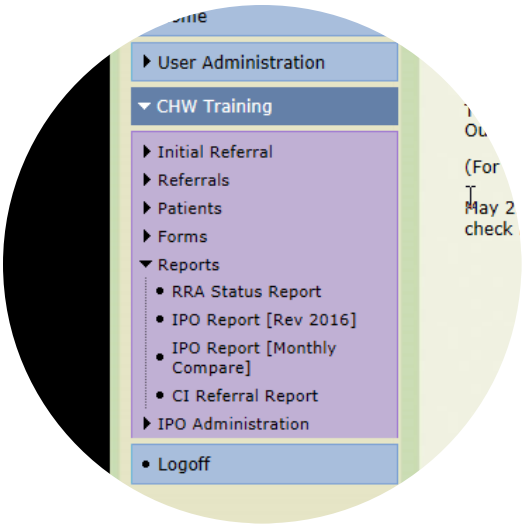
PRA|SPECT IPO Report

Improving Pregnancy Outcomes Outcome (IPO) Report

The Improving Pregnancy Outcomes (IPO) Report is available for Community Health Worker (CHW) Supervisors to showcase and evaluate program accomplishments. In addition, the IPO Report serves as a tool to enable CHW programs to improve and expand their outreach, services, and number of clients served. Reports are also used for identifying trends and advocating as needed.



[Monthly Compare] breaks out report by month and will differ if compared side-by-side to IPO Report

Report Design

The IPO Report is designed to be run for a three-month date range, and does not matter if it starts on the first or any other day of the month (ex: 01/20/16 – 04/20/16 is acceptable). The data out is only as good as the data entered into the system. Therefore, supervision should work closely with staff to ensure the accuracy of documentation on PRA|SPECT. Comparing IPO Report side-by-side to IPO Report Monthly Compare will yield different fields results depending on activity as broken out per month (ex: If Initial Referral progressed to CHS in month 2, IPO Monthly compare will breakout referral update per month. IPO Report will show all Initial Referrals progressed to CHS for entire time period.)

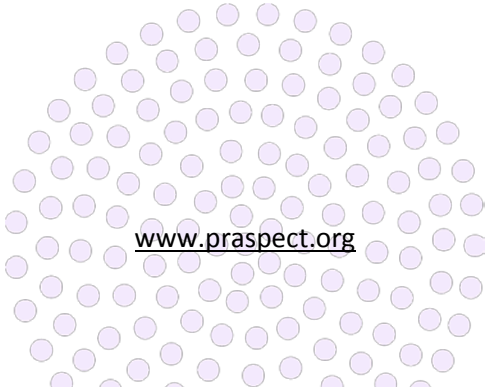
To generate IPO Report:
Click Program/Service > Click Reports > Click IPO Report > enter Begin and End Dates for three-month time period > Click Generate Report

To generate IPO Report [Monthly Compare]:
Click Program/Service > Click Reports > Click IPO Report [Monthly Compare] > enter Begin and End Dates for three-month time period > Click Generate Report

IPO Report Fields		
Section 1	Education/Consumers	
	# Programs	
	# Participants	
Section 2	Meetings/Professional Education	
	# of Meetings	
	# of Participants	
Section 3	Outreach/Activities	
	# of Activities	
	# of Participants	
Section 4	Referrals Initiated in Report Period	
	Total Referrals Initiated	
	IR not progressed to CHS	
	IR refused consent to continue to CHS	
	IR progressed to CHS during report period [referred to CI]	

	IR progressed to CHS during report period refusing consent to CI	
	IR progressed to CHS during report period but not referred to CI	
	IR progressed to CHS after report period [referred to CI]	
	IR progressed to CHS after report period refusing consent to CI	
Section 5	Patient Type (of referrals initiated in report period)	
	Initial Referral	
	# Preconception women	
	# Interconception women	
	# Pregnant women	
	# Men	
	Community Health Screening	
	# Preconception women	
	# Interconception women	
	# Pregnant women	
	# Men	
Section 6	CHS Completed (in report period)	
	Total CHS Completed	
	CHS Complete where Initial Referral made in report period	
	CHS Complete where Initial Referral made prior to report period	
Section 7	Case Management	
	Preconception women	
	Interconception women	
	Pregnant women	
	Fathers with children	
Section 8	Pregnancy Testing	
	Negative Pregnancy Test Results	
	# referred to interconception care during this report period	
	# referred to interconception care to date	
	Positive Pregnancy Test Results	
	# referred to prenatal care during this report period	
	# referred to prenatal care to date	
Section 9	Resources, Referrals, and Appointments	
	RRAs Made	
	Resources	
	Referrals	
	Appointments	

	Completed RRAs by Type and Outcome	
	Resources	
	Referrals	
	Appointments	
Section 10	Population Served	
	# Female	
	# Male	
	< 18	
	18 – 25	
	26 – 40	
	> 40	
	White	
	Black	
	Asian	
	Alaskan/Pacific Islander	
	Native American	
	Hispanic Origin	
	Multiracial	
	Other	



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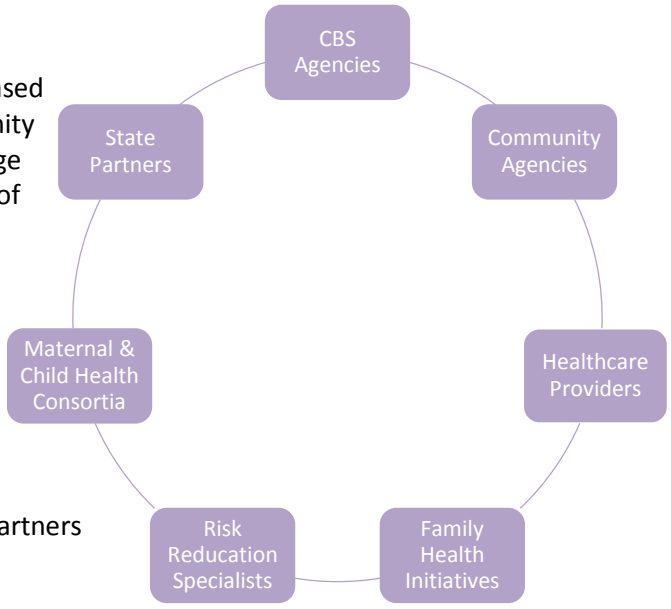
PRA|SPECT CBS Referral Marketing

Promoting the Community Based Services (CBS) Referral

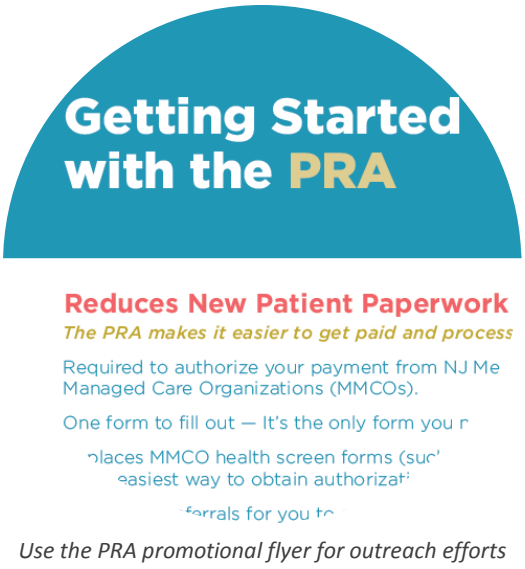
Agencies are responsible for marketing the Community Based Services (CBS) referral in their respective county. Community partners should always support one another and encourage openness to any program or service available in the state of New Jersey. Shared goals are as follows:

- Further collaboration amongst statewide partners
- Increase in public awareness of CBS Referral
- Increase in CBS referrals via Initial Referral/ Community Health Screening (CHS)
- Increase in CBS referrals via Perinatal Risk Assessment/PRA Follow-up
- Sharing outreach success stories with statewide partners



Community Partnerships		
Community Based Services Agencies	Agencies that use PRA|SPECT to manage clients referred to CBS and may also make CBS referrals	
Community Agencies	Agencies that make CBS referrals	
Family Health Initiatives	Private, nonprofit contracted by Department of Health under agreement with Department of Human Services Division of Medical Assistance & Health Services	
Healthcare Providers	Includes primary and prenatal care. Prenatal care providers make CBS referrals via Perinatal Risk Assessment/PRA Follow-up	
Maternal & Child Health Consortia	Partnership for Maternal & Child Health of Northern New Jersey	www.partnershipmch.org
	Central Jersey Family Heath Consortium	www.cjfhc.org
	Southern New Jersey Perinatal Cooperative	www.snjpc.org
Risk Reductions Specialists	Bergen, Essex, Hudson, Morris, Passaic, Sussex, Union, Warren	www.partnershipmch.org
	Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset	www.cjfhc.org
	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem	www.snjpc.org
State Partners	Department of Health	www.nj.gov/health
	Department of Human Services	www.state.nj.us/humanservices
	Department Children and Families	www.state.nj.dcf

Figure 1 Community Based Services (CBS) Referral Statewide Partners



Use the PRA promotional flyer for outreach efforts

Identifying Training Needs

All PRA|SPECT training for prenatal providers and community agencies is conducted by Family Health Initiatives (FHI). Agencies should direct providers and partners in need of assistance to FHI:

- Email site or partner details to SPECT@snjpc.org for FHI outreach
- Assist OB providers with FHI contact information 856-665-6000 or PRA@snjpc.org and linkage to PRA training. FHI contact information is available on the PRA promotional flyer

To access a web-friendly PRA promotional flyer file to distribute via email:
Visit www.praspect.org > Click Documents > Click Prenatal Care Providers > Click Getting Started with the PRA > Click floppy disk to save PDF file > Note: Email SPECT@snjpc.org to get a print-friendly copy of PRA promotional flyer

To help an OB provider sign up for PRA training:
Visit www.praspect.org > Click Documents > Click Prenatal Care Providers > Click training schedule > Click desired date/time link to access event registration > Enter name, email, job title, organization > Click register > Person will receive email with link and instructions to access live webinar training

To help a community partner sign up for PRA training:
Visit www.praspect.org > Click Documents > Click Community Based Services – Training Schedules > Click training schedule > Click desired date/time link to access event registration > Enter name, email, job title, organization > Click register > Person will receive email with link and instructions to access live webinar training

Promotional Materials

Individual agencies are responsible for designing and executing promotional materials used for CBS marketing and outreach. Think about your target audience, know your program or service, and be creative. Creative brainstorming is best nurtured in a free and open environment that encourages everyone to participate. What promotional item is your target audience likely to see or retain?

Promotional materials used by agencies include:

Baby bibs, baby bottles, door hangers, flyers, Frisbees, magnets, mousepads, mugs, notepads, keychains, onesies, pamphlets, pens, postcards, posters, rack cards, shirts, takeaway cards, USB drives, and more …

Successes with promotional materials should be shared with partner programs and services to foster a collaborative approach to statewide CBS outreach and marketing.

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PRA|SPECT FAQs

All Users	
Question	Answer
Why am I unable to view my referrals?	If the screen is gray or black, the cause may be a popup blocker. Change your settings to allow popups. Settings can change without your knowledge when your computer automatically downloads and installs Windows updates. For further assistance contact your IT department.
Why do I receive an error message when I change the record status from New to Pending Enrolled?	HTTP 400 Bad Request error message appears when the Newly Referred Clients list is very long (> 25 records) even when only one record is assigned at a time. Email SPECT@snjpc.org for assistance so programmer can temporarily reset the number of data elements until list is smaller. List will need to be decreased to (25) records at a time to avoid system timeout.
Why does the summary email indicate that there are new referrals, but no referrals appear on Unassigned Referrals, Newly Referred Clients, or Newly Assigned Patients List?	The email is a summary of the activity for the preceding (24-hour) period. If referrals were received and then processed during that same (24-hour) period, they will no longer appear on the respective list.
How do I change my password?	Login > Click User Administration > Click Account Update Options > Click Change Password
How do I register for webinar training?	Visit www.praspect.org > Click Documents > Click Community Based Services – Training Schedules > Click desired date/time link > Enter registration fields > Click Submit Registration > An email containing link and webinar instructions will be sent to supplied email address
How are referrals entered when the client only provides minimal information?	Some individuals refuse to provide any personal information aside from name and phone number. For these types of clients, canned required fields can be entered. For the address and city enter REFUSED. For phone enter 000-000-0000. For missing DOB use 01/01/1900. The zip and county determine which HUB receives the referral. Therefore, try an approach such as “I’d be happy to help you locate a food pantry. What city do you live in?”
Why am I unable to view a client on the Closed Patients List?	The Closed Patients List only displays the last (25) records based on record status date. If the client does not appear, use the Referrals Search (supervisor exclusive) to retrieve the record.
How do I take a screenshot?	Press Print Screen key > Press Control and letter V key to paste into body of email or document.

How do referrals get reassigned when clients move outside the current service area?	A new CBS referral is entered with the new address. The agency should alert the new HUB that the client is moving and a new referral will be entered into the system. HUB contact information is available on www.praspect.org > Click Documents > Click Prenatal Care Providers > Click Central Intake Contacts
Are race and ethnicity counted as one field?	No. Race and ethnicity are counted as separate fields.
How does a pregnant women not in prenatal care know her due date?	The client's last menstrual period (LMP) can be used to calculate her due date (EDD). If unknown, screeners can guestimate the EDD based upon the pregnancy details supplied by the client.
Should a closed record be opened if there is future contact with the client?	No. Encounters/Engagements and RRAs can be added to closed records. If circumstances have changed and client requires a new round of case management, a new CBS referral should be entered.
Can resources, referrals, and appointments be updated on closed records?	Yes. RRAs can be added or updated on closed records.
Would telling a client about childbirth classes and providing the registration link be entered as a referral or appointment?	Referral. Specific information was given to the client with a call to action.
How long are closed records viewable on PRA|SPECT?	Closed records do not have an expiration date and continue to be viewable on PRA|SPECT.
How do I close an Initial Referral when the client is unwilling to complete the Community Health Screening (CHS)?	Click Initial Referral > Click Search Modify > Click Advanced Search > Enter Client Name > Click Search Patients > Click date to left of client name > Click top pencil icon > Select Closed from Client Status > Select Patient Close Option > Click Update Information
How do I add an item that is not currently on the RRA Providers menu?	Email the type and full agency information to SPECT@snjpc.org (ex: Type – Healthcare, Program – Smoking Cessation, Provider Mom's Quit Connect)
Who is responsible for notifying the SPECT team when programs have supervisory or staff changes?	The agency is responsible for emailing SPECT@snjpc.org upon notification that users have been terminated or are out on extended leave of absence.
What does the open or closed status on the RRA Status Report control? Is it linked to the record status?	The open status displays incomplete RRAs. The closed status displays completed RRAs. The RRA status is completely independent from the record status.
What is the Program/Status History on the client profile? What does HUB/In Process mean?	The Program/Status History displays the referral path. Each separate program/service assignment receives its own line in the Program/Status History. HUB/In Process is the date the

	Community Health Screening (CHS) was submitted to the HUB.
Why does HUB/In Process appear in the Program/Status History for closed records?	HUB/In Process marks the date that the referral was sent to the HUB. It will always appear in the Program/Status History regardless of the record status.
Where is Community Home Visiting (CHV) on the RRA service provider and programs list?	A client can only be enrolled in one Community Based Services (CBS) agency at a time. Therefore, home visiting is not an RRA option. Enrolled clients desiring home visiting programs should be Closed with the Return to HUB option Returned for reassignment.
Why did PRA|SPECT timeout my account login?	For security purposes, the system will timeout after (45) minutes of inactivity. Another reason the system can logout a user is if another agency user accesses the same record at the same time.
What is the difference between referral specific- by participant and referral specific- by provider?	By participant means the client supplied the outcome. By provider means the agency supplied the outcome.
How do I reset the RRA dropdown menus if the incorrect type is selected?	Click SELECT at the top of the Type menu to reset the selections.
What does MIHOPE stand for?	Mother and Infant Home Visiting Program Evaluation is a legislatively mandated, large-scale evaluation of the effectiveness of home visiting programs.
What RRAs are automatically generated from Perinatal Risk Assessment/PRA Follow-up forms?	All Plan of Care items with Referred selections are generated as RRAs.
How should Substance Abuse Prevention Education or Substance Abuse Assessment referral generated from the 4Ps Plus on the CHS Update be logged?	The referral should be logged as an RRA item via Encounter/Engagement.
Who is responsible for CHS Updates?	The person that is managing the client.
How are Encounters/Engagements deleted?	Currently there is no way to delete an Encounter/Engagement. Deletion requests should be sent to SPECT@snjpc.org
Is the CHS update for both Pending Enrolled and Enrolled Clients?	Yes. The CHS Update should be completed for records on the Newly Assigned and Enrolled Patients Lists.

HUBS	
Question	Answer
Why did I receive a referral for a client that lives in a different county?	In most cases the incorrect county was entered on the PRA or CHS. HUBs should email SPECT@snjpc.org as soon as possible to move the referral to the correct HUB.

What should be done if the HUB receives a duplicate referral?	Duplicate referrals should be assigned with No Program Assignment [Denied] from Program Option.
How should a record be handled if services are necessary prior to availability of a program?	The referral can be assigned to a Central Intake (CI) Managed Service for linkage to resources until the program is ready to accept the client.
What is done with MIHOPE clients on the HUB Returned Referrals List?	Close the referrals by selecting No Program Assignment [Denied] from Program Option. The referral will still appear on the Patients tab under MIHOPE. MIHOPE referrals appear on the Returned Referrals List because many HUBs are responsible for sending out a packet of educational information and resources to clients. If the HUB does not need to send information or if it as already completed, assign the referral as No Program Assignment [Denied].
Will HUBs ever have the option to move referrals to different counties?	Currently only Family Health Initiatives (FHI) can move the referral. However, this feature may be added at some point in the future.
How should home visits be entered on Encounters/Engagements?	Select Met in Person from Contact Method > Select Contacted from Contact Outcome > Enter home visit and details (Ex: Home Visit: Discussed Chapter 2 of curriculum – Personal Hygiene) in Contact Notes

Community Health Workers (CHWs)	
Question	Answer
What is the correct way to identify the outreach type on the Initial Referral?	There are four outreach type options. Agency is used for forms entered as a result of agency outreach. Self is used for forms entered as a result of client self-referral. Door-to-door is used for forms entered as a result of door-to-door outreach. Event is used for forms as a result of outreach events.
Should Community Health Workers (CHWs) be creating outreach events for self-referrals?	Yes. CHWs should create weekly outreach events for self-referrals (ex: Self-Referrals Week of MM/DD/YY).
Are Community Health Workers (CHWs) able to enter outreach events from the past?	Yes. Outreach Events from the past can be entered in IPO Administration.
Under outreach event attendee totals, should only the target audience be entered?	No. Enter the total number of people (including men and women of all ages) that were interacted with at event.
How is an outreach entered for clients reached via food bank or other community location?	Use Public Setting as Event Type and include specifics in Event Name (i.e. Food Bank of South Jersey, Camden).

How is door-to-door outreach with flyers recorded in IPO Administration?	Select Door-to-door as the event type. List the number of flyers left in the Notes/Comments field. Record number of people interacted with as the total attend number. Record the total of completed Initial Referrals as the Initial/Screen number.

Community Home Visitors (CHV)	
Question	Answer
Are Community Home Visitors (CHVs) responsible for entering Resources, Referrals, and Appointments (RRAs) for Enrolled clients?	CHVs must enter RRAs for clients up to and including the point of enrollment in the program. Outcomes must be entered for all RRAs independent of enrollment.
Should Community Home Visitors (CHVs) add Encounters/Engagements after a client has enrolled in the program?	Encounters/Engagements must be recorded up to and including the point of enrollment in the program. It is helpful but not required to enter Encounters/Engagements after the point of enrollment.
If a client is active in a program for three years, does that mean that the CHS Update should be completed throughout the duration of services?	Prenatal fields for pregnant clients are only updatable for a specific time period based upon the client's due date. The CHS Update can be made at any point in time as long as the client is on the Newly Assigned or Enrolled Patients Lists. Updates are most common in the beginning of a participant's service. Often clients decline to answer some of the personal questions or do not yet feel comfortable in disclosing certain behaviors or risk factors. The CHS Update is geared towards these scenarios where more information is collected as trust is gained. CHS Updates are helpful after the point of enrollment, but are not required.

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PRA|SPECT Reports FAQs

CI Referral Report	
Question	Answer
Will our agency receive credit for a referral entered for a client outside of our service area?	Yes. The referral will show up as a CI Referral regardless of county entered.
Does the CI Referral Report pull information from the original CHS, CHS Update, or both?	The CI Referral Report pulls from both the original CHS and the CHS Update. Updated items are clearly indicated on the report.
When does the CHS count as a completed referral?	The Community Health Screening (CHS) counts as a completed referral once it is submitted.
What referrals are included in SectionA1A (Incoming)?	The HUB Report shows numbers for all referrals received by the HUB, including referrals received/entered by HUB plus those received/entered by programs. The referral source is viewable in Section 6A5.
How is the number of referrals to prenatal care calculated?	The CI Referral Report contains two line items for referrals to prenatal care: A2 Subset – Pregnant in need of prenatal care B CI Referral to prenatal care - The date range is the date the Initial Referral was submitted. This is a subset of pregnant patients. - If the participant is preconceptional, interconceptional, or male and a referral is marked for prenatal care, it is not included in the subset of pregnant women. - In order to count in the HUB Report, referral must be submitted. A4 Number of individual referrals to community services (including prenatal) - Date range for number of referrals made to community services is the actual date the RRA was made - Community Health Screening (CHS) referrals use date CHS submitted - RRAs added via Encounter/Engagement use date RRA made - Preterm Labor Prevention is counted as a referral for Prenatal Care - All HUB RRAs count toward the numbers in this section whether or not Community Health Screening (CHS) has been submitted to HUB
How is the number of referrals to CHV and CHW in Section 4 calculated?	The numbers are taken from RRAs added via Encounter/Engagement, and include only referrals made to programs. These are not the

	programs that HUB assigns to from Unassigned Referrals.

IPO Report	
Question	Answer
How is the number of participants calculated for Education/Consumers, Meetings/Professional Education, and Outreach Activities?	This number is taken from the Total Attend number entered on Outreach Events.
How is population served calculated?	This number is taken from the Event Attendee Totals for Age, Race, Ethnicity, and Gender.
Why are there numbers under pregnancy testing if agency does not perform pregnancy tests?	This number is calculated based upon pregnancy test date entered if information supplied by client regardless of agency that performed test.
How are the numbers under case management calculated?	These numbers only include clients with an Enrolled record status during the reporting period. The enrolled date is automatically generated when the record status is changed from Pending Enrolled to Enrolled. It is important to ensure that record status updates are made on the same day the client enrolls.

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PRA|SPECT Glossary

Term	Definition
1st trimester	1 to 12 weeks of pregnancy.
2nd trimester	13 to 27 weeks of pregnancy.
3rd trimester	28 to 40 weeks of pregnancy.
Alcohol Use	The consumption of any alcoholic substance including beer, wine, or liquor, during pregnancy.
Amnio Assess Lung Maturity	Fetal lung maturity testing involves taking a sample of amniotic fluid and testing it to determine whether the baby's lungs are mature enough for birth.
Amnio Genetic Screening	Genetic amniocentesis involves taking a sample of amniotic fluid and testing it for certain conditions, such as Down syndrome.
Artificial Insemination	Injection of semen into the vagina or uterus other than by sexual intercourse.
Assisted Reproductive Technology	Technology used to achieve pregnancy in procedures such as fertility medication, artificial insemination, in vitro fertilization and surrogacy.
Autism Spectrum Disorder	A serious developmental disorder that impairs the ability to communicate and interact.
Block Grant	A grant from a central government that a local authority can allocate to a wide range of services.
Blood Disorder	Affects one or more parts of the blood and prevents blood from doing its job.
Blood Type	Classification of blood based on the presence or absence of inherited antigenic substances on the surface of red blood cells.
Board of Social Services	New Jersey individual and family needs assistance and service agencies within the Department of Human Services Division of Family Development.
Cardiac Anomaly	Heart conditions that include diseased vessels, structural problems, and blood clots.
Cell Free DNA Test	Measures the relative amount of free fetal DNA in the mother’s blood which consists of approximately 2-6% of the total.
Cervical Cerclage	Treatment for cervical incompetence or insufficiency, when the cervix starts to shorten and open too early during a pregnancy causing either a late miscarriage or preterm birth.
Chlamydia	A common sexually transmitted infection that may not cause symptoms. The bacteria that causes chlamydia usually infects a woman's cervix or it may infect the urethra in men and women.
CMV	Cytomegalovirus is a genus of viruses in the order Herpesvirales, in the family Herpesviridae, in the subfamily Betaherpesvirinae.

Coarctation of the Aorta	A narrowing of the large blood vessel (aorta) that leads from the heart.
Cocaine	A powerful drug that is used in medicine to stop pain or is taken illegally for pleasure.
Commercial/Private Insurance	Non-Medicaid health insurance.
Community Based Services (CBS)	New Jersey CBS referral that links men, women, and children to local programs and services based upon individual needs.
Community Health Screening (CHS)	Two-page standardized tool used by community agencies to complete comprehensive screening to link pregnant women not in prenatal care, non-pregnant women, men, and children to Community Based Services (CBS) referral.
Congenital Anomalies	An often-inherited medical condition that occurs at or before birth.
Congenital Syndrome	Also known as congenital disease, birth defect or anomaly, is a condition existing at or before birth regardless of cause.
Contraceptives	A device or drug serving to prevent pregnancy.
CVS	Chorionic villus sampling, often referred to as CVS, is a diagnostic test for identifying chromosome abnormalities and other inherited disorders.
Department of Health (DOH)	Government agency that protects health and provides essential health services.
Department of Human Services (DOHS)	Government agency that protects health and provides essential health services.
Double Outlet Right Ventricle	(DORV) is a heart disease that is present from birth (congenital).
Ebstein Anomaly	A congenital heart defect in which the septal and posterior leaflets of the tricuspid valve are displaced towards the apex of the right ventricle of the heart.
Eclampsia	The onset of seizures (convulsions) in a woman with pre-eclampsia.
Epilepsy	A disorder in which nerve cell activity in the brain is disturbed, causing seizures.
External Cephalic Version Attempted	External cephalic version, or version, is a procedure used to turn a fetus from a breech position or side-lying (transverse) position into a head-down (vertex) position before labor begins.
Family Health Initiatives (FHI)	A private, nonprofit subsidiary of the Southern New Jersey Perinatal Cooperative contracted by the Department of Health under agreement with the Division of Medical Assistance and Health Services.

Fertility Enhancing Drugs	A drug used to increase a woman's fertility.
First Time Parent	A father or mother; one who begets or one who gives birth to or nurtures and raises a child; a relative who plays the role of guardian for the first time.
Gonorrhea	A sexually transmitted bacterial infection that, if untreated, may cause infertility.
Group Parent Support	Support groups designed to help families meet other families with similar needs.
Hep A	Highly contagious liver infection caused by the hepatitis A virus.
Hep B Serology	Testing involves measurement of several hepatitis B virus.
Hep B Surface Antigen	"Surface antigen" is part of the hepatitis B virus that is found in the blood of someone who is infected.
Hep C	An infection caused by a virus that attacks the liver and leads to inflammation.
Heroin	Heroin opioid pain killer. It is also used less commonly as a cough suppressant and as an antidiarrheal. Heroin is used as a recreational drug for its euphoric effects.
HPV	An infection that causes warts in various parts of the body, depending on the strain.
Hurricane Sandy	The deadliest and most destructive hurricane of the 2012 Atlantic hurricane season.
Hypertension	A condition in which the force of the blood against the artery walls is too high.
Hypoplastic Left Heart	A rare congenital heart defect in which the left heart is severely underdeveloped.
Illicit Drug Use	Abuse of illegal drugs and/or the misuse of prescription medications or household substances … use of any illegal or street drug during pregnancy.
Influenza	Influenza is a viral infection that attacks your respiratory system — your nose, throat and lungs.
Initial Referral Form (IRF)	The one-page standardized form used by community agencies to link pregnant women not in prenatal care, non-pregnant women, men, and children to the Community Health Screening (CHS) for CBS referral.
Interconceptional	Period between pregnancies for women of reproductive age.

Interrupted Aortic Arch	(IAA) is a relatively rare genetic disorder that usually occurs in association with a nonrestrictive ventricular septal defect (VSD) and ductus arteriosus or, less commonly, with a large aortopulmonary window or truncus arteriosus.
Intrauterine Insemination	(IUI) is a fertility treatment that involves placing sperm inside a woman's uterus to facilitate fertilization.
Listeria	Listeriosis, a serious infection usually caused by eating food contaminated with the bacterium Listeria monocytogenes.
Low Income	Insufficient monetary funds to support an individual or household.
Lung Disease	Any problem in the lungs that prevents the lungs from working properly.
Lyme Disease	A bacterial infection primarily transmitted by Ixodes ticks.
Malaria	A mosquito-borne infectious disease of humans and other animals caused by parasitic protozoans belonging to the Plasmodium type.
Marijuana	Cannabis, also known as marijuana among other names, is a preparation of the Cannabis plant intended for use as a psychoactive drug or medicine.
Medicaid MC	Managed Care Organizations (MCO) are healthcare partners that contract with a network of providers to provide covered services to their enrollees. MCOs are responsible to provide or arrange for the full range of healthcare services.
Medicaid PE	Presumptive eligibility (PE) allows children and pregnant women to get access to Medicaid or Chip services without having to wait for their application to be fully processed.
Medicare	Provides health insurance for Americans aged 65 and older who have worked and paid into the system. It also provides health insurance to younger people with disabilities, end stage renal disease and amyotrophic lateral sclerosis.
NJ Family Care	New Jersey's publicly funded health insurance program including CHIP, Medicaid and Medicaid expansion populations.
Opiate Dependence	Physical reliance on opioids (substance found in certain prescription pain medication and illegal drugs like heroin).

Opioid Replacement Treatment	Also called opioid substitution therapy or opioid maintenance therapy – replaces an illegal opioid such as heroin with a longer acting but less euphoric opioid. Such as methadone or buprenorphine.
Parvovirus	(CPV) infection is a highly contagious viral illness that affects dogs.
PRA First Visit Form	The two-page Perinatal Risk Assessment is completed for patients upon entry into prenatal care, and enables optional direct referral to Community Based Services (CBS).
PRA VIP Supplemental Form	The two-page Perinatal Risk Assessment Vital Information Platform (VIP) Supplemental is completed for patients between 30-34 weeks gestation, and enables optional direct referral to Community Based Services (CBS).
PRA|SPECT	Perinatal Risk Assessment & Single Point Entry Client Tracking is New Jersey's online web portal www.praspect.org that serves as secure and integral system of care to streamline community health navigation.
Preconceptional	Period of time prior to pregnancy.
Prevention Education	Educational methods or activities that seek to reduce or deter specific or predictable problems, protect the current state of well-being, or promote desired outcomes or behaviors.
Primary Care	A patient's main source for regular medical care, ideally providing continuity and integration of health care services.
Public Benefits	Government assistance for people who need help with food, healthcare, and day-to-day expenses.
Pulmonary Atresia	A form of heart disease that occurs from birth (congenital heart disease), in which the pulmonary valve does not form properly.
Pyelonephritis	Inflammation of the kidney due to a bacterial infection.
Reproductive Life Plan	A set of personal goals about having or not having children.
Rh Sensitization	A woman with a negative blood type (Rh negative) who has produced antibodies against her fetus with a positive blood type (Rh positive). The mother's body considered the fetal blood cells a foreign object and mounted an immune attack on it.
Rubella	A contagious viral infection preventable by vaccine and best known by its distinctive red rash.

Sandy Social Services	Funding that supports New Jersey efforts to address social services, health, and mental health services recovery needs of disaster survivors; and the repair, renovation and rebuilding of health care facilities (including mental health facilities), child care facilities, and other social services facilities damaged or destroyed by 2012 Hurricane Sandy.
Seizure Disorder	A disorder in which nerve cell activity in the brain is disturbed, causing seizures.
Selective Fetal Reduction	The practice of reducing the number of fetuses in a multifetal pregnancy.
Sensitive/bleeding gums	Swollen, red, tender gums that bleed when flossed or brushed. Also known as pregnancy gingivitis.
Single Ventricle	Defect are born with a heart that has only one ventricle large enough or strong enough to pump effectively.
Substance Abuse Prevention Education	Information on the effects of substance use.
Syphilis	A highly contagious disease spread primarily by sexual activity, caused by the bacteria Treponema pallidum.
Syphilis Serology	Tests detect antibodies in the blood and sometimes in the cerebrospinal fluid (CSF)
Tetralogy of Fallot	A congenital heart defect which is classically understood to involve four anatomical abnormalities of the heart.
Thalassemia	A blood disorder involving less than normal amounts of an oxygen-carrying protein.
Tocolysis	Tocolytics are medications used to suppress premature labor. They are given when delivery would result in premature birth.
Total Anomalous Pulmonary Venous Return	A rare congenital malformation in which all four pulmonary veins do not connect normally to the left atrium.
Toxoplasmosis	Results from infection with a common parasite found in cat feces and contaminated food.
Transp of Great Arteries	(TGA) is a heart condition that is present at birth, and often is called a congenital heart defect.
Trauma	A deeply distressing or disturbing experience or physical injury.
Truncus Arteriosus	A rare type of heart disease that occurs at birth (congenital heart disease), in which a single blood vessel (truncus arteriosus) comes out of the right and left ventricles, instead of the normal two vessels (pulmonary artery and aorta).

Tricuspid Atresia	A form of congenital heart disease whereby there is a complete absence of the tricuspid valve. Therefore, there is an absence of right atrioventricular connection. This leads to a hypoplastic (undersized) or absent right ventricle.
Ultrasound	A method of producing images of the inside of the body by using a machine that produces sound waves which are too high to be heard.
Uninsured/Self Pay	Includes charity pay, persons with no health insurance, and persons who pay cash for their healthcare.
Varicella Zoster	Virus (VZV) causes chickenpox and herpes zoster (shingles).
Vital Information Platform (VIP)	Web-enabled application www.vip.nj.gov used to register New Jersey vital events and related medical data.
West Nile Virus	West Nile fever is a mosquito-borne infection by the West Nile virus, and can cause neurological disease and death in people.