

User Guide

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child protection team
Children's Medical Services

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SECTION 1: OVERVIEW OF THE CHILD PROTECTION TEAM INFORMATION SYSTEM

1.1 Purpose of the System

This guide provides an overview of the operations of the Child Protection Team Information System (CPTIS). The system was created to meet the data needs of Child Protection Teams (CPT) and Children's Medical Services (CMS) by tracking abuse report reviews, intake, client registration, service provision and reports as well as training activities, determining program compliance with contractual requirements, and measuring program performance on key indicators. This system provides case coordinators, supervisors and managers with the ability to follow a case from the date services were initiated until the date the final case summary is sent to the protective investigator and the case is closed. Key elements of the system include on-line display of case-specific information, management reports, Help Center and on-line user guide for use by Child Protection Teams.

1.2 Introduction to the System

CPTIS version 1.11 is a .NET web-based program which is accessible via Internet Explorer. The web browser runs over secure sockets layer (SSL). This encrypts the data transmission between the client computers and the server that holds the CPTIS data.

The Child Protection Program Office and the Department of Health (DOH) Information Technology Division currently support CPTIS. Once CPTIS users enter data at their local CPT offices, reports can be pulled from this statewide system. These reports capture various elements, which are listed below.

1.3 Introduction to the User Guide

This guide is designed from the perspective of data entry and management, to facilitate easy use of CPTIS. It is divided into sections that correlate to the major data entry screens and reports. These screens and their functions are as follows:

- **Abuse Report Review** – Documents all abuse reports received from the Department of Children and Families (DCF) or designated sheriffs' offices and reviewed by the team. It also documents all abuse reports identified as meeting mandatory referral criteria.
- **Intake / Referral Screen** - Captures information pertaining to child abuse investigations, client and family demographic data, alleged maltreatments identified, assessment services agreed upon and the intake/referral decision. Intake/Referral Report can also be accessed on this screen.
- **Demographic Information** - Provides specific information on each client in the data system (name, address, age, race, etc). This screen is also used to enter family/household member information.

- **Registration Information** - Documents initiation and termination dates, alleged and assessed maltreatments, the overall case finding, and the dates that the Interim and Final Case Summary reports sent.
- **Assessment Activities** - Tracks all assessment activities provided by the team.
- **Assessment Reports** - Reports created as a result of CPT Assessment Activities.
- **Report Summary Screen** - Captures information on the reason for referral, assessments provided, assessment of risk, and conclusions/recommendations in a case.
- **Other CPT Training** - Tracks contractually mandated training provided or attended by team members and appropriate subcontracts.
- **Provider Information** - Contains information regarding individuals (such as psychologists, attorneys, medical providers, case coordinators, or team coordinators) who provide team services.
- **Reports** - Compiles data specific information in the team or statewide format.
- **Help Center** - Allows users to type in data requests, questions and concerns related to CPTIS.
- **System Guide** - This user guide will be maintained on the CMS website and in CPTIS. It will be updated regularly to reflect modifications to the system or changes in policy that might impact code tables or definitions.
- **Code Maintenance** - Allow the administrator of the system to update the code table. This item will not show for any user other than administrator.
- **Help Maintenance** – Allow the administrator of the system to update the definition of a specific field. This item will not show for any user other than administrator.
- **User Options** - Allow the user to enable/disable the pop-up calendar used in the system.
- **Sexual Abuse Treatment Program** - A hyperlink that will allow users, who have permission, to navigate to the system module for Sexual Abuse Treatment Program.

Each section of this guide provides detailed instructions for data entry for multiple screens in different modes, and describes the buttons and respective chaining options for the selected screen. Many of the fields contain drop-down boxes that require the user to select the appropriate information from a list, which is displayed on the screen. Most of the codes are included in the instructions for data entry found within each specific section of the guide. However, a few of the code tables are listed in the appendices. The sections of the guide are presented in an order that closely resembles the order a user might follow when entering data on a newly initiated case.

To access the website, open Microsoft Internet Explorer and type in the system address:

<https://adminapps35.doh.state.fl.us/CPTIS/main.aspx>

1.4 System Security

The .Net version of CPTIS will use the Single Sign-On (SSO). After the user enters a unique user ID and password to log on to the DOH network, he/she will be able to click on the URL to access the system, without being asked for USER ID and PASSWORD. In the background when the user clicks on the URL, the system will automatically verify his/her DOH login with the system login. The USER ID contains the security codes necessary for the various security profiles. There are four security levels for this system:

- **Level I-Administrator** - Allows the users to update records, view reports, and delete demographic information in the system. Only designated program office staff have approval for this access level.
- **Level II-View Only** - Allows the user to view records and print reports.
- **Level III-CPT Manager** - Allows the user to delete Registrations, Assessments, and Abuse Reports; and to add and update all records for his/her CPT.
- **Level IV-CPT User** - Allows users to add and update records for his/her CPT, but not to delete any records.

When an individual with a “CPT user” or “View Only” profile accesses the system, the “delete” buttons on various screens will not be displayed so as to not allow the user the ability to delete any information. Additionally, with “View Only” permissions, the “New” checkboxes found on the main menu (as shown below with “Administrator” permissions) will not be present. User ID’s and password must not be shared with anyone, including other persons who have access to CPTIS. Please contact the CMS program office for access requirements and user setup.

**Figure 1-1 Main Menu
(Administrator view)**

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

--

New **GO!**

Other CPT Training

New **GO!**

Provider

New **GO!**

Reports

--

Help Center

System Guide

Code Maintenance

Help Maintenance

User Options

Sexual Abuse Treatment Program

Logout

1.5 General Data Entry Information

- Each screen has multiple fields for data entry. Use the “Tab” button on the keyboard to move from field to field, or use the computer mouse to position for a select point of entry.
- Screens that contain **RED** field labels are mandatory fields that must be completed in order to create and update a record for that particular screen.

- Hovering the cursor over a field label, a tool tip will appear that provides a definition of the specific field or content requirements.
- Narrative sections have a spell check function which is enabled by clicking the spell check button next to the narrative field or at the bottom of the screen.
- Some screens have required fields for record closure/case termination. These fields do not contain any special markings, however the system will prompt users with instructions on what fields must be input before CPTIS will allow a successful update.
- All applicable fields should be completed as they may affect the accuracy of case specific information and management report results. Detailed guidelines for data entry, including the instructions and requirements for creating a new record or completing a case closure are outlined in the sections related to individual activity screens.
- All date fields will prompt the user to select a date from a pop up calendar that will automatically format them with date slashes the field to MMDDYYYY entries. Users, who prefer to not use the pop up calendar, can click on “User Options” on menu bar, and unclick the “Show Calendar Popup” field and then save.
- Enter all known and appropriate data and click “Update” to add or update a record. If the record is accepted, the screen returns and the user will receive a confirmation message; “Update Successful” at the top of the page. *If the user changes screens before clicking “Update,” entries will not be saved by CPTIS.* Throughout the user manual, a graphic is provided to remind readers to click the “update” button to save work.
- Users can use the scroll bars on the right hand side and bottom of the screen to see the whole screen. Users can also click the “minimize” or “maximize” icons in the upper right corner to adjust the screen.
- Number and letter keys will position the pointer in a dropdown list. This function is keyed off the first number or letter of the entry. The arrow keys can be used to move up and down among the entries of a dropdown list.
- Each screen has a number of edit checks built into the system. These edit checks are used to maintain data integrity and accuracy. Each section of this guide provides information on specific edit checks for each screen.
- The system allows twenty minutes of inactivity. After that, the message of “Session Expired” will appear on the screen. Users can always click the link on the same screen to return to the home page.
- In order to display full screens, users can adjust the screen resolution of the desktop by completing the following steps:
 - Click on “Start” at the bottom left, and select “Control Panel.”
 - Click on the icon “Display.”
 - Select “Settings.”



- At the bottom left of the Settings, you will see “Screen Resolution.”
- Reset Resolution to 1280 x 960 pixels by moving the down arrow backwards or forwards.

1.6 Business Continuity Plan

In the event that data cannot be entered into CPTIS, CPT staff will utilize the data forms found in Appendix I of this Guide to continue preparing the data necessary for input. These forms will be kept until such time as the information documented on them has been successfully entered into the Child Protection Team Information System, at which time the data forms can be destroyed.

SECTION 2: ACCESSING CPTIS

2.1 User Login

There are three ways to log into the CPTIS system:

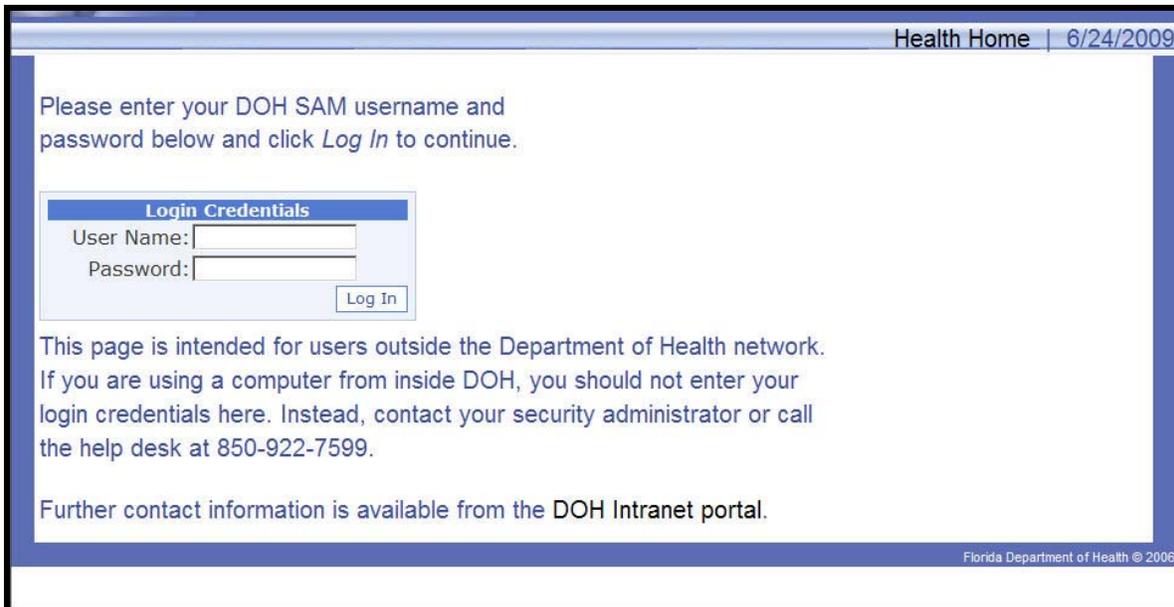
1. Click to open Microsoft Internet Explorer on your desktop and type in the system address:

<https://adminapps35.doh.state.fl.us/CPTIS/main.aspx>

2. If a user has already logged on to the DOH network, he/she will access the system directly by clicking on the system address.
3. For the user, who accesses the system from outside the DOH network, he/she will be prompted to input DOH credentials at a SSO (Single Sign On) screen. At the Login SSO Screen shown in figure 2-1 below, users will be prompted to enter user ID and password, press "Enter" on the keyboard or click "Log In."

Important Note: If users are logged into the system with more than 20 minutes of inactivity, they will be automatically logged out and returned to the Login Security Screen.

Figure 2-1 Login SSO Screen



The screenshot shows a web browser window with a blue header bar containing "Health Home | 6/24/2009". The main content area has a light blue background and contains the following text and form:

Please enter your DOH SAM username and password below and click *Log In* to continue.

Login Credentials

User Name:

Password:

This page is intended for users outside the Department of Health network. If you are using a computer from inside DOH, you should not enter your login credentials here. Instead, contact your security administrator or call the help desk at 850-922-7599.

Further contact information is available from the DOH Intranet portal.

Florida Department of Health © 2008

When the user ID and password are validated, users are taken to the main menu as shown in figure 2.2 below.

2.2 Child Protection Team Information System Home Page

The CPTIS home page screen, as shown in figure 2.2, allows access to the abuse report review, intake/referral, demographic, registration, assessment, report summary, and assessment report screens; both in search and create modes. Additionally, the main menu allows users access to screens to create or update other CPT training activities and providers; and to access both statewide and team specific reports.

Figure 2-2 CPTIS Home Page



The menu bar on the left side of the CPTIS home page is available from all screens and has searching capabilities which allow the user to search for:

- Abuse Reports;
- Intake/Referrals;
- Demographics;
- Registrations;
- Assessment Activities;
- Report Summaries; and
- Assessment Reports

These options lead directly from the menu to the chosen area of the website by using a client ID, abuse report number, or client/provider name depending on the selected screen. To access data, users should click on the button next to the type of record, input the required search criteria in the blank search field, and click on “Go”.

Required parameters include:

- Client ID must be nine alphanumeric characters. Users create the client ID using a pseudonym or a social security number.

Important Note: Always conduct a name search before creating a new client ID. If a new profile is created using information that already exists in the system, users will have to request that the program office merge the multiple profiles into a single client ID with the correct information.

- Abuse Report Number must be formatted ##### - ##### (dash required, no spaces).
- Name searches must be formatted Last,First (DO NOT include a space after comma). A partial name or simply the first letter of the first name is also a search option. When using two last names, place a hyphen between the two then a comma, followed by the first name (i.e. Smith-Johnson,Jane).
- Other CPT Training records may be searched by CPT team code, provider ID, or provider name.
- Provider records may be searched by CPT team code, provider ID, or provider name.
- The Reports drop down box lists the statewide, team and coordinator specific management reports that are available in CPTIS.
- The Client History report is available directly from the client Demographic screen.
- The Intake report is available directly from the Intake screen.
- The Help Center navigates the user to a screen where help requests are generated or results of a previous request can be viewed.
- Training Videos provides the user with a list of training videos in .mp4 format available for their user role.
- System (User) Guide allows the user to access this document online. When updates are made to CPTIS, a notice will be placed on this entry screen so that an updated guide can be downloaded from this link.
- User Option navigates the user to a screen that he/she can turn on/off the pop-up calendar and add any credentials to their electronic signature.
- Logout will cause you to exit from CPTIS.

SECTION 3: ABUSE REVIEW

3.1 Abuse Review Search Results

CPTIS offers the ability to search by client ID, abuse report number, and name. Once a search is submitted, the results are returned in the format shown in figure 3-1.

Figure 3-1 Abuse Report Review Search Screen

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary', and 'Assessment Reports'. The main area shows search results for 'Abuse Report Number: 111223542'. A table lists two records:

Abuse Report Number	Review Number	Hotline Date	CPT Received Date	CPT Review Date	Mandatory	Exception	CPT Office
2011-032444	1	8-23-2011	8-23-2011	8-23-2011	Y		07BA
2011-032444	2	8-23-2011	8-23-2011				01AA

Below the table are search filters for 'Other CPT Training', 'Provider', and 'Reports'. The footer indicates 'CPT Version (1.1.1.3) Florida Department of Health - CMS'.

If your search criteria results in only one record being returned, you will be taken directly to that abuse report. Otherwise, all abuse report review records will be returned based on the sequence of the Hotline date.

The following columns of information are listed on this screen.

- **Abuse Report #** - Clicking on this field will take you directly to the abuse report screen.
- **Review #** - CPTIS automatically assigns this number to record additional reviews for the same core abuse report number; this number is not to be confused with the abuse report sequence number assigned by the Hotline.
- **Hotline Date** - Date report was received by the Hotline.
- **CPT Received Date** - Date CPT received report (or notice of report for team printing).
- **CPT Review Date** - Date of initial CPT review.
- **Mandatory Referral Criteria** - Y or N to identify mandatory criteria status.

- **CPT Office** - The code of the office that receives the abuse report.

Click the specific abuse report review record highlighted. This will bring you directly to that record's screen.

3.2 Abuse Review Create/Update Screen

A new abuse report review screen is accessed by selecting Abuse Review on the menu bar, entering an abuse report number (formatted ##### - #####), checking "New", and clicking the "Go" button as indicated below in figure 3-2. The new abuse report review screen will appear as indicated in figure 3-3.

Figure 3-2 CPTIS Menu Bar



The screenshot shows a web application menu titled "Menu". At the top, it says "Welcome Jennifer Brittenham". Below this, there is a list of menu items, each with a radio button: "Abuse Review" (selected), "Intake/Referral", "Demographic", "Registration", "Assessment", "Report Summary", and "Assessment Reports". Below the menu items is a dropdown menu showing "--". At the bottom, there is a text input field containing "111223542", a checked checkbox labeled "New", and a purple circular button labeled "GO!".

If any prior abuse reports with the same abuse report number have been entered into the system, CPTIS will automatically assign a subsequent review number to distinguish this review from the previous abuse report reviews. If you simply want to update information regarding an existing abuse report review, do not check the new box. When the search results appear, click on the abuse review which requires updating and proceed.

Figure 3-3 New Abuse Report Review Record

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface for creating a new abuse report review record. The main form area is titled 'New Abuse Report Number: 2013-123459'. It contains a 'General Information' section with the following fields:

- Abuse Report Number: 2013-123459
- Review Number: 1
- CPT Office: 01AA (dropdown)
- Abuse Report County: Escambia (dropdown)
- Hotline Receive Date: 01/15/2013
- CPT Receive Date: 01/17/2013
- CPT Review Date: (empty)
- Mandatory Referral Criteria: Yes No
- Medical Review Date: (empty)
- Non-Caretaker Report: Yes No
- District Area Unit: (empty)
- Medical Evaluation Required: Yes No Medical Needed
- Link to Intake:
- Cross Team Review: (dropdown)
- Referral Declined: -- (dropdown)
- Date Referral Declined: (empty)
- Restricted Case:

Below these fields is a 'Comments' section with a text area and a 'Comments: (max 4000 characters)' label. The form also includes sections for 'New Abuse Report', 'Linked Abuse Reports', 'Alternate Registrations', and 'Linked Registrations'. At the bottom, it shows 'Updated By: Travis McLane', 'Created: 1/23/2013', and 'Updated: 1/23/2013', along with 'Update', 'Delete', and 'Go to Intake' buttons.

3.3 Instructions for Creating a New Abuse Report Review Record

The screen above is used to document the review of abuse reports. Required fields for entering the review of an abuse report are CPT Office, Abuse Report County, Hotline Date and CPT Receive Date. CPTIS will allow a successful update only if these fields are completed.

The Abuse Report # and Review Number will be automatically generated by CPTIS based on the abuse report number entered when creating a new Abuse Report Review record from the main menu.

1. CPT Office Code

- Select code from drop-down box (See Appendix I).
- Only CPT offices for which the user has access will be available for selection.

2. Abuse Report County

- Enter the county indicated on the abuse report.

3. Hotline Receive Date

- Enter date report received by the Hotline.
- Use format MM/DD/YYYY.

- The year the report was received by the Hotline must be consistent with the first four digits of the Abuse Report # within a 60 day window.
4. **CPT Receive Date**
 - Date must be equal to or greater than Hotline Date.
 - Use format MM/DD/YYYY and a valid date.
 5. **CPT Review Date** - the date of the initial team review
 - Date must be equal to or greater than CPT Receive Date.
 - Use format MM/DD/YYYY and a valid date.
 6. **Mandatory Referral Criteria** - As defined in statute, the reports requiring referrals to the CPT based on initial allegations.
 - Y – Yes
 - N – No
 - Must be filled out if CPT Review date and Medical Review date are entered.
 7. **Medical Review Date** - The date an authorized medical provider reviewed the report.
 - Date must be equal to or greater than Hotline Date.
 - Use format MM/DD/YYYY and a valid date.
 - Must be filled out if the Mandatory Referral Criteria field is filled out.
 8. **Non-Caretaker Report** - Indicates whether the report alleges abuse by a non-caretaker (i.e. child on child sexual abuse). Also captured in this field are foster care referrals. If it is a non-caretaker or foster care referral, the mandatory criteria field defaults to “No.” This abuse report will not appear on the list of Mandated Reports Not Referred Report. The system allows an Intake/Referral to be created. A VOCA check box will display on the right upper corner of the Intake/Referral Screen to capture the information if it is a case funded by VOCA.
 - Y - Yes
 - N – No
 - NOTE: The Mandatory Referral Criteria field will default to “No” if the Non Caretaker Report field is “Yes”.
 9. **District Area Unit (DAU)** - Refers to the DCF/SO unit assigned to investigate the report.
 - Six digit alpha numeric or numeric number.
 10. **Medical Evaluation Required** - Reports identified by medical staff that require a medical exam, based on the initial allegations.
 - Y – Yes
 - N – No
 - M – Medical Needed: This code is to be used for cases not meeting the mandatory referral criteria, but the medical director or designee determines, based on the abuse report allegations, that the child should be medically evaluated.

- Must be filled out if Medical Review Date is entered.
- 11. Link to Intake** – Checked only when an intake has already been completed for the same abuse report.
- Linking this review of the abuse report to the existing intake will remove it from the List of Mandated Abuse Reports Not Referred. PLEASE remember in order to link a mandatory report to the existing intake/referral the report must have been referred by the CPI.
- 12. Cross Team Review** - Identifies a team involved in a case in which the child presents at one team, but lives in another team's area. This may result in two teams being involved in the case and providing some type of assessment services. Click on the drop-down box to identify the other team reviewing the report.
- 13. Referral Declined Box** - Checked only for those cases in which the team has declined to provide services. "Late Referral" and "PI Closed Case" are the two options provided.
- Late Referral – It was determined that, due to the delay in the referral, assessment services would not be appropriate.
 - PI Closed Case – PI has closed the investigation and is not requesting services. PI is referring only to meet mandatory referral criteria.
- 14. Date Referral Declined** -
- Use format MM/DD/YYYY and a valid date.
 - Use the date that the referral was made, which, when compared to the CPT review date, will indicate if the delay in the referral was the reason for not accepting the referral.
 - The "Date Referral Declined" field is required if "Referral Declined" is checked.
- 15. Restricted Case** – Enabled for CPTMAN and ADMIN users only. Checked for cases that need to be restricted due to sensitivity of case. Once checked, a selection box appears enabling CPTMAN or ADMIN user to select from CPT staff from the team selected in the CPT Office field.
- 16. Comments** -
- A declined referral requires documentation of who made the decision and the reason.
 - Be brief and concise, given the limited space in the comment box.
 - CPTIS will warn you if you exceed the 4000 character limit.
 - Characters in excess of 4000 will not be saved when the record is updated.
- 17. New Abuse Report** - Automatic link to create another new abuse report screen.
- Enter new abuse report # to the right of "New Abuse Report" button.
 - Clicking this button creates a new abuse report screen for the number entered with the information from the previous screen in the (red) mandatory fields. These red fields must be updated to reflect the accurate information for this new abuse review and additional fields entered as appropriate.

- 18. **Linked to Abuse Report** – Link a duplicate abuse report to an existing abuse report.
 - Enter the existing abuse report # in the field of Abuse Report, and the review number in the field of Abuse Report Sequence.
 - Always click “Add” to save the record. You can check “Unlink” and then hit “Update” button to remove a linked abuse report.
- 19. **Alternate Registrations** - List the client ID (registration) that the abuse report is linked to. Those abuse reports displayed here, if meeting the mandatory referral criteria, will be removed from the “List of Mandated Abuse Reports Not Referred.”
- 20. **Linked Registrations** - Registrations associated with this abuse report number.

3.4 Linking Registrations

CPTIS will display at the bottom of any Abuse Report Screen all registrations in the system that share the same abuse report number, as shown below in figure 3-4.

Figure 3-4 Registration Links

Linked Registrations					
Client Id	Name	Registration #	Referral Date	Termination Date	Unlink
111223542	SMITH, SUE	1	8-23-2011		<input type="checkbox"/>
123121234	Smith, Sue	1	8-23-2011		<input type="checkbox"/>

If the CPT receives subsequent abuse reports on a case already open in CPTIS, the user can go to the bottom of the Registration Screen to link that abuse report to the open registration. Please see how to link the abuse report to an existing registration on the Registration Section of the User Guide.

Do not establish a link to client registrations unless all victims in the report being reviewed have open registrations, or have been referred to the team. If the abuse report identifies a new victim with maltreatments, and a referral is accepted for services for that victim, a registration may be created on that client (if an open one does not already exist) and linked to the appropriate abuse report.

If the team has terminated its case and is contacted for additional services for the same victim and abuse report (no new allegations), a new registration must not be created in CPTIS. Instead, the additional services provided should be added to the assessment activities screen associated with the terminated registration. Once the assessment activities are added, return to the Registration screen and click on the Report Summary Screen at the bottom of the page. Click on “Addendum,” complete the report, and send it to the requestor. If the case is still open in CPTIS, all appropriate information should be added to the open case.

A new registration, using the original abuse report number, with a system-generated “02” sequence, should be created when:

- The team receives new allegations for the same victim (even on same abuse number); and
- The case on the prior allegations is closed; and
- The team receives a new referral and plans to provide new assessment activities; or
- The team receives allegations on a new victim in the original abuse report.

All requirements for a new registration apply.

New maltreatments concerning the same victim on an open registration must be added to the existing registration.

The following columns of information are returned for each registration to help with identification:

1. **Client ID** - The ID # associated with the client.
2. **Client Name** - The client first and last name.
3. **Registration Sequence #** - CPTIS now permits multiple registrations under a single client for the same core abuse report number. This ordinal number is used to distinguish them and is automatically generated by CPTIS.
4. **Referral Date** - The date client was referred for service.
5. **Termination Date** - The date services were terminated and the case was closed.
6. **Link Status** - Users may check this box to link this abuse report to other registrations.

If there are no existing registrations for the abuse report number, or you would like to create a new registration for that abuse report, enter the client ID in the field and click the “Update” button. Details of this process will be covered in the instructions for entering a new registration.

There is a spell check feature associated with this screen of the website. By clicking on the button shown in figure 3-5 below, CPTIS will spell check user entries on this screen.

Figure 3-5 Spell Check Button



SECTION 4: INTAKE/REFERRAL

The Intake/Referral screen in CPTIS documents the case referral information and the decisions made during the intake and referral process.

4.1 Intake/Referral Search

CPTIS offers the ability to search by client ID, abuse report number and by the client's name. Once a search is submitted, the results are returned in the format shown in figure 4-1.

Figure 4-1 Intake/Referral Search Screen

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. A search for '123456789' has been executed, resulting in the following table of results:

Abuse Report Number	Intake Number	CPT Referral Date
2009-111111 - 1	1	9-07-2009
2009-202021 - 1	1	9-03-2009
2009-202025 - 1	1	9-21-2009
2009-232323 - 1	1	10-14-2009
2009-234568 - 1	1	9-21-2009
2009-303038 - 1	1	11-10-2009
2009-567890 - 1	1	2-02-2010
2009-660123 - 1	1	10-12-2009
2009-668888 - 1	1	10-12-2009
2009-799005 - 1	1	9-21-2009
2009-799010 - 1	1	9-21-2009
2009-799011 - 1	1	9-30-2009
2009-799012 - 1	1	9-28-2009
2009-890018 - 1	1	9-10-2009
2009-890034 - 1	1	9-09-2009

The interface also includes a left-hand menu with options such as 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary', and 'Assessment Reports'. A search input field contains '123456789' and a 'GO' button. The bottom of the screen shows 'Local intranet' and '100%' zoom.

When a search results in only one associated record, the user will be taken directly to that intake/referral record for the specified client. Otherwise, all intake/referral records will be returned based on the sequence of the CPT referral date.

Information on the intake/referral search screen follows:

1. **Abuse Report Number** - Clicking on this field will take the user directly to the intake/referral screen.
2. **Intake Number** - CPTIS automatically assigns this number to the record.
3. **CPT Referral Date** - Date the intake/referral was conducted.

4.2 New Intake/Referral Record

A new intake/referral screen is created by clicking on the button, “Go to Intake” at the bottom of the abuse review screen as shown below.

Figure 4-2 Creating New Intake/Referral from Abuse Review Record

Abuse Report Number: 2009-111111

General Information

Abuse Report Number: **2009-111111** Review Number: **1**

CPT Office: Abuse Report County:

Hotline Receive Date: CPT Receive Date:

CPT Review Date: Mandatory Referral Criteria: Yes No

Medical Review Date: Non-Caretaker Report: Yes No

District Area Unit: Medical Evaluation Required: Yes No Medical Needed

Link to Intake: Cross Team Review:

Referral Declined: Date Referral Declined:

Comments: (max 4000 characters)

Linked Abuse Reports

Linked To Abuse Review Linked From Abuse Review

UnLink Abuse Report Abuse Report Sequence

 Add

Alternate Registrations

Linked Registrations

Client Id	Name	Registration #	Referral Date	Termination Date	Unlink
990123428	Santos, Daisy 1				<input type="checkbox"/>

Updated By: **Kemper, Lauren** Created: 9/9/2009 Updated: 5/21/2012

The system will then launch the new intake/referral screen for data entry as shown in figure 4-3 below.

Figure 4-3 New Intake/Referral Record



CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

2012-020202 New

Other CPT Training New

Provider New

Reports

Help Center

System Guide

Code Maintenance

Help Maintenance

User Options

Sexual Abuse Treatment Program

Logout

Intake/Referral:

GENERAL INFORMATION

Abuse Report Number: **2012-020202** Review Number: **1** CPT Office: **02BA**
 Abuse Report County: **Leon** District Area Unit:
 CPT Received Date: **05/03/2012** Hotline Receive Date: **05/01/2012**
 Mandatory Referral Criteria: **N** Medical Evaluation Required: **N**

TEAM / CLIENT INFORMATION

Case Coordinator Completing Date: Case Coordinator:
 Referral Date: Referral Source:
 Law Enforcement Report Number: CPI/CBC Name:

Delete	Client ID	DOB	First Name	Last Name	MI	Sex	Race	Ethnicity
<input type="checkbox"/>	000112222	10/31/2005	Fake	Case		Male	White	Unknown
<input type="checkbox"/>	<input type="text"/>							

CrossTeam: 2nd CPT Office: VOCA

FAMILY INFORMATION

Delete	ClientID	DOB	First Name	Last Name	Relationship
<input type="checkbox"/>	<input type="text"/>				

REASON FOR REFERRAL

Referral Reason: (max 10000 characters)

ALLEGED MALTREATMENT

Delete	Alleged Maltreatment	Type
<input type="checkbox"/>	Burns - Cigarette	2 - Neglect
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

IDENTIFIED ISSUES

Substance Misuse: Domestic Violence: Criminal History: Mental Health: Child 0-6 yrs:

MEDICAL

Medical Evaluation Needed: Medical Evaluation Exception Reason:

Specify: (max 300 characters)

PRIORS

Priors: (max 3000 characters)

ASSESSMENT DECISION

Delete	Needed Assessment	Schedule Date
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Documentation of Intake / Referral Decision: (max 5000 characters)

Physician Review Date: Physician Concur: Supervisor Review Date:
 Closure Date: Closure Reason:

Updated By: **McLane, Travis** Created: **5/4/2012** Updated: **6/12/2012**

CPTIS Version (1.1.1.3) Florida Department of Health - CMS

Section 4

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4.3 Completing a New Intake and Referral Record

The new Intake/Referral record screen is used to capture information pertaining to client/family demographic data, alleged maltreatments, referral reason, the referral decision, and whether CPT services will be the provider or not. General information will auto-populate from the abuse review record. Mandatory fields are colored in red.

4-4 Team/Client Information Section

TEAM / CLIENT INFORMATION								
Case Coordinator Completing Date:	<input type="text" value="05/04/2012"/>	Case Coordinator:	<input type="text" value="2115-Puckett, Erica-CC (02BA)"/>					
Referral Date:	<input type="text" value="05/03/2012"/>	Referral Source:	<input type="text" value="DCF/Other"/>					
Law Enforcement Report Number:	<input type="text"/>	CPI/CBC Name:	<input type="text"/>					
Delete	Client ID	DOB	First Name	Last Name	MI	Sex	Race	Ethnicity
<input type="checkbox"/>	000112222	10/31/2005	Fake	Case		Male	White	Unknown
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--	--	--
<input type="button" value="Add"/>								
CrossTeam:	<input type="checkbox"/>	2nd CPT Office:	<input type="text"/>	<input checked="" type="checkbox"/> VOCA				

- Case Coordinator Completing Date** - The date the case coordinator completed the screen. The field will display a calendar for selection and provide the specified date in MM/DD/YYYY format. The completion date cannot be earlier than the client's referral date.
- Case Coordinator** - The user will select the name from a drop-down list.



- Referral Date** - The date the intake/referral was conducted. The field will provide the specified date in MM/DD/YYYY format.
- Referral Source** - This is the source of referral to the CPT. Select from a drop-down list.
- Law Enforcement Report Number** - If the intake/referral comes from the Department of Law Enforcement, a report number will be available to be entered into this field.



6. **CPI/CBC Name** - The name of the CPI/CBC handling the investigation or case. The correct forma is to list Last Name,First Name (no space between the Last and First Name).
7. **Client ID** - Enter the 9 characters of the client ID. The system will auto-populate the client ID to the demographic record from this screen, if a demographic record is created.
 - If the client already exists in the system, the remaining client information will auto-populate into the appropriate fields, if a demo record was created.
 - Note that after a client record is added, and the intake/referral screen is updated, the client ID will be a hyperlink to the registration screen, if one is created.
 - Clicking on the “Add” button next to the client’s information will save the information on the screen and generate a new row for another client.
 - If the user leaves the screen without clicking “update,” this information will be lost.
8. **DOB** - The client’s date of birth.
9. **Last Name** - Client’s last name.
10. **First Name** - Client’s first name.
11. **MI** - The first initial of the client’s middle name. Field consists of a maximum of 1 character.
12. **Sex** - Sex of client selected from a drop-down list.
13. **Race** - Race of client selected from a drop-down list.
14. **Ethnicity** - Ethnicity of client selected from a drop-down list.
15. **Cross Team** - Check if there is a cross team.
16. **2nd CPT Office** - Select 2nd CPT office if applicable.
17. **VOCA** - The VOCA checkbox will appear on this screen when the Non-Caretaker Report on the Abuse Report Screen is selected as “Yes.”



4-5 Family Information/Reason for Referral/Alleged Maltreatment Sections

FAMILY INFORMATION				
Delete ClientID	DOB	First Name	Last Name	Relationship
<input type="checkbox"/> 999999999		Ana	Lopez	Mother
				-- Add

REASON FOR REFERRAL
21 Referral Reason: (max 4000 characters)
<input type="text" value="21"/> <input type="text" value="Referral Reason: (max 4000 characters)"/>

ALLEGED MALTREATMENT	
Delete Alleged Maltreatment	Type
<input type="checkbox"/> Bruises - Other	1 - Abuse
<input type="checkbox"/> Sexual Battery (Incest) - Digital Penetration, Vagina	1 - Abuse
<input type="checkbox"/>	--

18. Family Information - Family members who have a role in the intake/referral record.

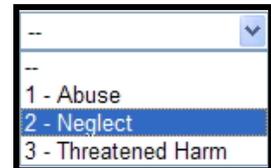
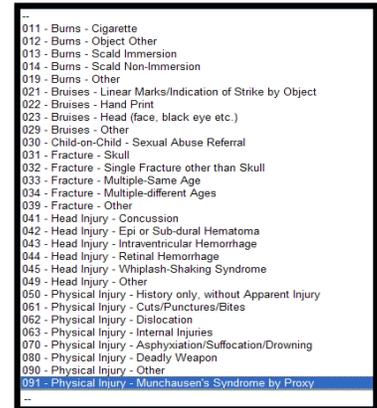
- **Client ID** - This is the client ID of the specified family member. If the client ID already exists in the system, the rest of the fields will be auto populated.
- **First Name** - First name of family member.
- **Last Name** - Last name of family member.
- **Relationship** - Family member’s relationship to client on the intake/referral record selected from a drop-down menu (mother, father, sibling, counselor, etc).

Users must click “Add” in order to save the record in holding and generate another row for another family member.

19. Reasons for Referral - Users have a maximum of 10,000 characters to document the reason for the referral. The referral narrative information should consist of the allegations in the FSFN report, additional information the CPI obtained during their initial contact with the subjects, and the CPT assessment services being requested by the CPI. This field is mandatory.

20. Alleged Maltreatment - Alleged maltreatments are those that are initially entered into the abuse report or those stated by the protective investigator who referred the case to CPT. Select code(s) from drop-down box or type the 3 digit code in the first field. See Appendix A for codes - Initial Diagnosis/Alleged Maltreatment/CPT Maltreatment.

- **Alleged Maltreatment Type** – Select from a drop-down menu. A message box should appear on the top of the browser screen to remind the user to select an alleged maltreatment type. If the user fails to do so, the system will not recognize the entry.



4-6 Identified Issues/Medical/Priors Sections

21. Identified Issues – This section of the report is to discern any known issues within the client’s household that could present a threat to the child.

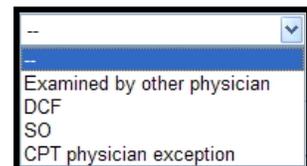
- **Substance Misuse** – This refers to any member of the child’s household who has been identified as having a substance abuse problem. This can include teenage children in the home. If this field is checked, there must be supporting documentation in the case record, and the substance abuse must be addressed in the FCS.
- **Domestic Violence** – This refers to any incident of domestic violence between members of the child’s household. This information does not have to be verified. However, if this field is selected, there must be supporting documentation in the case record, and the domestic violence issues must be addressed in the FCS.
- **Criminal History** – This refers to any member of the household who has a criminal history that could pose a threat to the children in the home. If this field is selected, there must be supporting documentation in the case record, and the concern regarding the criminal history must be addressed in the FCS.
- **Mental Health** – This refers to any member of the household who has a mental health issue that could pose a threat to the children in the home. If this field is selected, there must be supporting documentation in the case record, and the concern regarding the mental health must be addressed in the FCS.
- **Child 0 - 6 yrs** – This refers to any member of the household who is at the age from 0 to 6 years old. If this field is selected, there must be supporting documentation in the case record, and the concern regarding the child must be addressed in the FCS.

22. Medical – Document the need for a medical evaluation. Users must check the box indicating that a medical evaluation is needed or must select an option in the field “Medical Evaluation Exception Reason.”

- **Medical Evaluation Needed** – When a mandatory case is initially referred to CPT and the initial medical review of the allegations indicates that a medical evaluation is necessary, the field “Medical Evaluation Required” on the Abuse Report screen will show “Yes,” “No” or “Medical Evaluation Needed.”

When an Intake/Referral report is created from that Abuse Report screen, the “Medical Evaluation Needed” field will automatically be selected. Upon review of additional information, the medical director or designee can determine that an evaluation is not necessary. The “Medical Evaluation Needed” field should be unchecked, enabling the “Medical Evaluation Exception Reason” and “Specify” fields.

- **Medical Evaluation Exception Reason** – When the medical director or designee determines that an evaluation is not necessary, he/she will select the appropriate reason from the drop-down menu. 



- **CPT Physician Exception** – For all exception reasons, the “Specify” field will be enabled.
- 23. Specify** – Document the reason why an exception has been given by the CPT physician. This field should not be left blank when “CPT Physician Exception” is chosen as the exception reason.
- 24. Priors** – List any prior CPT and/or FSFN reports with summaries in up to 3,000 characters.

4-7 Assessment Decision Section

- 25. Needed Assessment** – Type of CPT assessment services to be provided. Select from drop-down menu. →
- 26. Schedule Date** – If the assessment service is scheduled during the intake assessment, the date may be indicated here.
- 27. Documentation of Intake/Referral Decision** – This text field provides the documentation and justification for the decision to either provide or not to provide CPT assessment services. Maximum of 5,000 characters. The documentation in this section will include:

- Child Not Located
- No Jurisdiction
- No Assessment Needed
- Closed After Intake
- Court Activities
- CPT Staffing
- Forensic Interview
- Legal Consultation
- Medical Consultation
- Medical Evaluation
- Multi-Agency Staffing
- Nursing Assessment
- Psychological Consultation
- Psychological Evaluation
- Psychological Evaluation - Child
- Psychological Evaluation - Other
- Social Assessment
- Spec Int(C) - Social Assessment
- Spec Int(O) - Social Assessment
- Specialized Interview
- Specialized Interview - Child
- Specialized Interview - Other
- Staffing Attended
- Team Assessment Summary
-

- Discussion of CPI interview/investigative information concerning the abuse report referred.
- Discussion of appropriate assessment services to be provided (this should include CPI requested services and CPT recommended assessments to be provided).
- Discussion of prior abuse reports and CPT referrals.
- Documentation of the justification for the decision to not provide services.

- 28. Physician Review Date** – Date the Medical Director or designee reviewed the Intake/Referral Report. This is a requirement for mandatory reports for cases which will have services provided or cases which will not have a medical evaluation. This date cannot be earlier than the referral date.

29. Supervisor Review Date – Date the supervisor or designee reviewed the Intake/Referral Report. This date cannot be earlier than the referral date.

30. Physician Concur – Indicates whether or not the Medical Director concurred with the Intake/Referral decision.

31. Closure Date – Date the intake/referred is closed

32. Closure Reason – Select one of the reasons why the intake/referral is closed.

- **Child Not Located** – Use if diligent efforts of DCF/SO CPI are documented and child child/family can not be located.
- **Lack of Information / Follow-up Provided by DCF/SO** – Use if CPI did not follow-up with CPT with the needed information to ascertain if CPT services were needed. If using this reason, do not check the ‘Link to Intake’ box on the Abuse Screen.
- **No Assessment – PI Closed Case** – Use if CPI closed the case.
- **No Assessment due to Late Referral** – Use if it was determined that due to the delay in the referral assessment services would not be appropriate.
- **No Assessment Needed, Closed After Intake** – Use when it is determined that CPT services are not needed.
- **No Jurisdiction** – Use only when it is determined by DCF/SO CPI that the jurisdiction is out of state. Do not use if child/family is in another Florida county.
- **Services Refused** - Use if Family or CPI refused to bring child to CPT.

Important Note: If the case is a mandatory report, the system will not allow the user to close an intake/referral without entering data to these fields: Physician Review Date, Physician Concur and Supervisor Review Date. However, if it is a non-mandatory report, the user may close an intake/referral without entering data in these fields.

33. Print Intake Report – Will allow the user to generate an intake/referral report.

34. Update - Users must click update to enter data and save work.

35. Delete - Delete allows users to delete the intake.

36. Spell Check Buttons – Allow the user to spell check the data entered in each narrative section before clicking “update.”

Updated By: **Renzenbrink, Kathryn** Created: 3/14/2012 Updated: 3/14/2012



4.4 Creating an Intake/Referral Addendum

The system does not allow a new intake/referral screen to be created with the same abuse report number when an intake/referral has already been created and closed, or a registration is created. An addendum is created when a new abuse report (same abuse report number but different sequence, with new allegations) is referred.

Below the fields of Closure Date and Closure Reason, there is an “Addendum” button. After the intake/referral has been closed, or the existing registration, under the same abuse report has been created, the user can click the “Addendum” button to document additional referrals received. Figure 4-8 displays the Intake/Referral Addendum screen.

Figure 4-8 Intake/Referral Addendum

Delete	Client ID	DOB	First Name	Last Name	MI	Sex	Race	Ethnicity
<input type="checkbox"/>	990123428	08/10/1990	Daisy	Santos		Female	White	Hispanic
						--	--	--

1. **Case Coordinator** - Select the name of the case coordinator who completes the intake/referral addendum from the drop down list provided.
2. **Referral Date** - Date that the additional intake/referral is completed.
3. **Addendum Closure Date** - Date that the intake/referral addendum is closed, no services. If the additional referral results in CPT assessment being provided.
4. **Documentation of Reason for Addendum** - Document the decision to provide CPT assessment services after the original intake/referral or after the existing registration has been closed in a maximum of 10,000 characters.
5. **Client ID** - Nine character client ID. The system will pass the client ID that was entered to the demographic screen.
 - If the client already exists in the system, the rest of the client information will auto-populate.
 - Note that after a client record is added, and the intake/referral screen is updated, the Client ID will be a hyperlink to take the user to the registration screen.
 - Click “Add” to save the record in holding and generate a new row for another client.
6. **DOB** - Client’s date of birth.

- 7. **Last Name** - Last name of client. Consists of a maximum of 20 characters.
- 8. **First Name** - Client's first name. Consists of a maximum of 16 characters.
- 9. **MI** - Client's first initial of his/her middle name. Consists of a maximum of 1 character.
- 10. **Sex** - Select sex of client from drop-down menu.
- 11. **Race** - Race of client. Select from drop-down menu.
- 12. **Ethnicity** - Ethnicity of client. Select from drop-down menu.

Important Note: Client demographic information will be auto-populated from the original intake/referral to the addendum when the "Addendum" button is clicked. The user can remove a client from the addendum by selecting the "delete" checkbox, and clicking "update."



SECTION 5: DEMOGRAPHIC

5.1 Demographic Screen

The demographic screen in CPTIS can only be accessed after an intake/referral screen has been completed. Demographic records in CPTIS are not limited to victims. Demographic records should be created for all family or household members by entering the SSN of the family members on the registration screen.

Before creating a new demographic screen for a client, users should conduct a search of the system for demographics that may already exist for the client. Users should also ensure the client ID entered for the search is accurate and has been entered correctly. Failure to do so may result in duplicate demographic screens being created.

To determine if a demographic screen already exists for an individual, CPTIS offers the ability to search for demographic records by client ID, abuse report number, and/or client name. When searching by client name, users must enter the last name, then the first name with no space after the coma. Users also have the option of searching by last name only. Once a search is submitted, the results are returned in the format shown in figure 5-1.

Figure 5-1 Demographic Search Screen

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like Abuse Review, Intake/Referral, Demographic (selected), Registration, Assessment, Report Summary, and Assessment Reports. Below the menu are search filters for 'Other CPT Training', 'Provider', and 'Reports'. The main area shows 'Demographic Search Results for Client 2011-032444' with a table of results.

Client ID	Last Name	First Name	Mid. Initial	DOB	Address	City
111223542	SMITH	SUE		1-01-2010	123 Any St.	Melbourne
123121234	Smith	Sue		1-01-2010		

At the bottom right of the screen, it says 'CPT Version (1.1.1.3) Florida Department of Health - CMS'.

If the search criteria results in only one record being returned, the user will be taken directly to that demographic record. If not, a listing of records that meet the search criteria will appear. If the record being searched is located in the list, the user must click on the client ID to be taken to the associated demographic record. The following columns of information for the client are returned for each record to help identify it.

1. Client ID
2. Last Name
3. First Name
4. Middle Initial
5. Date of Birth
6. Address
7. City

5.2 Demographic Create/Update Screen

If the demographic search finds no existing record, a new demographic record must be created prior to entering a registration. Demographics can be created from the Intake/Referral Screen by clicking the client ID in the Team/Client Information section, as shown in figure 5-2.

Figure 5-2 Team/Client Information Section in Intake/Referral Screen

TEAM / CLIENT INFORMATION								
Case Coordinator Completing Date:	<input type="text" value="08/23/2011"/>	Case Coordinator:	<input type="text" value="1652-ANDERSON-RATLIF, SHIANN-CC (07BA)"/>					
Referral Date:	<input type="text" value="08/23/2011"/>	Referral Source:	<input type="text" value="Protective Investigator"/>					
Law Enforcement Report Number:	<input type="text"/>	CPI/CBC Name:	<input type="text"/>					
Delete	Client ID	DOB	First Name	Last Name	MI	Sex	Race	Ethnicity
<input type="checkbox"/>	111223542	01/01/2010	SUE	SMITH		Female	White	Unknown
<input type="checkbox"/>	123121234	01/01/2010	Sue	Smith		Female	White	Unknown
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--	--	--
<input type="button" value="Add"/>								
CrossTeam:	<input type="checkbox"/>	2nd CPT Office:	<input type="text"/>					

5.2.1 Duplicate Demographics

If any prior demographic record with the same client ID has been entered, CPTIS will automatically take you to that demographic record, as shown in figure 5-3. For demographics created with a pseudo client ID, the user should use a different ID for the new client being entered in the system.

Users should never overwrite existing demographic information with new client information. This will not create a new client, but will replace the existing client’s information. However, if the user has the client social security number, once he/she verifies that the demographic is the same child, the user may overwrite the pseudo number with the social security number, along with any other updated information and click “update.”

CPTIS may display the message: “Client ID exists, please enter a unique number” when attempting to updating an existing client ID or pseudo ID. This means the client ID being used is already in the system. When this occurs, the user must submit a “Request to Merge Client ID or Delete Client Record” to the program office to merge or delete the duplicate records. The form is available at the following link:

<http://dohiws.doh.state.fl.us/Divisions/CMS/PrevenInterven/Forms/ClientDelReq.doc>

Figure 5-3 Demographic Screen

Florida's health
The Florida Department Of Health

CHILD PROTECTION TEAM INFORMATION SYSTEM

DEMOGRAPHIC Information for Client 111223542

Client ID: 111223542 Name: Last: SMITH First: SUE M. Init:

AKA:

Address: 123 Any St.
City: Melbourne State: Florida ZIP: 32301
Country: Brevard Country: United States Phone: (321)555-2255

Date Of Birth: 01/01/2010 Verification Of DOB: Declared Date Of Death:
Sex: Female Race: White Ethnicity: Unknown
Disability: No

4 Comments: (max 255 characters)
test

Search For: Intake/Referral
Registration
Assessment

Registration	Client ID of Victim	Name of Victim	Relationship to Victim
Registration as Victim			
2011-032444 # 1			

Updated by: Kemper, Lauren Created: 8/23/2011 Updated: 5/21/2012

5.3 Creating a Demographic Screen

The client ID, last name, first name, DOB, sex, race and ethnicity will be automatically populated from the one that you enter in the Intake/Referral screen. Data field descriptions and parameters for the Demographic screen are as follows. Mandatory input fields are identified in red.

1. **Client ID** - The system will pass the Client ID that you have entered on the Intake/Referral Screen to this screen.
2. **Last Name** - Enter client last name. Last Name field consists of a maximum of 20 characters.
3. **First Name** - Enter client first name. First Name field consists of a maximum of 16 characters.
4. **M. Init.** - Enter client middle name initial. Middle Initial field consists of a maximum of 1 character.
5. **AKA** - Enter any know alias or nickname. The system does not use this field in completing name searches.
6. **Address** - Street address of where the child resides. This field consists of a maximum of 30 characters.
7. **City** - Child's city of residence
8. **State** - Child's state of residence (select from drop-down box) - 2 character field consistent with US Postal Service codes.
9. **Zip code** - Child's residential zip code.
10. **Phone** - The telephone number at the child's residence. Field contains a format mask (###)### - #####.
11. **County** - County in which child resides (select from drop-down box)
12. **Country** - If child migrated to the United States, the country from which he/she came. The first option in the drop down list is United States, or user can select other choices from drop-down box.
13. **Date of Birth** - Child's date of birth. User will use the pop up calendar to select a date (MM/DD/YYYY).
14. **Verification of DOB** - Select options from the drop down box regarding verification of the child's date of birth.
 - D – Declared indicates the person providing information stated date of birth with certainty, but provided no formal documentation.
 - E - Estimated indicates the person providing information was uncertain of the exact date and approximated with no formal documentation.
 - V - Verified indicates the user viewed documentation, such as birth certificate.
15. **Date of death** - Date that child died if applicable.
16. **Race** - Child's race. (available options from drop-down box)

- 17. **Sex** - Child's sex. (available options from drop-down box)
- 18. **Ethnicity** - Child's ethnicity (available options from drop-down box)
- 19. **Disability** - Select one of the options if the child has disability.
- 20. **Comments** - Enter comments as appropriate and necessary for a maximum of 255 characters.

5.4 Intake/Referral, Registration, and Assessment Searches

CPTIS allows users to access the assessment activities and registrations for the client from links provided on the demographic screen. Next to the "Comments" box on the demographic screen are three links. Clicking on these hyperlinks performs the same search function as entering a client ID-in this case the client ID of the Demographic screen-in the menu bar to search for assessment activities or registrations. The user will be taken to the intake/referral, registration record(s), or the assessment record(s) for the related client ID.

Figure 5-4 Intake-Referral/Registration/Assessment Links



5.4.1 Registration History

Previous registrations in which a specific demographic record plays a role will be displayed at the bottom as shown in figure 5-5.

Figure 5-5 Registration History

Registration	Client ID of Victim	Name of Victim	Relationship to Victim
2011-032444 # 1	111223542	SMITH, SUE	Father

The following columns of information are returned:

- **Registration** - Abuse report number and registration number; this number also serves as a link directly to that registration record.
- **Client ID of Victim** - Social Security Number or pseudo ID of the victim in that registration.
- **Name of Victim** - Name of victim in that registration.
- **Relationship to Victim** - The relationship of entrant to victim in that registration.

5.4.2 Identification of Prior Registrations

This section displays registrations in which the individual specified in the demographic record was the victim as shown below.

Figure 5-6 Prior Registration Information

Registration as Victim	Initiation	Termination
2011-032444 # 1	08/23/2011	

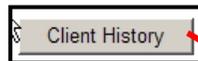
The following columns of information are returned for each registration.

- **Registration as Victim** - Abuse report number serves as a link directly to that registration record.
- **Initiation** - Date case opened by team.
- **Termination** - Date case closed by team.

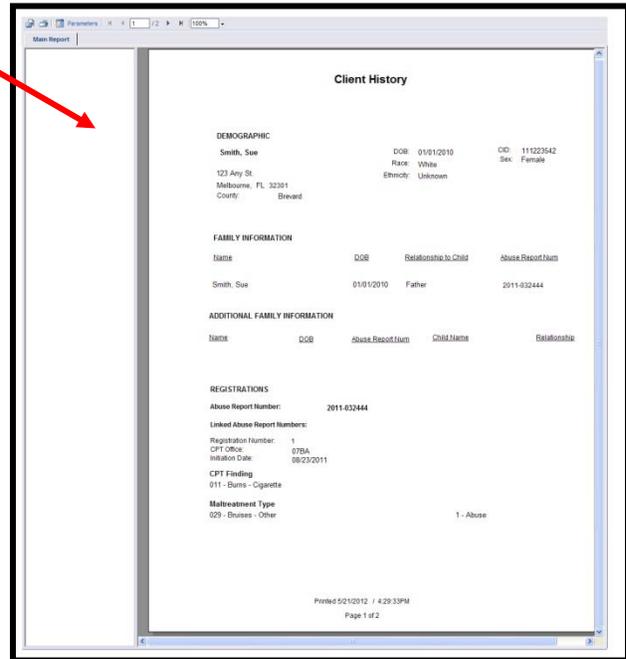
Figure 5-7 Demographic Screen Buttons



1. **Client History Button** - Clicking on this button will display the client history report, shown below.



2. **New Registration Button** - Clicking on this button will bring the user to a blank registration screen. However, if the existing registration is still open, or if that is a family member's demographic record, this button will be disabled as shown in figure 5-7.



SECTION 6: REGISTRATION

The Registration screens are designed to record individual CPT cases. Specific guidelines for creating registrations (criteria for accepting a referral for service) are detailed in the CPT Handbook. The Registration screen allows the user to record assessed maltreatments in the case. Users can access the registration screen through the Demographics screen or by searching on the main menu.

6.1 Registration Information Search Screen

CPTIS offers the ability to search for registration records by client ID, abuse report #, and client name. The system will return a list of registration records associated with the name or number submitted. If the search criteria results in only one record, the user will be taken directly to that registration. If a list of records appears, users should click on the abuse report number of the desired registration. The client ID number links to the related demographic screen. If the child has not been registered in CPTIS, the user will receive a “No Records Found” message.

Figure 6-1 Registration Search Results

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration' (selected), 'Assessment', 'Report Summary', and 'Assessment Reports'. Below the menu are search fields for 'Abuse Report #', 'Client ID', 'Reg.#', 'Last Name', 'First Name', 'Mid. Initial', 'DOB', 'CPT Office', and 'County'. A search button 'GO!' is present. The main area shows 'Registration Search Results for Client 2011-032444' with the following table:

Abuse Report #	Client ID	Reg.#	Last Name	First Name	Mid. Initial	DOB	CPT Office	County
2011-032444	111223542	1	SMITH	SUE		1-01-2010	07BA	Brevard
2011-032444	123121234	1	Smith	Sue		1-01-2010	01AA	Brevard

At the bottom right of the interface, it says 'CPT Version (1.1.1.3) Florida Department of Health - CMS'.

The following columns of information are returned for each registration:

1. **Abuse Report Number** - Links to the registration record for that client ID and registration number.
2. **Client ID** - Links to the demographic record for that client ID.
3. **Registration #** - Ordinal automatically generated by CPTIS to distinguish registrations under a single client with the same abuse report #.
4. **Last Name** - Client last name.
5. **First Name** - Client first name.
6. **Middle Initial** - Client middle initial
7. **Date of Birth** - Client DOB.
8. **CPT Office Code** - CPT Office where registration was generated.
9. **County** - County of residence.

Users can access the registration record by clicking on the abuse report number listed in the first column. Updates can be made by entering data and clicking “update.” CPTIS will automatically record the name of the user updating the record, as well as the date of the update at the bottom of the screen above the update button.



6.2 Creating a New Registration

New registration records must be created through the Demographic screen. Clicking on the client ID on the Intake/Referral screen will direct the user to the Demographic screen (either new or existing) for the client. Once the Demographic screen has been created or updated, the user can click on “New Registration,” which will direct CPTIS to a new registration screen.

If a demographic record for that client ID already exists, the user will have the opportunity to verify that the information is correct before proceeding to the Registration screen.

For a new client, a new demographic record will be created for the client ID and all mandatory fields must be filled before proceeding to the Registration. The user must verify or enter the requisite information and click “update” to save the record. Only then can the user continue to the registration screen by clicking the “New Registration” button.

The figure below demonstrates a Registration record.

Figure 6-2 Registration Screen

REGISTRATION # 1

Client ID: 111223542	Name: SMITH, SUE	State: Florida	ZIP: 32301
Address: 123 Any St.	City: Melbourne	Race: White	Sex: Female
DOB: 1/1/2010			

Abuse Report Number: 2011-032444	Referral Date: 08/23/2011	CPI/CBC Name:
CPT Office: 07BA	Case Coordinator: 1652-ANDERSON-RATLIF_SHIANN-CC	<input type="checkbox"/> Cross Team
2nd CPT Office:	2nd Case Coordinator: --	<input type="checkbox"/> Switch Team
Child's County: Brevard		<input type="checkbox"/> FL Shot Report
Referral Source: Protective Investigator	2nd Referral Source: --	Early Steps Currently Enrolled: <input type="checkbox"/>
Early Steps Screened: <input checked="" type="checkbox"/>	Early Steps Meets Referral Criteria: <input checked="" type="checkbox"/>	Early Steps Referred: <input type="checkbox"/>

FAMILY INFORMATION

Delete Demographic	Relationship
<input type="checkbox"/> 123121234 Smith, Sue	Father
	--

ALLEGED MALTREATMENT

Delete Alleged Maltreatment	Type
<input type="checkbox"/> Bruises - Other	1 - Abuse
	--

ASSESSED MALTREATMENT

Delete Assessed Maltreatment
<input type="checkbox"/> Burns - Cigarette

Assessments: [New](#)
 Case Progress Notes: [New](#)

Overall CPT Assessment: 1 - Abuse Indicated	Termination Date: <input type="text"/>
Date ICS Sent/Notification: 04/02/2012	
Date FCS sent to PI: <input type="text"/>	

29 Comments: (max 500 characters)
 Test updating record message.

Delete Linked Abuse Report (Alternate)

<input type="text"/>

Other Registrations of Abuse Report Number: 2011-032444

Abuse Report	Reg Seq #	Client ID	Referral Date	Termination Date
2011-032444	1	123121234	8-23-2011	

Updated by: **Kemper, Lauren** Created: **8/23/2011** Updated: **4/13/2012**

Update
Report Summary Screen
Go to Intake

Demographic information is auto-populated at the top of the Registration screen. Information follows regarding the client's case and associated Child Protection Team, including referral source and date and any CPT members working on the case. Fields are as follows:

- Referral Date** - Date will be auto populated from the Referral Date on the Intake/Referral screen. However, the user can also update the date if that is different from the Referral

Date on the Intake/Referral screen. For instance, if an intake/referral was originally closed, no services; however, a subsequent request for services was made.

2. **CPT Office Code** - CPT office code where referral was initiated. Select code from drop-down box (See Appendix D, CPT Office Codes). Only CPT Offices for which the user has access will be available for selection.
3. **Case Coordinator** - Code/name of case coordinator. Select assigned case coordinator from the drop-down box, which displays the case coordinator code, name, and type based on user's CPT office code(s).
4. **Cross Team** - Used to track cases when two separate teams provide assessment services. This box must be checked for the second team to enter their information. Only the primary team has access to this field.
5. **2nd CPT Office** - The second team providing services.
6. **2nd Coordinator** - The case coordinator assigned for the second team.
7. **Switch Team** - Allows the primary CPT to switch to the secondary team (only the primary team has access to this field).
8. **Child's County** - Select from drop-down box.
 - Standard county codes 01-67
 - 99 – Unknown
 - 00 – Out of State
9. **FL Shot Report** - Check if user accessed client shot record and downloaded.
10. **Referral Source** - This field will be auto populated from the Referral Source on the Intake/Referral screen when the "Update" button is hit.

Important Note: If "CBC Case Man" is selected as the referral source, the team can only provide services that are not investigation oriented. The following fields will be disabled:

2nd CPT Office
2nd Coordinator
Cross Team
Switch Team
Alleged Maltreatments
Assessed Maltreatments
Overall CPT Assessment
Termination Date

11. **2nd Referral Source** - This is the second source of referral to CPT. This field is only enabled when CBC Case Man and Protective Investigator are selected as the primary referral source. Select code from the drop down box:
 - I – PI

- C - CBC Case Man
- 12. Early Steps Currently Enrolled** - Select the checkbox if the client is currently enrolled in the Early Steps program.
- 13. Early Steps Screened** - Select the checkbox if the client is at, or under, the age of 36 months, and has been screened for the Early Steps program.
- 14. Early Steps Referral Criteria** - Select the checkbox if client meets referral criteria.
- 15. Early Steps Referred** - Select the checkbox if the client is at, or under, the age of 36 months, and has been referred to the Early Steps program.

6.2.1 Family Information

This sub-section of the Registration screen records data regarding family members who have a role in the case and the associated registration.

Figure 6-3 Family Information Section

FAMILY INFORMATION		
Delete	Demographic	Relationship
<input type="checkbox"/>	123121234 Smith, Sue	Father
		--

16. Family Demographic - Include family members who have a role in the registration by entering the following data:

- Enter client ID of family member
- Enter Relationship of family member
- After a client ID is entered, CPTIS will verify whether a demographic record exists for the client ID. If a demographic record exists for that client ID; the client ID, last name, first name and middle initial will be displayed. If a demographic record for the client ID does not exist, the user will see the following:

- **Do not click on [111223333 - Insert new demographic](#) the link to go the demographic screen at this point.** Users should click the “update” button first, and then go back to click the link to go to the Demographic screen. Once the demographic data has been entered and the “update” button clicked, the user can return to the registration by clicking the appropriate ABUSE REPORT number link to the registration displayed at the bottom.

Important Note: These family demographic records must be created prior to case closure (entry of a Termination Date). If a demographic record has been linked to a registration by mistake, it should be removed by checking the box under the column marked 'delete' and clicking the "update" button.

6.2.2 Alleged Maltreatment Section

Users can record abuse allegations on the Registration screen using the parameters described below.

Figure 6-4 Alleged Maltreatment Section

ALLEGED MALTREATMENT	
Delete	Type
<input type="checkbox"/>	Bruises - Other
<input type="text"/>	1 - Abuse
<input type="text"/>	--

17. Alleged Maltreatment - Alleged maltreatments will be auto-populated from the intake/referral screen. The user can enter other alleged maltreatments by selecting from the drop-down list. The alleged maltreatments are those that are initially entered into the abuse report or those stated by the protective investigator who referred the case to CPT. Select code(s) from drop-down box (See Appendix A, Initial Diagnosis/Alleged Maltreatment/CPT Maltreatment) or type the 3 digit code in the first field.

18. Alleged Maltreatment Type - Select code from drop-down box:

- Abuse
- Neglect
- Threatened Harm

Important Note: A message box will appear to remind you to select a type for each alleged maltreatment when the "update" button is clicked.

6.2.3 Assessed Maltreatment Section

Users can record assessments of the maltreatments alleged in the case by using the parameters below.

The screenshot shows a web form titled "ASSESSED MALTREATMENT". At the top left, there is a "Delete" button and a dropdown menu with "Burns - Cigarette" selected. Below this is a large empty text area. To the right, there are links for "Assessments: New" and "Case Progress Notes: New", and a "Termination Date" field. In the center, there is a dropdown menu for "Overall CPT Assessment" with "1 - Abuse Indicated" selected. Below that are fields for "Date ICS Sent/Notification" (containing "04/02/2012") and "Date FCS sent to PI". A "Comments" section with a character count of 29 contains the text "Test updating record message.". At the bottom, there is another "Delete" button and a dropdown menu for "Linked Abuse Report (Alternate)".

Figure 6-5 Assessed Maltreatment Section

19. Assessed Maltreatment - The CPT assessed maltreatment is the maltreatment for which services were provided and/or identified by CPT staff during evaluation of the child. It may be the same as the alleged maltreatment or different, depending upon the information gathered during the course of CPT's evaluation of the child. Select code(s) from drop-down box (See Appendix A, Initial Diagnosis/Alleged Maltreatment/CPT Maltreatment) or type the 3 digit code in the first field. Currently, CPTIS will not auto populate this field with the alleged maltreatments. After an assessed maltreatment is entered into the field, an empty field will be generated for the next entry.

20. Assessments & Case Progress Notes Links - CPTIS allows user to both access existing and create new assessments and case progress notes from these links.

21. Overall CPT Assessment - The overall CPT assessment must not be entered until all assessment activities and reports have been completed and the final case summary has been completed. Select code from drop-down box:

- Abuse Indicated
- Neglect Indicated
- Threat Indicated
- Abuse – Some Indication
- Neglect – Some Indication
- Threat – Some Indication
- Abuse – Not Indicated
- Neglect – Not Indicated
- Threat – Not Indicated
- Not Assessed

Important Note: "Not Assessed" is only used for those cases where the team is unable to provide a service, despite documentation of diligent efforts. Since services were not provided, the overall assessment should be "Not Assessed." The case would then be closed with no assessment documented.

22. Termination Date - Date CPT closes case.

- CPTIS will accept MMDDYY date field entries and automatically format them with slash marks (/). CPTIS will automatically format any YY entry less than 81 as a year 2000 date. e.g. 010180 would be formatted 01/01/2080 and 010181 would be formatted 01/01/1981.
- To avoid error messages enter dates prior to 1981 as MMDDYYYY.
Edit Check: The termination date must be equal to or greater than the date FCS sent to CPI.

23. Date ICS Sent/Notification - The date that the Interim Case Summary (ICS) sent to the protective investigator (PI) can be entered from the Registration Screen or auto populated from the Report Summary screen if the ICS report is completed.

Effective on May 10, 2007, The ICS is no longer mandatory. The user can choose to enter this field and use the ICS template.

Important Note: The date the ICS was sent to PI must be equal to or greater than the initiation date, and also must be equal to or less than the termination date. If you enter a date less than the initiation date or greater than the termination date, you will receive an error message.

24. Date FCS Sent to PI - The date that the Final Case Summary (FCS) is sent to the child protective investigator (PI) is auto populated from the Report Summary screen.

Important Note: The date the FCS was sent to PI must be equal to or greater than the initiation date, and also must be equal to or less than the termination date. If you enter a date less than the initiation date or greater than the termination date, you will receive an error message.

25. Comments - Use this section to document information not captured elsewhere.

6.2.4 Link Abuse Reports

There are two pieces of information in this Link Abuse Report section. The top portion is used to link an abuse report to an existing registration, while the bottom portion lists all the other registrations under the same abuse report number.

Figure 6-6 Link Abuse Reports Field

Delete Linked Abuse Report (Alternate)				
<input type="text"/>				
Other Registrations of Abuse Report Number: 2010-202020				
Abuse Report	Reg Seq #	Client ID	Referral Date	Termination Date
2010-202020	1	789909091	3-01-2010	
2010-202020	1	987654321	3-01-2010	
2010-202020	2	123456789	3-11-2010	

Link Abuse Reports (Alternate) – Top Portion (below the labels of Delete and Linked Abuse Report)

- When another abuse report is received on a child with an open registration in CPTIS, and this abuse report has a different abuse report number than the abuse report linked to the open registration, the Link Abuse Report – Top Portion will allow it to be linked to the open registration.
- NOTE – A new abuse report (which meets mandatory referral criteria) should be linked only if it has been referred for services.
- The Link Abuse Report field will also allow the user to link an abuse report that has duplicate allegations to a registration on a victim that has already received services through the team, whether that registration is open or closed.
- To link an abuse report to an existing registration, the user should enter the abuse report number which will link to the registration. The user must move the cursor out of the field by clicking the left mouse button or hitting the "Tab" or "Enter" key. The user must click "Update" to save the change before leaving the registration screen. The linked abuse report number will then become a hyperlink that brings you back to the abuse report screen. The linked abuse reports will also be reflected on the Client History report.

Figure 6-7 Other Registrations

Other Registrations of Abuse Report Number: 2011-032444				
Abuse Report	Reg Seq #	Client ID	Referral Date	Termination Date
2011-032444	1	123121234	8-23-2011	

Other Registrations of Abuse Report Number - xxxx-xxxxxx – Bottom Portion CPTIS displays all the other registrations that share the same abuse report number. The other registrations will be automatically listed there when it is created.

6.2.5 Completing the Registration Screen

Users should finish entering data and click “update” to add the record. If the record is accepted, the screen returns with a confirmation message at the top of the page: “Update Successful.”

At the bottom of the screen, next to the “Update” button, is the “Report Summary Screen” button. Clicking this button will direct the user to another set of screens which generate the Interim Case Summary, Final Case Summary, and Addendum Reports. The “Go to Intake” button directs the user to the intake screen.



Figure 6-8 Completing Registration



6.3 Existing Registrations

If there are pre-existing, terminated registrations for a client with the same core abuse report number, CPTIS will assign a subsequent registration number to distinguish the separate registrations. CPTIS will not permit more than one open registration (registrations without a termination date) per client. A runtime error message may appear if the user tries to create a new registration with an existing open registration.

6.4 Links to Other Screens from Registration

The registration screen contains several links that allow users to navigate to other screens. Some of these links are discussed elsewhere in this section of the CPTIS User Manual, others are only identified below:

The client ID at the top of the registration screen is a link to the demographic record for that client.

[Client ID: XYZ987654](#)

The abuse report # is a link that will perform the same function as entering the abuse report number in the menu bar and searching for abuse report review records. Clicking on this link will return you to the “abuse report search” screen if there are multiple results from the search, or take you directly to the “abuse report review” create/update screen if there is only one CPTIS abuse report entry for that abuse report number.

[Abuse Report#: 2002-321321](#)

Assessments:  New

Clicking on the folder icon will perform a search for all assessment activities related to the registration. It will return the user to the “assessment activities search” screen if there are multiple results from the search, or take you directly to the “assessment activities” screen if there is only one CPTIS assessment activity entry for that registration.

Clicking on “new” will direct the user to the “assessment activities” create/update screen to enter a new assessment activity.

Case Progress Notes:  New

Clicking on the folder icon will perform a search for all case notes related to the registration. Clicking “new” will direct the user to the screen to create a new case note.

6.5 Active Clients with New Abuse Reports

When creating a registration, users may find that a new abuse report is submitted for a client that is already active in CPTIS. In these cases users should follow the instructions below for generating a registration.

The team must not generate a new registration on a child if:

- The team has an open case (active registration) in CPTIS
- A new report (different abuse report number, same victim) is received, and a referral is accepted

The team must:

- Complete the “Abuse Report Review” screen
- Add all alleged and assessed maltreatments and any additional assessment activities completed for the new report to the active registration.

This applies to all active cases, regardless of the length of time the case has been open.

If the new report has a child already active in CPTIS, and another alleged victim (i.e. a sibling) is not in CPTIS, the team, after completing the Intake/Referral Addendum, will create a new registration under the same abuse report. The appropriate alleged and assessed maltreatments will be added to the active registration.

6.6 Termination with No Completed Assessment Activities

Under normal circumstances, once a referral is accepted for services a case is opened (registration screen created) in CPTIS and assessment screens will be created for each assessment activity provided. However, there are cases in which clients fail to show for scheduled appointments and, despite diligent efforts on the team’s part, assessment activities are not completed. CPTIS will allow for the termination of a registration without adding

assessment activity screens. Documentation of the case coordinator's diligent efforts to provide the services should be found in the Final Case Summary in CPTIS as well as in the case file.

If an assessment screen has been created, it must be deleted prior to termination of the case in CPTIS. In addition, the supervisor must review the case file documentation as well as the CPTIS data to ensure that there are no assessment activities in CPTIS that were not completed prior to approving the case for closure.

SECTION 7: ASSESSMENT SCREEN

7.1 Assessment Information Search Screen

The Assessment Screen tracks all assessment activities provided by the CPT and includes data fields that are self-contained to this specific CPTIS screen. Input to this screen is subsequent to the Registration screen and is linked to the Registration screen by the client's first and last name. A user searches CPTIS for assessment activity records by client ID, abuse report #, and name from the main menu.

Figure 7-1 Assessment Search

The screenshot shows a web application interface for the Assessment Search screen. At the top, there is a blue header bar with the word "Menu" in white. Below the header, the text "Welcome Jennifer Brittenham" is displayed. A list of menu items follows, each with a radio button: "Abuse Review", "Intake/Referral", "Demographic", "Registration", "Assessment" (which is selected), "Report Summary", and "Assessment Reports". Below the menu items is a dropdown menu showing "--". At the bottom of the screen, there is a text input field containing the number "111223542", a checkbox labeled "New", and a purple circular button with the text "GO!".

Once a search is submitted the results are returned in the format noted in figure 7-2. The Assessment Activities Search screen will display if there are multiple results from the search. To access a specific assessment activity on the search results screen, a user will click on the activity sequence number in the list and an individual assessment activity screen will display.

If there is only one CPTIS assessment activity entry for that registration, the user will be brought directly to the Assessment Activities create/update screen for that record.

Figure 7-2 Assessment Search Results

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options: Abuse Review, Intake/Referral, Demographic, Registration, Assessment (selected), Report Summary, and Assessment Reports. Below the menu are search filters for Client ID (111223542), Other CPT Training, Provider, and Reports. The main area shows 'Assessment Search Results for Client 111223542' in a table.

Client ID	Registration	Last Name	First Name	Mid. Initial	Act. Type	Act. Seq#	Completed Date	CPT Office
111223542	2011-032444 # 1	SMITH	SUE		FI	2	8-23-2011	07BA
111223542	2011-032444 # 1	SMITH	SUE		S1	1	8-23-2011	07BA
111223542	2011-032444 # 1	SMITH	SUE		SA	4	8-23-2011	07BA
111223542	2011-032444 # 1	SMITH	SUE		SA	5	1-01-2010	01AA
111223542	2011-032444 # 1	SMITH	SUE		TS	3	8-23-2011	07BA

At the bottom right of the interface, it says 'CPT Version (1.1.1.3) Florida Department of Health - CMS'.

The following columns of information are returned for each record to help identify it:

1. **Client ID** - This is a link to the demographic record for that client ID.
2. **Registration** - The abuse report number and registration number are links to the registration record.
3. **Last Name** - Identifies client's last name.
4. **First Name** - Identifies client's first name.
5. **Middle Initial** - Identifies client's middle initial.
6. **Activity Type** - Identifies (by initials) the type of assessment activity completed.
7. **Activity Sequence Number** - Automatically generated by CPTIS used to distinguish activities under a single registration. To access a specific assessment activity, clicking on the activity sequence number in the list will bring up the individual assessment activity screen.
8. **Completed Date** - Date assessment activity completed.
9. **CPT Office** - The CPT office code where the assessment activity was completed.

7.2 Assessment Create/Update Screen from the Registration Screen

To access existing or create new assessment records for a registration, it is necessary first to select the Registration. Below the Assessed Maltreatment section on the Registration Screen is a link that when clicked, will take the user to a new assessment screen for input.



Figure 7-3 Click New Assessment

Clicking on the “Folder Icon” shown above will perform a search for all assessment activities that are related to this registration. It will return to the Assessment Activities Search screen if there are multiple results from the search. To access a specific assessment activity, clicking on the activity sequence number in the list will bring up the individual assessment activity screen.

If there is only one CPTIS assessment activity entry for that registration, it will take you directly to the Assessment Activities create/update screen.

Clicking on “New” will take you to the Assessment Activities Create/Update screen, allowing you to enter a new assessment activity for this registration. See figure 7-4 below.

Figure 7-4 Assessment Activities New

7.3 Instructions for Creating a New Assessment Screen

Data field descriptions and parameters (i.e. drop-down choices) for the Assessment screen are as follows. Mandatory input fields are identified in red.

1. **Client ID** - This field will auto populate from the Registration Screen as a label on this page.
2. **Client Name** – This field will auto populate from the Registration Screen as a label on this page.
3. **CPT Office** - Select code from drop-down box. See Appendix D for CPT Office Codes. CPT Office is required to insert a new record.
4. **Assessment Type** - Select code from drop down box:
 - Assessment
 - Link

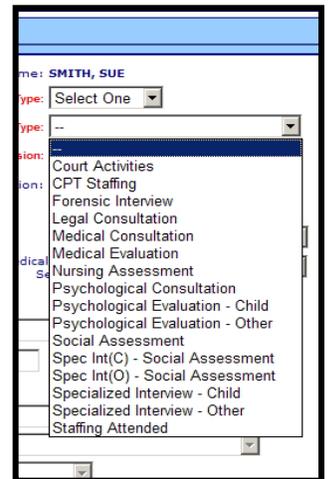
This field is used to distinguish between a primary service and a link to siblings. Its purpose is to avoid duplication of primary assessments that result in an inaccurate count of assessment activities in the annual funding allocations to the teams, as well as in the “Summary of Child Protection Team Activities” report. For all activities where one service can be linked to numerous other victims in the report, attach the assessment activity to the primary child (eldest or first received) as an “assessment” and attach the same activity to other victims in the report as a “link.” The associated report will only count the activities with “assessment” in this field.

For example: A psychological evaluation completed on the mother can be identified as an assessment for one child only and linked to any other siblings. Similarly, if a social assessment is completed and involved specialized interviews with both parents, the social assessment will be an assessment for one child and linked to any siblings. Additionally, the specialized interviews can be an assessment activity for one child and linked to the siblings. At no time will an assessment activity be a primary activity for more than one child.

5. Provider – Select the individual who conducted the assessment service/activity from the drop-down list. This list will show all current providers for the CPT Office selected. (Please note that individual teams only have access to their specific provider list). Box will display Provider ID and Name based on the alphabetical order of the provider’s last name. When medical evaluations occur at a telemedicine site, the provider should be the CPT medical staff who directed the medical evaluation, not the individual at the telemedicine site who handled the equipment.

6. Activity Type - Select type from drop-down box (See Appendix B, Service/Assessment Type and Codes).

- If Activity Type is either “Court Activities,” “Legal Consultation,” “Specialized Interview (child) – Social Assessment,” or Specialized Interview (other) – Social Assessment,” the Date Report Sent to CPI field is disabled.
- If Activity Type is either “Court Activities,” “Legal Consultation,” “Staffing Attended,” or “CPT Staffing,” the Positive Finding field is disabled.
- Users must fill in the Activity Type if a Completed Date is entered.



7. County of Service Provision - This is the county where the service is provided.

Select the county from the drop-down box.

- Standard county codes 01-67
- 99 – Unknown
- 00 – Out of State

8. Completed Date - Enter either the date the activity occurred for one-time services, such as a medical evaluation, specialized interview, etc., or the date of the last activity for those activities that may involve multiple interviews or contacts (such as a social assessment or psychological evaluation).

- Use format MM/DD/YYYY.
- Users must fill in Completed Date if an activity type is selected.

9. Location - Location where the activity occurred.

Select location from drop-down box:

- Attorney's Office.
- CPT Office.
- Emergency Room.
- Court House.
- Hospital In-patient.
- Other.
- Physician's Office.
- Telemedicine Site.
- County Health Unit.

10. Court Activity Type - If the Court Activity option is selected in the field of Activity Type, this field will be enabled. It captures the detailed court activity type. Users may select an option below from the drop down box.

- Court Testimony – Criminal.
- Court Testimony – Dependency.
- Deposition – Criminal.
- Deposition -- Dependency.
- Subpoena and Court Wait 1 Hour or More.

11. Wait Time - If Subpoena and Court Wait 1 Hour or More is selected in the drop down box of Court Activity Type, the field Wait Time will be enabled. The purpose of this field to give credit to those staff that waits more than 1 hour for the subpoena.

12. Medical Exam/Consult Physical Findings - Overall findings from examination, not allegation specific findings. Required for Activity Type "Medical Evaluation"

Select from drop-down box:

- Findings.
- Indeterminate.
- No Findings.
- Not Applicable.

13. Medical Exam/Consult Sexual Findings - Overall findings from examination, not allegation specific findings. Required for Activity Type “Medical Evaluation.”

Select from drop-down box:

- Findings.
- Indeterminate.
- No Findings.
- Not Applicable.

For users entering a Medical Exam or Medical Consult *with* Sexual Findings the section for an STD Assessment will be added to the Assessment screen as shown in figure 7-5 below.

Figure 7-5 STD Assessment

The screenshot shows a form titled "STD Assessment" with the following sections:

- Sexual Activity within 60 days:** Radio buttons for Yes, No, and Undetermined.
- Presumptive Diagnosis:** Checkboxes for Chlamydia, Gonorrhea, Herpes, Other, and Syphilis.
- Treatments:** Checkboxes for Azithromycin PO 1 gram, Cefixime (Suprax) PO 400 mg, Metronidazole (Flagyl) PO 2 grams, and None.
- Specimens Collected:** Checkboxes for Chlamydia, Gonorrhea, Herpes, HIV, Other, and Syphilis.
- Signs and Symptoms:** Checkboxes for Abdominal pain, Discharge, Edema of genitals, Erythema of genitals, Genital itching, Genital odor, Genital or anal bleeding, Genital pain, Genital ulcers or lesions, None, and Urinary symptoms.
- Pregnancy Test:** Radio buttons for Administered -- Positive Result, Administered -- Negative Result, and Not Administered.
- Referred for Follow-Up:** Checkboxes for HIV Testing and Treatment (EP), HPV, Other, and Syphilis.
- Referred To:** A dropdown menu.
- Date/Time of Medical Services:** A text input field.
- Prepared By:** A text input field.
- Date:** A text input field.

Instructions for filling in this section are shown below under “Sexually Transmitted Disease Assessment.”

14. Medical Exam/Consult Neglect Findings

Overall findings from exam, not allegation specific findings. Required for Activity Type “Medical Evaluation.”

Select from drop-down box:

- Findings.
- Indeterminate.
- No Findings.
- Not Applicable.

CPTIS requires that all three medical exam finding fields be filled out in order to update this screen. The drop-down box provides the different findings as well as a “not applicable” selection. Choose the appropriate finding for the type of exam completed and then select “not applicable” for the other(s).

15. Date Report Sent to PI – Enter the date that the report is sent to the child protective investigator. Required for all the activity codes except Court Activities, Legal Consultation, and Specialized Interview (Child and Other) – Social Assessment. (**Note:** This field is disabled until *either* an Assessment Report is created or a document is scanned/uploaded to the assessment screen.)

CPTIS will accept MMDDYY date field entries and automatically format them with slash marks (/). CPTIS will automatically format any YY entry less than 81 as a year 2000 date (e.g., 010180 would be formatted 01/01/2080 and 010181 would be formatted 01/01/1981).

- To avoid error messages enter dates prior to 1981 as MMDDYYYY.
- The date the report sent to PI must be equal to or greater than the assessment service completion date.

16. Reason for Delay - Use this field only when the assessment activity was not completed within 20 days of the initiation date (Registration Screen). There are six reasons listed in the drop-down box. Only those assessment activities with “Late – No Exception” will be counted toward the non-compliance (category of over 20 Days) in the Performance Measures Report. Others will be exempt.

- **Additional Referral/Assessment:** This refers to a new injury or incident involving a victim in an open case. Additional referrals/assessments occur when a new sequence has been generated to an existing abuse report. If the injury or incident resulted in a new abuse report, it should be treated as a new referral rather than an additional referral.
- **Assessment No-Show:** This refers to situations where the client has failed to show up for a scheduled assessment activity (social assessment, specialized interview, etc.) and the assessment activity was not completed within 20 days due to extraordinary circumstances. In all situations, CPT staff must document notification of the client no-show in writing to the child protective investigator and in the case progress notes. Documentation must also include CPT staffs’ diligent efforts to reschedule the appointment within the required 20 days.
- **Late – No Exception:** This refers to situations where the assessment activity was completed over 20 days from referral date, with no acceptable reason.

- **Medical No-Show:** This refers to situations in which the client has failed to show up for a scheduled medical evaluation, and the medical evaluation was not completed within 20 days due to extraordinary circumstances. In all situations, CPT staff must document notification of the client no-show in writing to the child protective investigator and in the case progress notes. Documentation must also include CPT staff's diligent efforts to reschedule the appointment within the required 20 days.
- **Post - Termination:** This refers to situations where additional CPT assessment activity or activities were provided after the case was closed.
- **Waiting for Medical Records:** The user is waiting for medical records to complete the assessment.

17. Positive Finding Date - Enter the date if there was a positive finding. Positive Finding is defined as a professional determining, based on information gathered, that the abuse or neglect occurred; or there was a situation in which the child's welfare was threatened. If Positive Finding has a value, Verbal Notification date is required. Also, Positive Finding Date must be equal or greater than the service Completed Date.

18. Verbal Notification Date - Enter the date the verbal Notification was sent to the child protective investigator. The Verbal Notification Date must be equal or greater than the service Completed Date.

19. Telemedicine - Click on the check box if telemedicine was utilized in the assessment activity. Once checked, the "Remote Site" and "Hub Site" fields will be enabled for data entry. The telemedicine fields are enabled only for teams who utilize telemedicine equipment.

20. Remote Site - Select the local site from which the medical evaluation is transmitted.

21. Hub Site - Select the main office for the CPT catchment area, where the CPT medical director is located. **Note:** The fields of Telemedicine, Remote Site and Hub Site will be enabled only when the assessment activities are Medical Evaluation and Nursing Assessment.

22. Handbook Requirement Not Met - Click on the check box in order to document the services that are considered not meeting the core requirement in the CPT Handbook during the Quality Improvement Review.

23. CAC Funding - This box should be checked if this assessment is funded by using **CAC state dollars**. If this box is checked, the assessment will not be counted for allocation of CPT funding.

24. Other Funding/Comment - Do not check CAC funding box, however note comment if source is **state dollars other than CAC dollars**.

25. Comments - Enter comments, as appropriate and necessary, such as to identify who was interviewed.

26. Medically Complex: When the *Activity Type* of 'Medical Evaluation' or 'Medical Consultation' is selected, the following **Medically Complex**, **Obesity**, and **Nutritional Counseling** fields display. The Medically Complex and Weight Issue fields are required once the Date Reports Sent to PI value is entered on the Assessment screen. (Note: **Included in Recommendation to DCF/SO: is required IF Nutritional counseling needed:** = "Yes".)

27. Medical Neglect Substantiated: For ‘Medical Evaluation’ or ‘Medical Consultation’ activity types, the Medical Neglect Substantiated: field is *required* IF Findings is selected for the Neglect Findings: field. If “Yes” is selected, the Date DCF Notified of Medical Neglect: is *required*.

Medically Complex: Yes No
 Medical Provider Consulted: CMS Network Physician:
 Physician with Expertise:
 Other:
 Unable To Comply:
Obesity: Yes No
 Nutritional counseling needed: Yes No
 Included in Recommendation To DCF/SO:
Medical Neglect Substantiated: Yes No
 Date DCF Notified of Medical Neglect:

7.3.1 Sexually Transmitted Disease (STD) Assessment

This section has been developed to collect data for the CPT STD prophylactic medication initiative. This collaborative effort between the DOH STD program, CMS/Bureau of Child Protection and Special Technologies, and the DOH pharmacy will give CPT medical providers the ability to order STD medicines from the DOH pharmacy to utilize with CPT patients who have been sexually abused and are at risk for developing STDs. The CPT medical provider will be entering data into CPTIS on each child treated with the STD prophylactic medications. A monthly report will be delivered to the DOH STD program.

If the field of “Activity Type” is “Medical Evaluation” and the field of “Medical Exam/Consult Sexual Findings” is “Finding”, the STD section will be displayed on the Assessment screen. Teams who are participating in the program are required to complete this section for all patients treated with DOH pharmaceuticals.

28. Sexual Activity within 60 Days - Click on the checkbox if there is any reported sexual activity (oral, vaginal and anal) within the last 60 days.

29. A Presumptive Diagnosis - Identifies the likely condition based on probable findings gathered during a medical exam or interview.

30. Signs and Symptoms - These are the most common signs and symptoms, which can indicate a diagnosis of STD.

31. Treatments - Recommended CPT prophylactic STD treatments guidelines are found in The TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG) “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, which is located in the CPT Handbook, Appendix F.

32. Pregnancy Test - Recommendations regarding pregnancy testing are found in the TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG) “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, which is located in the CPT Handbook, Appendix F.

33. Specimens Collected - Specimen collection recommendations are found in The TECHNICAL ASSISTANCE GUIDELINE: STD-39 (TAG) “Technical Assistance for the Provision of Unit of Use of Re-packaged Prophylactic Medicines to Child Protection Team Provider Sites in the Prevention of Sexually Transmitted Diseases (STDs) for Sexual Assault in Adolescents and Pre-pubertal Children”, which is located in the CPT Handbook, Appendix F.

34. Referred for Follow-Up - Indicate when the child served by CPT requires a follow-up referral for additional diagnostics and/or treatment. If this field is completed, must complete “Referred To”.

If the field “Referred for Follow-Up” is checked, the user must have to select an option in the field of “Referred To.”

35. Referred To - Indicate referral agency for the child served by the CPT who requires follow-up referral for additional diagnostics and/or treatment.

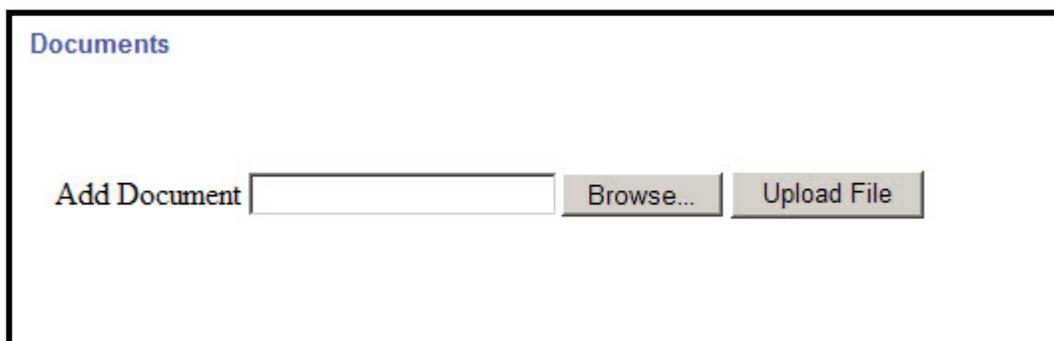
36. Date/Time of Medical Services - Date and time that the medical evaluation was completed. Date will be (MMDDYYYY) and time is hours followed by minutes with am or pm.

37. Prepared by - Medical Provider electronic signature.

7.3.2 Document Storage

The system allows users to upload CPT assessment activity reports which are not found in CPTIS. Specifically, the following reports can be uploaded and saved to the electronic case file: medical evaluation, medical consult, psychological evaluation, early steps developmental checklist. Please note that only reports, generated as a result of CPT services may be placed in the document storage. For instance, if a medical consult is being completed, the copies of the medical files that were reviewed are not to be uploaded.

Figure 7-6 Document Storage



To save a document, click on “browse” and locate the document you want to upload. Double click on the document and it should appear in the “Add Document” text field. Click on “Upload File” and the saved document should appear under the “Documents” field. Double click on the document “name” to make sure that the document displays.

If, after uploading a document, you realize the document does not belong with that particular case file, you can remove the document by clicking on the “Delete” field, located to the right of the document name and file size.

38. New Assessment Report - Clicking on this button will generate a new assessment from this current Assessment screen and avoid having to return to the main menu or the Registration in order to create a new assessment.

39. Update - Clicking on this button will update the CPTIS database with assessment data. Do not leave New Assessment Activities screen without clicking “Insert” as all data will be lost.

Important Note: The system will not allow you to change an activity once it has been added. For example, if you had entered a medical exam and wanted to change it to a medical consult, you would have to delete the activity and re-enter all the data for the medical consult.

Once you have entered all your information and clicked on the update button, the screen will return with a successful update message. The “New Assessment” button will allow you to go to a new assessment screen from the current assessment screen, thus avoiding having to go back to the registration screen or the main menu. Be sure that you have successfully updated the data you had previously entered prior to creating a new assessment activity screen. Remember to click on the “update” button and confirm the successful update prior to going to a new screen, otherwise data you have entered will not be saved.

7.4 Instructions for Updating an Assessment Screen

Follow instructions in Section 7.1 to search for Assessments. At the screen in figure 7-2 Assessment Search Results, select the desired Assessment by clicking on the Activity Sequence Number. Then click the “New Assessment” button at the bottom of the screen. The screen shown below in figure 7-8 allows users to update an Assessment Activity.

Figure 7-8 Update an Assessment Activity

ASSESSMENT Activities 2011-032444-1 # 2	
Client ID: 111223542	Name: SMITH, SUE
CPT Office: 07BA	Assessment Type: Assessment
Provider: 1652 - ANDERSON-RATLIF, SHIANN	Activity Type: Forensic Interview
Completed Date: 08/23/2011	County of Service Provision: Brevard
	Location: CPT Office
Court Activity Type: --	Wait Time: --
Medical Exam/Consult: --	Medical Exam/Consult: --
Physical Findings: --	Sexual Findings: --
Medical Exam/Consult: --	
Neglect Findings: --	
Date Report Sent to PI: 04/08/2012	Reason for Delay: --
Positive Finding Date:	Verbal Notification Date:
Handbook Requirement Not Met: <input type="checkbox"/>	Telemedicine: <input type="checkbox"/>
	Remote Site: --
	Remote Provider: --
	Hub Site: --
<input type="text" value="0"/> Comments: (max 255 characters)	
<input type="text"/> Documents	
Updated by: Brittenham , Jennifer	Created: 8/23/2011
	Updated: 4/16/2012
<input type="button" value="New Assessment"/>	<input type="button" value="Update"/>
<input type="button" value="New Assessment Report"/>	Forensic Interview

From this screen users may update the following fields only:

- Date Report Sent to PI** - Users may enter the date this report was sent to the PI.

Important Note: Once a date is entered in this field, the report is locked and cannot be updated or edited. Users should not enter the date the report is sent to the PI until the report is finalized.

- Reason for Delay** - Users may enter the reason for delay in completing the related assessment activities.
- Positive Finding Date** - The date a positive finding was discovered.
- Verbal Notification Date** - The date the client was verbally notified of the finding.
- Handbook Requirement Not Met** - Users should check this option when requirements were not met.
- Comments** - Up to 255 characters allow the user to provide a narrative description related to the assessment activity.

New assessments or new assessment reports can be accessed using the buttons and drop down menu at the bottom of the screen. Additional information regarding the use of Assessment Reports is included in Section 8 of this user guide.

SECTION 8: ASSESSMENT REPORTS

8.1 Creating New Assessment Reports

New Assessment Reports can only be created once an Assessment Activity has been created using the client ID or abuse report number for a case. To create a new Assessment Report, users may click “Assessment” on the main menu, enter the client ID or abuse report number, and click “Go.” This will lead to the assessment activity search result screen. Users should click on one of the activity sequence #s shown in the 7th column from the right. This will pull up an Assessment Activity screen shown in figure 8-1 below. At the bottom of the screen, users can access a drop down menu, select a report and click the button labeled “New Assessment Report.”

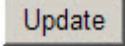
Figure 8-1 Accessing New Assessment Reports from Assessment Activities

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. The main window is titled 'ASSESSMENT Activities 2011-032444-1 # 3'. It features a left-hand menu with options like 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary', and 'Assessment Reports'. The main form area contains several fields: Client ID (111223542), Name (SMITH, SUE), CPT Office (07BA), Provider (1652 - ANDERSON-RATLIF, SHIANN), Completed Date (08/23/2011), Assessment Type (Assessment), Activity Type (CPT Staffing), and County of Service Provision (Brevard). There are also dropdown menus for Court Activity Type, Medical Exam/Consult, Physical Findings, Neglect Findings, Wait Time, Reason for Delay, Verbal Notification Date, and Hub Site. A 'Comments' field (max 255 characters) and a 'Documents' section are also present. At the bottom, there are buttons for 'New Assessment', 'Update', and 'New Assessment Report', along with a dropdown menu for selecting a report type (Specialized Interview, Forensic Interview, CPT Staffing, Social Assessment, Nursing Assessment, Spec Int/Soc Assess, CPT Staffing). The footer indicates 'CPT Version (1.1.1.3) Florida Department of Health - CMS'.

8.1.1 Assessment Report Functions

Each of the assessment reports referenced in this section of the manual have similar functions. As with other screens in CPTIS, data fields provide instructions via a “tool tips” function, which appears when the user holds the cursor over the title to the data field. These tips appear in a cream colored box and provide directions regarding the type of data to enter in that field. All narrative fields and some full screens, provide a spell check function via a spell check button next to the field or at the bottom of the screen. Assessment Reports are “locked” and no further changes can be made once the field “date sent to PI” is entered. The following table provides information on the functional buttons found throughout the assessment report screens.

Table 8-1 CPTIS Assessment Reports Button Functions

Button	Function
	Allows the user to add another Specialized Interview to the system.
	Allows the user to save new information to the fields of the screen currently displayed. If the user leaves the current screen without clicking the “update.”
	Allows the user to print the current interview, all interviews for the abuse report number, or all interviews for the abuse report number and client number, depending on the selection from the drop down menu.
	Allows the user to spell check the field next to the button. Spell check buttons at the bottom of the screen spell check each field on a screen.
Prepared By: <input data-bbox="354 1482 760 1535" type="text"/>  Date: <input data-bbox="927 1482 1073 1535" type="text"/>	CPTIS auto-populates these fields with an electronic signature and the current date when the user clicks the “Sign” button based on the users log-in ID.
Reviewed By: <input data-bbox="354 1787 760 1839" type="text"/>  Date: <input data-bbox="927 1787 1073 1839" type="text"/>	CPTIS auto-populates these fields with an

	electronic signature and the current date when the user clicks the “Sign” button based on the users log-in ID. Only users with supervisor privileges may review a report.
--	---

There are 7 types of Assessment Reports in CPTIS:

- Specialized Interview
- Forensic Interview
- CPT staffing
- Social Assessment
- Nursing Assessment
- Specialized Interview/Social Assessment
- Case Progress Note

The only Assessment Report that cannot be accessed from the Assessment Activity screen is the Case Progress Note. Instructions for creating a new Case Progress Note are found in Section 9 of this user manual.

8.2 Creating New Specialized Interview Reports

To create a specialized interview report, users can select “Specialized Interview” from the drop down menu and click “New Assessment Report.” This will lead to the screen shown in figure 8-2 below.

Figure 8-2 Specialized Interview



CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

111223542 New **GO!**

Other CPT Training New **GO!**

Provider New **GO!**

Reports --

Help Center

System Guide

Code Maintenance

Help Maintenance

User Options

Sexual Abuse Treatment Program

Logout

New Specialized Interview Number: 2

Specialized Interview Report

Abuse Report Number: 2011-032444	Registration Seq #: 1	Assessment Seq #: 1
Specialized Interview Number: 2	CPT Office: 07BA	CPI/CBC Name: <input type="text"/>
Name: SMITH, SUE	DOB: 01-01-2010	Client ID: 111223542
Interview Date: 08-23-2011	Interview Location:	Provider Name: ANDERSON-RATLIF, SHIANN

Person Interviewed: Date of Birth: Relationship: --

Household Composition:

Delete	First Name	Last Name	DOB	Relationship
<input type="checkbox"/>	Sue	Smith	01/01/2010	Father
<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	--

Recording Method: DVD

Purpose of Interview: (max 20,000 characters) **ABC**

Summary of Interview: (max 40,000 characters) **ABC**

Additional Interview Summaries

Person Interviewed: DOB: Relationship: --

Interview Date: Interview Location: --

Summary of Interview: (max 40,000 characters)

Interview Summary: **ABC** Add

Safety, Risk and Protective Capacity: (max 20,000 characters) **ABC**

Impressions and Recommendations: (max 20,000 characters) **ABC**

Prepared By: Sign Date:

Reviewed By: Sign Date:

CC: (max 250 characters)

Updated By: **Jennifer Brittenham** Created: **4/24/2012** Updated: **4/24/2012**

Add **Update** **Print** Current interview only

The first section of the Specialized Interview screen is pre-populated with the following data (with the exception of CPI/CBC Name which must be entered by the user when applicable):

1. **Abuse Report Number** - The system links the specialized interview to the abuse report number associated with the case. The number on this screen links back to the associated registration.
2. **Registration Sequence #** - The system identifies each registration related to the case with a sequence number, which displays in this field.
3. **Assessment Sequence #** - The system identifies each assessment related to the case with a sequence number, which displays in this field.
4. **Specialized Interview Number** - CPTIS identifies each specialized interview related to the case with a sequence number, which displays in this field.
5. **CPT Office** - The CPT office pre-populates in this field.
6. **CPI/CBC Name** - This field must be entered by the user if there is a CPI/CBC associated with the case.
7. **Name** - Client's last,first name.
8. **DOB** - Client's DOB.
9. **Client ID** - Client ID associated with the Registration and Assessment activity.
10. **Interview Date** - Date the interview took place.
11. **Interview Location** - Where the interview took place.
12. **Provider Name** - The name of the provider conducting the assessment, which is pulled using the user's log-in.

Important Note: The information in these pre-populated fields is pulled from the client's previously created Registration and Assessment screens. Once a user creates a new Assessment Report, these fields are auto-populated by CPTIS using the existing information. *If this information is subsequently changed, enhanced or updated, the report fields which have been auto-populated will not be updated.* Users must add new family members and other new information to reports separately.

The following sections of the Specialized Interview must be entered by the user. Fields labeled in **red** on the screen are required fields.

13. **Person Interviewed** - Enter the name of the primary individual the provider is interviewing to complete this report.
14. **Date of Birth** - Enter the date of birth of the primary individual being interviewed.
15. **Relationship** - Enter the relationship of the primary person being interviewed to the client for whom the case has been created.
16. **Household Composition** - This section will auto-populate household members from previous screens. To add additional household members, use the fields First Name, Last Name, DOB, and Relationship to enter information about each person living in the client's

household. Click “Add” to the right of the relationship field to add a new household member. IF the user leaves the screen without clicking “Add,” the information in those fields will not be saved. Check the delete box to delete a household member. The household member will be deleted when the user clicks “update” before leaving the screen. User may add as many household members as appropriate.

- 17. Recording Method** - Use the drop down menu in this field to indicate the type of recording device used to record the interview. If it was not recorded, select “None.”
- 18. Purpose of the Interview** - A maximum of 20,000 characters allows the user to describe the purpose of the interview. A spell check button allows the user to spell check this field.
- 19. Summary of the Interview** - A maximum of 40,000 characters allows the user to describe the interview in a narrative format. A spell check button allows the user to spell check this field.
- 20. Additional Interview Summaries** - This section allows users to add information about related interviews. Users should complete the Person Interviewed, DOB, Relationship (to the client), Interview Date & Location, and Summary of Interview. Related interviews entered in this section should provide clarity or add needed information which would further summarize information in the primary interview being documented. Users must click “Add” to the right of the spell check button in this section to enter the information in the field. *If “Add” is not clicked before “update” or before the user leaves the screen, the information will be lost.*
- 21. Safety, Risk and Protective Capacity** - A maximum of 20,000 characters allows the user to provide a narrative assessment of the client’s safety and risk and of the household’s protective capacity. Spell check function provided.
- 22. Impressions and Recommendations** - A maximum of 20,000 characters allows the user to summarize overall impressions and recommendations regarding the case as they relate to the interviews documented on this screen. Spell check function provided.
- 23. Prepared By & Date** - When the user clicks the “Sign” button next to the “Prepared By” field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID. The date can be edited.
- 24. Reviewed By & Date** - When the user clicks the “Sign” button next to the “Reviewed By” field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID. Only users with supervisor privileges may review a report. CPTIS will not allow other users to sign this field. The date can be edited.
- 25. CC** - Users enter information regarding other team members who were sent a copy of this report.
- 26. Updated By** - Auto-populates based on the user’s log-in ID.
- 27. Created** - Auto-populates with the date the report was created.
- 28. Updated** - CPTIS auto-populates this field with the date the report was last updated.



8.3 Creating New Forensic Interview Reports

From the Assessment activity screen discussed in subsection 8.1, users may select “Forensic Interview” from the drop down menu and click “New Assessment Report.” This will lead to the screen shown in figure 8-3 below.

Figure 8-3 Forensic Interviews

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' sidebar with options like Abuse Review, Intake/Referral, Demographic, Registration, Assessment, Report Summary, and Assessment Reports. The main area is titled 'New Forensic Interview Number: 2' and contains a 'Forensic Interview Report' form. The form includes fields for Abuse Report Number (2011-032444), Registration Seq # (1), Assessment Seq # (2), Forensic Interview Number (2), CPT Office (07BA), CPI/CBC Name, Name (SMITH, SUE), DOB (01-01-2010), Client ID (111223542), Interview Date (08-23-2011), Interview Location (CPT Office), and Provider Name (ANDERSON-RATLIF, SHIANN). Below these are fields for Person Interviewed (SUE SMITH), Date of Birth (01/01/2010), Individual/Agency Requesting Interview, and Recording Method (DVD). There are five large text areas for 'Purpose of Interview', 'Summary of Interview', 'Safety and Risk Factors', and 'Interview Findings', each with a character count and a 'REC' button. At the bottom, there are 'Prepared By' and 'Reviewed By' fields with 'Sign' and 'Date' buttons, a 'CC' field, and a footer with 'Updated By: Jennifer Brittenham', 'Created: 4/24/2012', 'Updated: 4/24/2012', and buttons for 'Add', 'Update', 'Print', and a dropdown for 'Current interview only'.

The first section of the Forensic Interview screen is pre-populated by CPTIS with the same information as the Specialized Interview report screen (see subsection 8.2). Field #4 would denote the sequence number of the forensic interview, in this case. The subsequent fields must be entered by the user. Required fields are indicated in red on the screen.

1. **Person Interviewed** - Enter the name of the primary individual the provider is interviewing to complete this report.
2. **Date of Birth** - Enter the date of birth of the primary individual being interviewed.
3. **Individual/Agency Requesting Interview** - Enter the name of the person or organization which has requested the forensic interview being documented on the current screen.
4. **Agency** - If an individual has requested the interview, enter the agency for which they are associated in this field. If an agency requested the interview, restate the agency or organization in this field.
5. **Recording Method** - Use the drop down menu in this field to indicate the type of recording device used to record the interview. If it was not recorded, select "None."
6. **Purpose of the Interview** - A maximum of 20,000 characters allows the user to describe the purpose of the interview. A spell check button allows the user to spell check this field.
7. **Summary of the Interview** - A maximum of 40,000 characters allows the user to describe the interview in a narrative format. A spell check button allows the user to spell check this field.
8. **Safety and Risk Factors** - A maximum of 20,000 characters allows the user to provide a narrative assessment of the client's safety and level of risk in their current situation. A spell check button allows the user to spell check this field.
9. **Interview Findings** - A maximum of 20,000 characters allows the user to summarize overall findings regarding the case as they relate to the interview documented on this screen. A spell check button allows the user to spell check this field.
10. **Prepared By & Date** - When the user clicks the "Sign" button next to the "Prepared By" field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID.
11. **Reviewed By & Date** - When the user clicks the "Sign" button next to the "Reviewed By" field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID. Only users with supervisor privileges may review a report.
12. **CC** - Users enter information regarding other team members who were sent a copy of this report.
13. **Updated By** - Auto-populates based on the user's log-in ID.
14. **Created** - Auto-populates with the date the report was created.
15. **Updated** - CPTIS auto-populates this field with the date the report was last updated.



8.4 Creating New CPT Staffing Reports

From the Assessment activity screen discussed in subsection 8.1, users may select “CPT Staffing” from the drop down menu and click “New Assessment Report.” This will lead to the screen shown in figure 8-4 below. The purpose of this report is to document the staffing on a case.

Figure 8-4 CPT Staffing Reports

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CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu
Welcome Lauren Kemper
 Abuse Review
 Intake/Referral
 Demographic
 Registration
 Assessment
 Report Summary
 Assessment Reports
 --
 111223542 New **GO!**

Other CPT Training New **GO!**

Provider

 New **GO!**

Reports
 --

Help Center
 System Guide
 Code Maintenance

Help Maintenance
 User Options
 Sexual Abuse Treatment Program
 Logout

New CPT Staffing Number: 2

CPT Staffing Report
 Abuse Report Number: 2011-032444 Registration Seq #: 1 Assessment Seq #: 3
 CPT Staffing Number: 2 CPT Office: 07BA
 Child Name: SMITH, SUE DOB: 01-01-2010 Client ID: 111223542

Staffing Date:
 CPI/CBC name: Confidentiality Statement signed by attendees:
 CPT Staffing Lead: Position:

Family Information

Delete	First Name	Last Name	DOB	Relationship
<input type="checkbox"/>	Sue	Smith	01/01/2010	Father
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-- <input type="text"/> Add

Attendees

Delete	Last Name	First Name	Position/Agency
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> Add

Purpose of Staffing: (max 20,000 characters)

Summary of Discussion: (max 40,000 characters)

Safety, Risk and Protective Capacity: (max 20,000 characters)

Summary of Services and Supports Needed: (max 20,000 characters)

Barriers to Service Provision: (max 20,000 characters)

Prepared By: Sign Date:
 Reviewed By: Sign Date:

CC: (max 250 characters)

Updated By: Lauren Kemper Created: 4/17/2012 Updated: 4/17/2012
 Add Current Staffing only

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The first section of the CPT Staffing screen is pre-populated by CPTIS with most of the same information as the Specialized Interview report screen (see subsection 8.2). The subsequent fields must be entered by the user. Required fields are indicated in **red** on the screen.

1. **Staffing Date** - Enter the date the staff meeting took place.
2. **CPI/CBC name** - Enter the name of the CPI/CBC related to the case.
3. **Confidentiality Statement signed by attendees** - Check this box only when a confidentiality statement has been signed by and collected from each attendee.
4. **CPT Staffing Lead** - Users should identify the staffing lead in this field.
5. **Position** - This field indicates the official position of the staffing lead.
6. **Family Information** - Use the fields First Name, Last Name, DOB, and Relationship to enter information about each person living in the client's household. Click "Add" to the right of the relationship field to add a new household member. Check the delete box to delete a household member. The household member will be deleted when the user clicks "update" before leaving the screen. User may add as many household members as appropriate. This section may pre-populate from previously entered data from other screens.
7. **Attendees** - Use the fields Last Name, First Name, Position/Agency to add the names of individuals in attendance, their position, and the agency they represent. Click "Add" to the right of the relationship field to add an attendee. IF the user leaves the screen without clicking "Add," the information in those fields will not be saved. Check the delete box to delete an attendee. The attendee will be deleted when the user clicks "update" before leaving the screen. User may add as many attendees as appropriate.
8. **Purpose of Staffing** - A maximum of 20,000 characters allows the user to describe the purpose of the staffing in a narrative format.
9. **Summary of Discussion** - A maximum of 40,000 characters allows the user to describe the discussion in a narrative format.
10. **Safety, Risk, and Protective Capacity** - A maximum of 20,000 characters allows the user to summarize the meeting discussion related to the client's safety and risk in their current situation, as well as the protective capacity of their current household and optional households. Barriers to service should also be documented.
11. **Summary of Services and Supports Needed** - A maximum of 20,000 characters allows the user to summarize the discussion related to the client's services and supports needed.
12. **Prepared By & Date** - When the user clicks the "Sign" button next to the "Prepared By" field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID.
13. **Reviewed By & Date** - When the user clicks the "Sign" button next to the "Reviewed By" field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID. Only users with supervisor privileges may review a report. CPTIS will not allow other users to sign this field.

- 14. **CC** - Users enter information regarding other team members who were sent a copy of this report.
- 15. **Updated By** - Auto-populates based on the user's log-in ID.
- 16. **Created** - Auto-populates with the date the report was created.
- 17. **Updated** - Auto-populates with the date the report was last updated.



8.5 Creating New Social Assessments

From the Assessment activity screen discussed in subsection 8.1, users may select “Social Assessment” from the drop down menu and click “New Assessment Report.” This will lead to the screen shown in figure 8-5. The purpose of this report is to document the client’s psychological and social history, as well as present needs and strengths.

As shown in figure 8-5, the first section of the Social Assessment screen is pre-populated by CPTIS with most of the same information as the Specialized Interview report screen (see subsection 8.3). The fourth field would be the Social Assessment sequence number, in this case. Four additional fields are auto-populated by CPTIS for Social Assessment reports.

1. **CPT Service Provider** - CPTIS fills in the name of the service provider from the Child Protection Team.
2. **Referred By** - This field contains information regarding who referred the client for services.
3. **Date of Assessment Activity** - The date of the assessment activity auto-populates in this field.
4. **Referred Children** - This field indicates the names of individuals who were under the age of 18 when referred to CPT in reference to this case.

Important Note: These fields are automatically populated using information from previously updated screens. *If those screens are subsequently changed, this report will not auto-populate again. New information must be indicated when the report is updated.*

Figure 8-5 Social Assessments



CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Travis McLane

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment**
- Report Summary
- Assessment Reports

2016-000001 New

Other CPT Training New

Provider New

Reports --

Allocation Reports

Help Center

Training Videos

System Guide

Administration

User Options

Sexual Abuse Treatment Program

Logout

New Social Assessment Number: 1

Social Assessment Report			
Abuse Report Number:	2016-000001	Registration Seq #:	1
Social Assess. #:	1	CPT Office:	01AA
Child Name:	Case, Nota	DOB:	10-31-2013
CPT Service Provider:	MCLANE, TRAVIS	Referred By:	DCF/Other
		Assessment Seq #:	8
		CPI/CBC Name:	
		Client ID:	654654654
		Date of Assessment Activity:	03-25-2016

Referred Children			
Client ID	First Name	Last Name	DOB
987654321	mikey	testy1	02/02/2010

Family/Other Household Members				
Delete	First Name	Last Name	DOB	Relationship
				-- Add

History of Presenting Problems: (max 20,000 characters)

Reason for referral text

Family History:

Family Functioning: (max 20,000 characters)

Overall Risk Assessment: (max 20,000 characters)

Impressions: (max 20,000 characters)

Recommendations: (max 20,000 characters)

Prepared By: Date:

Reviewed By: Date:

CC: (max 250 characters)

Updated By: **Travis McLane**

Created: **3/28/2016**

Updated: **3/28/2016**

Current interview only

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The subsequent fields on this screen must be entered by the user. Required fields are indicated in **red** on the screen. Spell check buttons allow the  user to spell check each narrative field.

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1. **Family/Other Household Members** - Use the fields to add First Name, Last Name, DOB, and Relationship to enter information about each person living in the client's household. This section will pre-populate data from other screens, but may be edited. Click "Add" to the right of the relationship field to add a new household member. IF the user leaves the screen without clicking "Add," the information in those fields will not be saved. Check the delete box to delete a household member. The household member will be deleted when the user clicks "update" before leaving the screen. User may add as many household members as appropriate. This section may pre-populate from previously entered data from other screens.
2. **History of Presenting Problems** - A maximum of 20,000 characters allows the user to describe the purpose of the staffing meeting in a narrative format.
3. **Family History** - Allows the user to describe the family history in a narrative format. If a Specialized Interview/Social Assessment Report has been completed and the Summary Interview field is completed, this section will auto-populate. (*No maximum character limit*)
4. **Family Functioning** - A maximum of 20,000 characters allows the user to describe the family functioning in a narrative format.
5. **Overall Risk Assessment** - A maximum of 20,000 characters allows the user to describe the client's overall risk in their household in a narrative format.
6. **Impressions** - A maximum of 20,000 characters allows the user to describe the overall impressions of the interviewer in a narrative format.
7. **Recommendations** - A maximum of 20,000 characters allows the user to describe the interviewer's recommendations in a narrative format.

8.6 Creating New Nursing Assessments

From the Assessment activity screen discussed in subsection 8.1, users may select "Nursing Assessment" from the drop down menu and click "New Assessment Report." This will lead to the screen shown in figure 8-6. The purpose of this report is to document the client's nursing assessment. This assessment is longer and has more sections than the other assessment reports. This sub-section will show each screen within the nursing assessment separately.

Figure 8-6 Nursing Assessments



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CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

111223542 New

Other CPT Training New

Provider New

Reports New

Help Center

- System Guide
- Code Maintenance
- Help Maintenance
- User Options
- Sexual Abuse Treatment Program
- Logout

New Nursing Assessment Number: 1

Nursing Assessment Report

Abuse Report Number: 2011-032444	Registration Seq #: 1	Assessment Seq #: 5
Nursing Assessment Number: 1	CPT Office: 01AA	
Name: SMITH, SUE	DOB: 01-01-2010	Client ID: 111223542
Evaluation Date: 01-01-2010	Evaluation Location:	Provider Name: BUCEY, KIRSTEN
Referral Source:		

Alleged Maltreatment	Allegation Type
Bruises - Hand Print	1 - Abuse
Physical Injury - Other	1 - Abuse
Mental Injury - Inappropriate/Excessive Isolation (Facility)	2 - Neglect
Bruises - Other	1 - Abuse

Present During Examination

Delete Last Name	First Name	Relationship	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Medical History

Parent/Caregiver Not Present

Patient History per:

Primary Care Provider

Last Name First Name

Address 1

City State Zip

Acute Medical Condition: (max 5,000 characters)

Chronic Medical Condition: (max 5,000 characters)

Allergies

Delete Allergen	Reaction	
<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Clinical History

Delete Clinical History (last 12 months) # Occurrences Reason	
<input type="text" value="Hospitalization Services"/> <input type="text" value="0"/>	<input type="button" value="Add"/>

Immunizations

Delete Vaccine	Reason	
<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Current Medication

Delete Name	Dose	Route	Frequency	Reason	Time Frame Administered By	
<input type="text"/>	<input type="text" value="Child"/>	<input type="button" value="Add"/>				

Treatment/Therapy

Delete Name	Frequency	Reason	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Equipment

Delete Equipment	Frequency	Reason	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Add"/>

Updated By: Created: Updated:

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Figure 8-8 Nursing Assessments Pre-Populated Fields

New Nursing Assessment Number: 1					
Nursing Assessment Report					
Abuse Report Number:	2011-032444	Registration Seq #:	1	Assessment Seq #:	5
Nursing Assessment Number:	1	CPT Office:	01AA		
Name:	SMITH, SUE	DOB:	01-01-2010	Client ID:	111223542
Evaluation Date:	01-01-2010	Evaluation Location:		Provider Name:	BUCEY, KIRSTEN
Referral Source:					
Alleged Maltreatment		Allegation Type			
Bruises - Hand Print		1 - Abuse			
Physical Injury - Other		1 - Abuse			
Mental Injury - Inappropriate/Excessive Isolation (Facility)		2 - Neglect			
Bruises - Other		1 - Abuse			

Nursing Assessment Pre-populated Fields

As with the other Assessment Reports, the first section of the Nursing Assessment screen is pre-populated by CPTIS.

- 1. Abuse Report Number** - The system links the specialized interview to the abuse report number associated with the case. The number on this screen links back to the associated registration.
- 2. Registration Sequence #** - The system identifies each registration related to the case with a sequence number, which displays in this field.
- 3. Assessment Sequence #** - The system identifies each assessment related to the case with a sequence number, which displays in this field.
- 4. Nursing Assessment Number** - CPTIS identifies each nursing assessment related to the case with a sequence number, which displays in this field.
- 5. CPT Office** - The client's home office pre-populates in this field.
- 6. Name** - Client's last,first name.
- 7. DOB** - Client's DOB.
- 8. Client ID** - Client ID associated with the Registration and Assessment activity.
- 9. Evaluation Date** - Date the assessment took place.
- 10. Evaluation Location** - Where the assessment took place.
- 11. Provider Name** - The name of the provider conducting the assessment, which is pulled using the user log-in.
- 12. Referral Source** - This field indicates how the client was referred to CPT. Auto-populates from Registration.
- 13. Alleged Maltreatment/Allegation Type** - This section pre-populates from the Intake, and subsequently, the Registration screens.

Important Note: Once a user creates a new Nursing Assessment, these fields are auto-populated by CPTIS using the existing information. If this information is subsequently changed, enhanced or updated, the report fields which have been auto-populated will not be updated for existing reports. Users must add new family members and other new information to reports separately.

The following sections of the Nursing Assessment must be entered by the user.

14. Present During Examination - Use the fields First Name, Last Name, and Relationship to enter information about each person present during the nursing exam. The Relationship field offers a drop down box of options to select from. Click “Add” to the right of the relationship field to add a new person. IF the user leaves the screen without clicking “Add,” the information in those fields will not be saved. Check the delete box to delete a person. The person will be deleted when the user clicks “update” before leaving the screen. User may add as many persons present during the examination as appropriate.

Figure 8-9 Nursing Assessment - Present During Examination

The screenshot displays the 'Present During Examination' form. At the top, there are tabs for 'Medical History', 'Social/Family History', 'ADL/Nutrition', and 'Physical Examination'. Below the tabs, there is a table with the following columns: 'Delete', 'Last Name', 'First Name', and 'Relationship'. The first row contains the text 'Test' in both the 'Last Name' and 'First Name' fields, and a dropdown menu in the 'Relationship' field. The dropdown menu is open, showing a list of relationship options: '--', 'Aunt', 'Case Coordinator', 'DCF' (highlighted), 'Family Foster', 'Father', 'Grandfather', 'Grandmother', 'Guardian', 'Mother', 'Other', 'Other Relative', 'Sibling', 'Stepfather', 'Stepmother', 'Uncle', and 'Unknown'. To the right of the 'Relationship' dropdown is an 'Add' button. Below the table, there are several form fields: 'Parent/Caregiver Not Present' with a checkbox, 'Patient History per:' with a text input field, 'Primary Care Provider' section with 'Last Name' (containing 'Unknown'), 'First Name', 'Address 1', 'City', and 'State' fields, and an 'Acute Medical Condition: (max 5,000 characters)' field with a counter '0'.

The remainder of the Nursing Assessment is comprised of four screens. These screens are denoted by tabs: Medical History, Social/Family History, ADL/Nutrition, and Physical Examination. To access each section, users should click the related tab.

Figure 8-10 Nursing Assessment - Documenting Nursing Information



Nursing Assessment - Medical History

Figure 8-11 demonstrates the Medical History portion of the Nursing Assessment. This section of the assessment has two comment boxes in which the medical provider may describe the client's condition. There are also six subsections which contain drop down boxes with matching fields where users can document other types of information.

Figure 8-11 Nursing Assessment - Medical History

Users fill in the following fields to complete the Medical History portion of the Nursing Assessment:

- 15. Parent/Caregiver Not Present** - Check this box if the patient's caregiver or parent is not present during the interview and physical exam.
- 16. Patient History per** - Document who provided the information of the patient's medical history.
- 17. Primary Care Provider** - Use the fields provided to document the Last Name, First Name, Address, City, State, and Zip Code of the patient's primary care provider.
- 18. Acute Medical Condition** - A maximum of 5,000 characters allows the user to provide a narrative summary of the patient's acute medical conditions.
- 19. Chronic Medical Condition** - A maximum of 5,000 characters allows the user to provide a narrative summary of the patient's chronic medical conditions.
- 20. Allergies** - To activate the fields documenting allergies, users must select the correct answer in the drop down box next to allergies. Selecting NKA, or No Known Allergies, leaves these fields in gray. The user will not be able to enter any allergies or reactions as the selection "No Known Allergies" has already been made. Selecting "Unknown" also causes the related fields to remain in gray. Only selecting "Yes" from this drop down menu will allow the user to fill in allergies and their reactions. Users must click "Add" to save the information in these fields before clicking "Update" to save the entire assessment. Once an allergy has been added, users can check the "Delete" box to delete an allergy.

Figure 8-12 Medical Assessment - Allergies

Delete All	Allergies	Reaction
<input type="checkbox"/>	NKA	
<input type="checkbox"/>	Yes	
<input type="checkbox"/>	Unknown	

Add

- **Allergen** - Document the allergen.
 - **Reaction** - Document the patient's reaction to the allergen.
- 21. Clinical History** - To activate the fields documenting the client's clinical history, users must select "Yes" from the corresponding drop down menu. Once "Yes" is selected, user can document clinical history occurring within the previous 12 month period.
 - **Clinical History (last 12 months)** - This field has a drop down menu. Users should select an option from the drop down menu shown in figure 8.6.6.
 - **# Occurrences** - Use the arrows to select a number of occurrences.
 - **Reason** - This field documents the reason for the clinical occurrence.

Figure 8-13 Clinical History

The screenshot shows the 'Clinical History' section of a form. At the top, there is a dropdown menu set to 'Yes'. Below it is a table with columns: 'Delete Clinical History (last 12 months)', '# Occurrences', and 'Reason'. The first row has a dropdown menu for 'Hospitalization Services', a spinner box with '0', and an empty 'Reason' field. A dropdown menu is open over the 'Hospitalization Services' dropdown, listing options: 'Hospitalization Services', 'Outpatient Services', 'Diagnostic Procedures', 'None', and 'Unknown'. An 'Add' button is visible to the right of the first row.

Once the user completes the fields and clicks “Add,” the history is documented as shown below.

Figure 8-14 Clinical History Added

The screenshot shows the 'Clinical History' section after an entry has been added. The 'Delete Clinical History (last 12 months)' checkbox is now checked. The first row in the table shows 'Hospitalization Services' in the dropdown, '2' in the '# Occurrences' column, and '2 hospitalizations for severe asthma attacks' in the 'Reason' column. A second row is visible below with 'Hospitalization Services' in the dropdown and '0' in the '# Occurrences' column. An 'Add' button is to the right of the second row.

All of the subsections on the Medical History screen operate in the same fashion. Their fields are described below.

22. Immunizations - Select “Current” or “Not Current” from the drop down menu. Selecting “Not Current” allows users to document the vaccine and the reason, if known, it is not current.

- **Vaccine** - Select a vaccine from the drop down menu.
- **Reason** - Document reasoning, if known, why it is not current.

Figure 8-15 Vaccinations

The screenshot shows the 'Immunizations' section of a form. At the top, there is a dropdown menu set to 'Not Current'. Below it is a table with columns: 'Delete Vaccine', 'Reason', 'Dose', 'Route', 'Frequency', and 'Reason'. The first row has a dropdown menu for 'Vaccine' with a list of options: 'DTAP', 'Hepatitis A', 'Hepatitis B', 'Hib', 'Meningococcal', 'MMR', 'Pneumococcal', 'Polio', and 'Varicella'. An 'Add' button is to the right of the first row. Below the table, there are fields for 'Dose', 'Route', 'Frequency', and 'Reason'.

23. Current Medication - Document medication the patient is currently taking.

- **Name** - Medication Name.

- **Dose** - Medication Dose.
- **Route** - Select the means by which the medication is administered from drop down menu.
- **Frequency** - Select from drop down menu.
- **Reason** - Reason the patient is taking the medication.
- **Time Frame** - When the patient takes the medication.
- **Administered By** - Select who administers the medication from the drop down menu shown below.

Figure 8-16 Current Medication Menu

Delete Name	Dose	Route	Frequency	Reason	Time Frame	Administered By	
		--	--			Child	Add

Treatment/Therapy: No

24. Treatment/Therapy - Selecting “Yes” from the drop down menu activates these fields.

- **Name** - Name of the treatment.
- **Frequency** - Frequency of treatment from drop down menu.
- **Reason** - Reason for treatment.

25. Equipment - Selecting “Yes” from the drop down menu activates these fields.

- **Name** - Name of the equipment.
- **Frequency** - Frequency of equipment use from drop down menu.
- **Reason** - Reason for equipment use.

Nursing Assessment - Social/Family History

Figure 8-17 demonstrates the Social/Family History portion of the Nursing Assessment. This section of the assessment allows users to document the social history in one section and the family history just below in a subsequent subsection of the screen.

Figure 8-17 Nursing Assessment - Social/Family History

The screenshot shows the 'Social/Family History' tab selected. The 'Social History' section includes the following fields:

- Child Lives With: [Father] (dropdown menu open)
- Events Affecting child and family: [Concerns] (dropdown menu)
- Behavioral and Emotional Issues: [None] (dropdown menu)
- Caring for child (Include day care and caregivers): [None] (dropdown menu)
- Family Strengths, priorities and concerns: [None] (dropdown menu)
- Family Support System: [None] (dropdown menu)
- Family Employment/Financial Information: [None] (dropdown menu)
- Home Environment: [None] (dropdown menu)
- Transportation Information: [None] (dropdown menu)
- School and Learning Activities: [None] (dropdown menu)
- Cultural, Ethnic and Spiritual Factors: [None] (dropdown menu)
- Substance Abuse Information: [None] (dropdown menu)
- Community Services, Resources and Referrals (current): [None] (dropdown menu)

The 'Family History' section at the bottom features a table with the following structure:

Delete Health Type	Family Member	Description	
--	--		Add

User's document the patient's Social and Family History by entering data in the following fields. Each field in the Social History section, except "Child Lives With," provides a drop down menu with the options None, Unknown, and Concerns. The field next to the drop down menu will allow the user to fill in narrative information no matter which selection is made from the drop down menu. These fields default to "none" if nothing is selected.

Social History

- 1. Child Lives With** - Select an option from the drop down menu shown above in figure 8.6.10.
- 2. Events Affecting child and family** - Select from the drop down menu and fill in the related field.
- 3. Behavioral and Emotional Issues** - Select from the drop down menu and fill in the related field.
- 4. Caring for child (Include daycare and caregivers)** - Select from the drop down menu and fill in the related field.
- 5. Family Strengths, priorities and concerns** - Select from the drop down menu and fill in the related field.
- 6. Family Support System** - Select from the drop down menu and fill in the related field.
- 7. Family Employment/Financial Information** - Select from the drop down menu and fill in the related field.
- 8. Home Environment** - Select an option from the drop down menu and fill in the related field.

9. **Transportation Information** - Select from the drop down menu and fill in the related field.
10. **School and Learning Activities** - Select from the drop down menu and fill in the related field.
11. **Cultural, Ethnic and Spiritual Factors** - Select from the drop down menu and fill in the related field.
12. **Substance Abuse Information** - Select from the drop down menu and fill in the related field.
13. **Community Services, Resources and Referrals (current)** - Select from the drop down menu and fill in the related field.

Figure 8-18 Family History

Family History			
Delete	Health Type	Family Member	Description
<input type="checkbox"/>	--	--	
<input type="checkbox"/>	Other		
<input type="checkbox"/>	Substance/Alcohol/Drug Abuse		
<input type="checkbox"/>	Tobacco		

Family History

Use the fields Health Type, Family Member, and Description to enter information about each of the client’s family members. The Health Type and Family Member fields offer a drop down box of options to select from. Click “Add” to the right of the Description field to add a new person. IF the user leaves the screen without clicking “Add,” the information in those fields will not be saved. Check the delete box to delete a person. The person will be deleted when the user clicks “update” before leaving the screen. User may add as many health types/family members as appropriate.

Once the user adds a health type/family member to the family history, the screen will update as shown below:

Figure 8-19 Family History Added

Family History			
Delete	Health Type	Family Member	Description
<input type="checkbox"/>	Tobacco	Sibling	Older brother smokes 1 pack/day
<input type="checkbox"/>	Substance/Alcohol/Drug Abuse	Father	Father reportedly a heavy drinker-one six pack of beer/day
<input type="checkbox"/>	--	--	

Nursing Assessment - ADL/Nutrition

Figure 8-18 demonstrates the Activities of Daily Living (ADL)/Nutrition portion of the Nursing Assessment. The ADL section of the assessment allows users to document the patient's Status for each ADL and make a comment. The nutrition section allows the user to answer three questions and make comments.

Figure 8-20 Nursing Assessment - ADL/Nutrition

Activities of Daily Living	
Status	Comments
Feeding: WNL	
Bathing: Unknown	
Toileting: Concerns	
Dressing: WNL	
Mobility: WNL	
Play: WNL	
Sleep Habits: WNL	
Communication: WNL	
Cognitive: WNL	
Social/Emotional: WNL	
Developmental Status: WNL	

Nutrition	
	Comments
Does your child tend to choke on foods or liquids? No	
Is your child a picky eater? No	
Is your child on a special diet or formula? No	

Activities of Daily Living

Each Status field by the identified ADL's has a drop down menu where users may select from the following options:

- 1. Unknown** - Users should select this option when there is insufficient information to assess the ADL.
- 2. WNL** - This option should be selected when the patient's ADL's are Within Normal Limits (WNL). The "status" field defaults to WNL.
- 3. Concerns** - This option indicates that there are concerns regarding this ADL for the patient being assessed.

Nutrition

Each question in this section has a drop down menu with the following options:

1. **Unknown** - Users should select this option when there is insufficient information to assess the answer to the question.
2. **No** - The answer to the question is “No.”
3. **Yes** - The answer to the question is “Yes.”
4. **WNL** - This option should be selected when the patient’s behavior with regard to the given question is Within Normal Limits (WNL).

Comment boxes are provided beside each ADL and each question, allowing the user to provide additional information.

Physical Examination

Figure 8-21 demonstrates the Physical Examination section of the Nursing Assessment.

Figure 8-21 Nursing Assessment - Physical Examination



CHILD PROTECTION TEAM INFORMATION SYSTEM

New Nursing Assessment Number: 1

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

111223542 New

Other CPT Training New

Provider New

Reports New

Help Center

- System Guide
- Code Maintenance
- Help Maintenance
- User Options
- Sexual Abuse Treatment Program
- Logout

Nursing Assessment Report

Abuse Report Number: 2011-032444 Registration Seq #: 1 Assessment Seq #: 5

Nursing Assessment Number: 1 CPT Office: 01AA

Name: SMITH, SUE DOB: 01-01-2010 Client ID: 111223542

Evaluation Date: 01-01-2010 Evaluation Location: Provider Name: BUCEY, KIRSTEN

Referral Source:

Alleged Maltreatment	Allegation Type
Bruises - Hand Print	1 - Abuse
Physical Injury - Other	1 - Abuse
Mental Injury - Inappropriate/Excessive Isolation (Facility)	2 - Neglect
Bruises - Other	1 - Abuse

Present During Examination

Delete	Last Name	First Name	Relationship	
<input type="checkbox"/>			--	<input type="button" value="Add"/>

Medical History Social/Family History ADL/Nutrition **Physical Examination**

Height: Weight: HC: BMI: Charts:

Observations (Diagrams)

Comments

General Appearance:

Physical Abuse:

Bruises:

Cuts/Punctures:

Burns:

Fracture:

Other:

Sexual Abuse (Check all that apply)

Penile/Vaginal Oral/Vaginal Forced Masturbation
 Penile/Anal Oral/Anal Alleged Perp/CV
 Digital/Vaginal Object/Vaginal Fellatio
 Digital/Anal Object/Anal Exposure to Porn
 Forced Participation/Porn

Sexually Transmitted Disease:

Other Sexual:

Systems

System	Status	Comments
Eye/Vision	WNL	<input type="text"/>
Ear/Hearing	WNL	<input type="text"/>
Nose/Throat	WNL	<input type="text"/>
Oral/Dental	WNL	<input type="text"/>
Respiratory	WNL	<input type="text"/>
Cardiovascular	WNL	<input type="text"/>
Gastrointestinal	WNL	<input type="text"/>
Genitourinary	WNL	<input type="text"/>
Endocrine	WNL	<input type="text"/>
Dermatologic	WNL	<input type="text"/>
Musculoskeletal	WNL	<input type="text"/>
Hematologic	WNL	<input type="text"/>
Neurological	WNL	<input type="text"/>
Development	WNL	<input type="text"/>

Photos: No telemed digital

Diagrams: No HC Growth Charts

FDLE Kit: Yes

Crimes victims Info, Sexual assault general and resource info given: Yes

Risk Factors (Check all that apply)

Child Under 2 Special Needs/Medically Complex Child
 Caregiver Arrest HX Child States Fear of Caregiver
 Prior DCF Reports HX of Violence Reported for Caregiver
 Severity of Incident Parent with HX of Abuse as Child
 Prior CPT Referrals Child too Young to Give History of Injury
 Isolation of Family/Isolation

Diagnosis

Nursing Diagnosis:

Referrals

Medical Provider: Yes Name:

Early Steps: Yes Name:

Other: Yes Name:

Provider Signature: Date:

Updated By: Created: Updated:

CPT Version (1.1.1.3) Florida Department of Health - CMS

Patient Data

The Physical Examination tab begins with the following fields:

1. **Height** - Patient's height.
2. **Weight** - Patient's weight.
3. **HC** - Patient's heart rate.
4. **BMI** - Patient's Body Mass Index (BMI).
5. **Charts** - A drop down menu is provided to indicate which type of chart was used in identifying client data.

8-22 Physical Examination

The screenshot shows the 'Physical Examination' tab selected. It contains four input fields: 'Height', 'Weight', 'HC', and 'BMI'. To the right of these fields is a 'Charts' dropdown menu with a downward arrow. The dropdown is open, showing 'Boys' and 'Girls' as options. Below the input fields, there is a horizontal line. Underneath this line, the text 'Observations (Diagrams)' is visible, with 'Comments' written below it.

Observations

Clicking the word "Diagrams" next to the word "Observations" will access a chart which can be printed for the user to document observations. This file is a .pdf and is not manipulate-able within the program. It must be printed, written on, and uploaded to CPTIS. The observation section allows users to document observations within the following parameters:

6. **General Appearance**
7. **Physical Abuse**
8. **Bruises**
9. **Cuts/Punctures**
10. **Burns**
11. **Fracture**
12. **Other**

Use the comment boxes next to each parameter to document observable facts related to the patient's condition.

8-23 Observations

Observations (Diagrams)	
	Comments
General Appearance	<input type="text"/>
Physical Abuse	<input type="text"/>
Bruises	<input type="text"/>
Cuts/Punctures	<input type="text"/>
Burns	<input type="text"/>
Fracture	<input type="text"/>
Other	<input type="text"/>

Sexual Abuse

A checklist is provided allowing users to check off each parameter which applies to the patient's history of sexual abuse. Two comment fields are provided. One field to document any "Sexually Transmitted Diseases" and another field, "Other Sexual," documents any other data of a sexual nature. Figure 8-24 below demonstrates this section of the nursing assessment.

Figure 8-24 Sexual Abuse

Sexual Abuse (Check all that apply)		
<input type="checkbox"/> Penile/Vaginal	<input type="checkbox"/> Oral/Vaginal	<input type="checkbox"/> Forced Masturbation
<input type="checkbox"/> Penile/Anal	<input type="checkbox"/> Oral/Anal	<input type="checkbox"/> Alleged Perp/CV
<input type="checkbox"/> Digital/Vaginal	<input type="checkbox"/> Object/Vaginal	<input type="checkbox"/> Fellatio
<input type="checkbox"/> Digital/Anal	<input type="checkbox"/> Object/Anal	<input type="checkbox"/> Exposure to Porn
<input type="checkbox"/> Forced Participation/Porn		
Sexually Transmitted Disease	<input type="text"/>	
Other Sexual	<input type="text"/>	

Systems

This section allows users to document the condition of the patient's biological systems within the following parameters:

- 13. Eye/Vision
- 14. Ear/Hearing
- 15. Nose/Throat
- 16. Oral/Dental
- 17. Respiratory
- 18. Cardiovascular
- 19. Gastrointestinal
- 20. Genitourinary

- 21. Endocrine
- 22. Dermatologic
- 23. Musculoskeletal
- 24. Hematologic
- 25. Neurological
- 26. Development

The “Status” field next to each parameter has the same drop down menu (Unknown, WNL, Concerns) as shown below. Users select a status and fill in the comment box relating to that parameter, documenting the condition of each system.

Figure 8-25 Systems

System	Status	Comments
Eye/Vision	WNL	
Ear/Hearing	Unknown	
Nose/Throat	WNL	
Oral/Dental	WNL	
Respiratory	WNL	
Cardiovascular	WNL	
Gastrointestinal	WNL	
Genitourinary	WNL	
Endocrine	WNL	
Dermatologic	WNL	
Musuloskeletal	WNL	
Hematologic	WNL	
Neurological	WNL	
Development	WNL	

Photos: telemed digital
 Diagrams: HC Growth Charts
 FDLE Kit: Yes
 Crimes victims Info, Sexual assault general and resource info given Yes

Users can also document the types of related information provided in the patient's file.

- 27. **Photos** - Select “yes” or “no” and check the type of photo.
- 28. **Diagrams** - Select “yes” or “no” and check the type of chart/diagram.
- 29. **FDLE Kit** - Check “Yes” if a FDLE kit was used.
- 30. **Crimes victims Info, Sexual assault general and resource info given** - Check “Yes” if the patient and/or their caregiver were given this information.

Risk Factors

A checklist is provided, which allows users to indicate which items apply to the patient being assessed. The checklist includes the following items:

- 31. Child under 2** - Patient being assessed is under the age of 2.
- 32. Caregiver Arrest Hx** - Patient’s primary caregiver has an arrest history.
- 33. Prior DCF Reports** - Patient has been the subject of prior reports to the Department of Children and Families.
- 34. Severity of Incident** – Incident is severe.
- 35. Prior CPT Referrals** - Patient has been the subject of prior CPT referrals.
- 36. Isolation of Family/Isolation** - Patient is isolated or their family is isolated.
- 37. Special Needs/Medically Complex Child** - Patient is medically complex or has special needs.
- 38. Child States Fear of Caregiver** - Patient has made statements, to the provider, indicating a fear of the primary caregiver.
- 39. Hx of Violence Reported for Caregiver** - Patient’s primary caregiver has a reported history of being violent toward any one.
- 40. Parent with Hx of Abuse as Child** - Patient’s parents have a history of being abused as a child.
- 41. Child too young to Give History of Injury** - Patient is too young to provide a statement explaining their injury.

8-26 Risk Factors

Risk Factors (Check all that apply)

<input type="checkbox"/> Child Under 2	<input type="checkbox"/> Special Needs/Medically Complex Child
<input type="checkbox"/> Caregiver Arrest HX	<input type="checkbox"/> Child States Fear of Caregiver
<input type="checkbox"/> Prior DCF Reports	<input type="checkbox"/> HX of Violence Reported for Caregiver
<input type="checkbox"/> Severity of Incident	<input type="checkbox"/> Parent with HX of Abuse as Child
<input type="checkbox"/> Prior CPT Referrals	<input type="checkbox"/> Child too Young to Give History of Injury
<input type="checkbox"/> Isolation of Family/Isolation	

Nursing Diagnosis

This field allows the user to select a nursing diagnosis from the drop down menu.

Figure 8-27 Nursing Diagnosis

Referrals

The final section of the Nursing Assessment-Physical Examination provides fields for referrals to other providers or programs. The user may select from the following:

- 42. Medical Provider** - Check “yes” if applicable and provide the name of the provider in the field to the right.
- 43. Early Steps** - Check “yes” if applicable and provide the name in the field to the right.
- 44. Other** - Check “yes” if applicable and provide the name in the field to the right.

Figure 8-28 Referrals

The provider signature allows the provider to type their name and add the date in a MM/DD/YYYY format. Users must click “update” to save the data entered in the nursing assessment. The assessment can be printed by clicking “print.” (See Section 13 on how to print reports.) Clicking “add” will take the user to a screen with a new nursing assessment form.

8.7 Creating New Specialized Interview/Social Assessments

From the Assessment activity screen discussed in subsection 8.1, users may select “SpecInt/SocAssess” from the drop down menu and click “New Assessment Report.” This will lead to the screen shown in figure 8-29 below. The purpose of this report is to document specialized interviews for the purpose of creating a social assessment report.

Figure 8-29 Specialized Interview/Social Assessments

The first four fields are auto-populated by CPTIS, pulling information from other screens.

1. **Name** - Client's last,first name.
2. **DOB** - Client's DOB.
3. **Interview Date** - Date of interview being documented.
4. **Interview Location** - Location of interview being documented.

The subsequent fields must be completed by the user.

5. **Person Interviewed** - Name of the person being interviewed.
6. **Date of Birth** - DOB of person being interviewed.
7. **Relationship** - Select the relationship of the person being interviewed to the client.
8. **Recording Method** - Select a recording method from the drop down menu.
9. **Summary of Interview** - A maximum of 40,000 characters allows the user to provide a narrative summary of the interview. A spell check button is provided for this field.

Users must click "update" to save the information entered into these fields. If the user leaves the screen without clicking "update," all the data entered will be lost.

Users may print this interview, all interviews for the related abuse report number, or all interviews for this abuse report number and client number by selecting an option from the drop down menu and clicking "print."



8.8 Accessing Existing Assessment Reports

The figure below demonstrates how to search for existing Assessment Reports. Users select Assessment Reports, enter a client ID, abuse report number, or a client name, and select the type of report from the drop down menu. The drop down menu, accessible beside the Assessment Reports button, offers six types of reports including:

- Specialized Interview
- Forensic Interview
- CPT Staffing
- Social Assessment
- Nursing Assessment; and
- Specialized Interview/Social Assessment

Figure 8-30 Accessing Existing Assessment Reports from the Main Menu

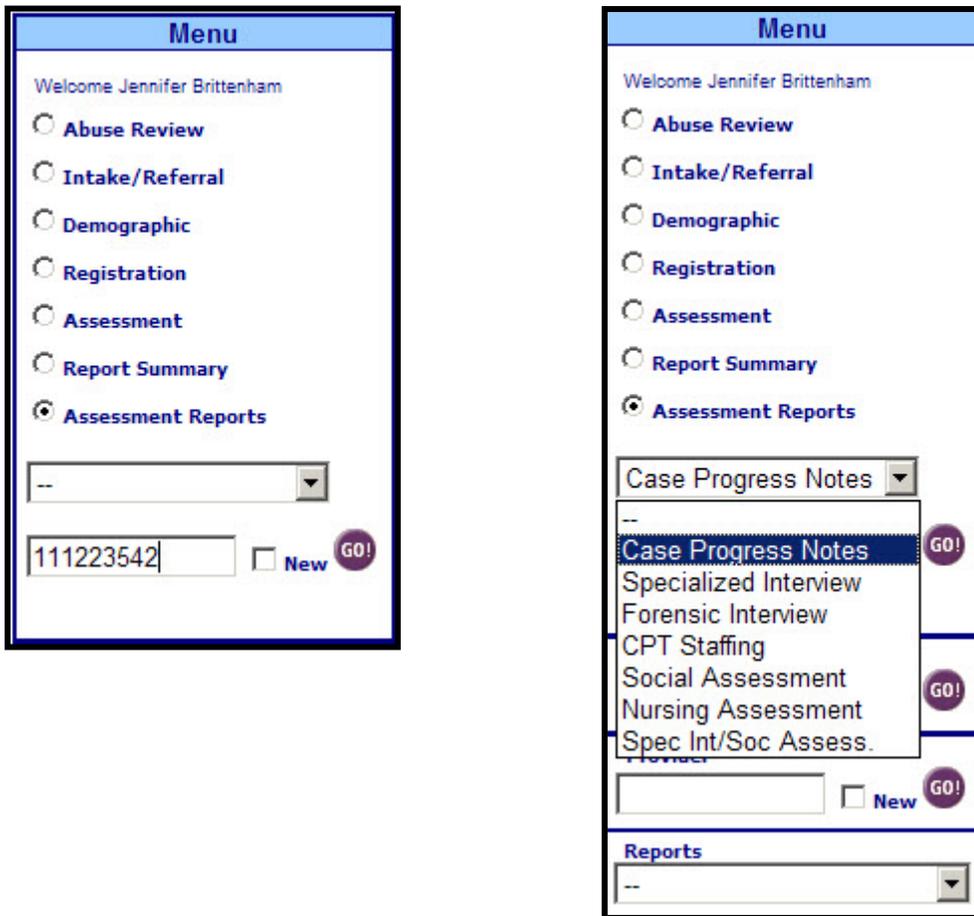


Figure 8-31 Searching for Existing Assessment

Reports

Abuse Report #	Case Note #	Reg Seq. #	Client ID	Client	DOB	Activity Date	Activity
2011-032444		1	111223542	SMITH, SUE	01-01-2010		
2011-032444	1	1	111223542	SMITH, SUE	01-01-2010	8-23-2011	Phone Call From
2011-032444	2	1	111223542	SMITH, SUE	01-01-2010	8-23-2011	Supervisor Review

8.9 Updating Existing Assessment Reports

To update any Assessment Report, users should select “Assessment Reports” on the main menu and the type of report from the drop down menu, entering the client ID or abuse report number, and click “Go.” This will lead to a search result screen listing each report relating to the case. Clicking the report sequence number will lead the user to the report selected.

The example shown in figure 8-29 demonstrates a search for existing Case Progress Notes; however, any type of Assessment Report could be selected.

The user can update available fields with new information and click the “Sign” button next to the “Prepared By” field. To save all new information users must click the “Update” button when complete. CPTIS will save this information and indicate the date in the auto-populated “Updated” field at the bottom of the screen.



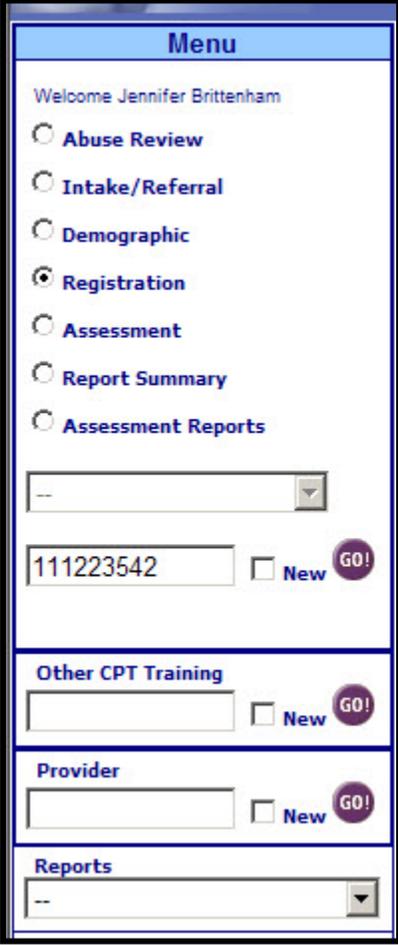
SECTION 9: CASE PROGRESS NOTES

9.1 New Case Progress Note

There are two ways for users to access a new Case Progress Note.

1. Users may create a new Case Progress Note by pulling up an existing note and clicking “New Note.”
2. To create the first Case Progress Note for a client ID or abuse report #, users must first create a Registration for the case. Using the main menu, users should click “Registration,” enter a client ID or abuse report number, and click “Go.”

Figure 9-1 Using Registration Screen to Create New Case Progress Note



The screenshot shows a mobile application interface titled "Menu". At the top, it says "Welcome Jennifer Brittenham". Below this is a list of menu items, each with a radio button: "Abuse Review", "Intake/Referral", "Demographic", "Registration" (which is selected), "Assessment", "Report Summary", and "Assessment Reports". Below the menu items is a dropdown menu showing "--". Underneath is a text input field containing "111223542", followed by a "New" checkbox and a "GO!" button. Below this is another section titled "Other CPT Training" with a text input field, a "New" checkbox, and a "GO!" button. The next section is titled "Provider" with a text input field, a "New" checkbox, and a "GO!" button. The final section is titled "Reports" with a dropdown menu showing "--".

This action will bring the user to the Registration screen shown below.

Figure 9-2 Registration Screen To Access New Case Progress Note



CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

111223542 New 

Other CPT Training New 

Provider New 

Reports

Help Center

System Guide

Code Maintenance

Help Maintenance

User Options

Sexual Abuse Treatment Program

Logout

REGISTRATION # 1

Client ID: **111223542** Name: **SMITH, SUE**
 Address: **123 Any St.** City: **Melbourne** State: **Florida** ZIP: **32301**
 DOB: **1/1/2010** Race: **White** Sex: **Female**

Abuse Report Number: **2011-032444** Referral Date: **08/23/2011** CPI/CBC Name:

CPT Office: **07BA** Case Coordinator: **1652-ANDERSON-RATLIF, SHIANN-CC** Cross Team
 2nd CPT Office: **--** 2nd Case Coordinator: **--** Switch Team
 Child's County: **Brevard** FL Shot Report

Referral Source: **Protective Investigator** 2nd Referral Source: **--** Early Steps Currently Enrolled:
 Early Steps Screened: Early Steps Meets Referral Criteria: Early Steps Referred:

FAMILY INFORMATION

Delete Demographic Relationship

123121234 | Smith, Sue **Father**

 --

ALLEGED MALTREATMENT

Delete Alleged Maltreatment Type

Bruises - Other **1 - Abuse**

 --

ASSESSED MALTREATMENT

Delete Assessed Maltreatment

Burns - Cigarette

 --

Assessments:  New
Case Progress Notes:  New

Overall CPT Assessment: **1 - Abuse Indicated** Termination Date:

Date ICS Sent/Notification: **04/02/2012**

Date FCS sent to PI:

29 Comments: (max 500 characters)
 Test updating record message.

Delete Linked Abuse Report (Alternate)

Other Registrations of Abuse Report Number: 2011-032444

Abuse Report	Reg Seq #	Client ID	Referral Date	Termination Date
2011-032444	1	123121234	8-23-2011	

Updated by: **Kemper, Lauren** Created: 8/23/2011 Updated: 4/13/2012

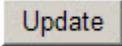
Figure 9-3 New Case Progress Note

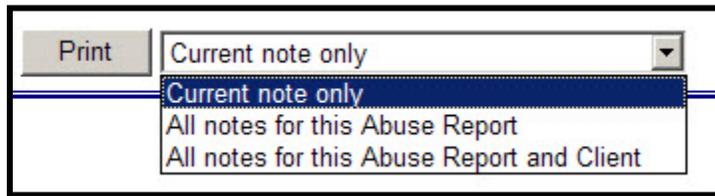
The following fields of information are displayed on the Case Progress Note. Fields 1-11 are auto-populated by CPTIS. The rest of the fields must be filled in by the user and *“update” must be clicked before the user moves on to another page.* If the user moves off the screen without clicking “update,” the new information will be lost.

1. **Case Progress Number** – This field will automatically display the sequence number of the case progress note.
2. **Abuse Report Number** – Displays the associated abuse report number.
3. **Child’s County** - County where the client resides.
4. **Referral Date** - Date client was referred to the program.
5. **Referral Source** - Type of referral.
6. **CPI Name** – Identifies the name of the Child Protective Investigator assigned to the case if one exists.
7. **Name** - Client name.
8. **DOB** - Client DOB.



9. **Client ID** – Client ID associated with the case note.
10. **Registration Sequence Number** - CPTIS automatically assigns the associated registration a sequence number and it displays in this field.
11. **Case Progress Number** - CPTIS automatically assigns the associated registration a case progress number and it displays in this field.
12. **Date of Activity** - Enter the date the activity took place.
13. **Time of Activity** - Enter the start time of the activity.
14. **Data Entry Date** - Enter the date the user created the case progress note.
15. **Case Activity** - Select the type of activity from the drop down menu show in Figure 9-4
 - **Phone Call From** - Documents a call from someone associated with the case.
 - **Phone Call To** - Documents a call to someone associated with the case.
 - **Face to Face** - Documents a meeting that occurred in person.
 - **Assessment Activity** - Documents an assessment by a provider.
 - **Report Received** - Documents the receipt of a report by email or written correspondence.
 - **Report Sent** - Documents when a provider sends a report by email or written correspondence.
 - **Fax** - Documents receipt of a fax or when a provider sends a fax.
 - **Email** - Allows the user to copy and paste an email into the Case Activity Summary section.
 - **Supervisor Review** - Documents a supervisor’s review of case progress notes for approval or feedback. Signature field available for CPTMAN and ADMIN users.
16. **Provider Name** - Depending on the type of Case Activity, a drop down list of providers will be available in this field.
17. **Linked Registrations** - Checking the box in this field links this case progress note to other registrations under the same client ID.
18. **Comments** - A maximum of 6000 characters allows the user to summarize the activity being documented in a narrative format.
19. **Completed by** - An electronic signature assigned by CPTIS depending on the user log in. Clicking “sign” auto-populates this field.
20. **Date** - Clicking “sign” auto-populates this field with the current date.
21. **Updated by** - CPTIS auto-populates this field with the name of the user logged into the system when the note was created.
22. **Created** - CPTIS auto-populates this field with the date the note was created.
23. **Updated** - CPTIS auto-populates this field with the date the note was last updated.

- Users may click the spell check button  to correct spelling and grammar in the fields on the case note progress screen before clicking “update.”
- Users must click “update” in order for CPTIS to save the new information entered. 
- Users may print the current case progress note, all notes for the associated abuse report number (includes multiple registration case notes) , or the associated client ID and abuse report number by selecting an option from the drop down menu and clicking “print” located at the bottom of screen.



9.2 Search for Existing Case Progress Notes

Figure 9-4 demonstrates a search result screen for existing Case Progress Notes. Selecting Case Progress Notes from the drop down menu and entering a client ID or abuse report #, then clicking “Go” will take the user to a search result screen as demonstrated below.

Figure 9-4 Case Note Search Result



Florida's health
The Florida Department Of Health

CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

Case Progress Notes

111223542 New

Other CPT Training New

Provider New

Reports

Case Progress Notes Results for Client 111223542

Abuse Report #	Case Note #	Reg Seq. #	Client ID	Client	DOB	Activity Date	Activity
2011-032444	1	1	111223542	SMITH, SUE	01-01-2010		
2011-032444	1	1	111223542	SMITH, SUE	01-01-2010	8-23-2011	Phone Call From
2011-032444	2	1	111223542	SMITH, SUE	01-01-2010	8-23-2011	Supervisor Review

To access an existing Case Progress Note report, click on the Case Note # shown in the second column from the right. This number links the user to the Case Progress Note. Other fields with links to subsequent screens include the following:

1. **Abuse Report #** - The Abuse Report # in the first column links the user to the associated Registration.
2. **Case Note #** - Links the user to the associated case note report.
3. **Registration Sequence #** - CPTIS assigns this number to each registration in order of creation.
4. **Client ID** - Links the user to client Demographic screen.

The other columns on this screen do not link to any other screen in the website.

1. **Client** - Contains the name of the client for whom the case notes are associated.
2. **DOB** - Client's date of birth.
3. **Activity Date** - Date on which the Case Progress Note was created.
4. **Activity** - Provides a note indicating what type of activity is described by the Case Progress Note.

Using this screen, users access existing Case Progress Notes to review or update them. The following figure shows an existing report, accessed by clicking the Case Note #.

Figure 9-5 Existing Case Progress Note

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary', and 'Assessment Reports'. The main area shows 'Update successful' and 'Case Progress Number: 2'. It contains fields for 'Date of Activity' (08/23/2011), 'Time of Activity' (08:00 pm), and 'Data Entry Date' (08/23/2011). The 'Case Activity' is set to 'Supervisor Review' and the 'Provider Name' is 'ANDERSON-RATLIFF, SHIANN'. Below this is a 'Linked Registrations' table:

Linked	Client ID	First Name	Last Name	DOB
<input type="checkbox"/>	123121234	Sue	Smith	01/01/2010

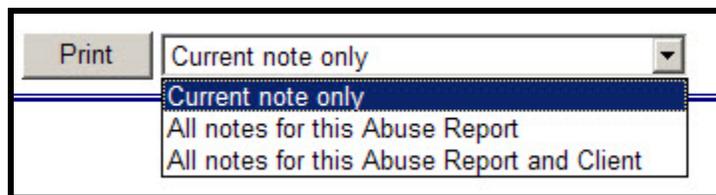
There is also a 'Comments' section with a text area containing 'Test for first entry.' and 'Testing update feature for user manual update 4/17/12.'. At the bottom, it shows 'completed by: Jennifer Brittenham' with a 'Sign' button and 'Date: 04/17/2012'. The footer includes 'Updated By: Alley, Chris', 'Created: 8/23/2011', 'Updated: 11/22/2011', and buttons for 'New Note', 'Update', 'Print', and a dropdown for 'Current note only'.

The following fields of information are displayed on the Case Progress Note. Fields 1-11 are auto-populated by CPTIS. The rest of the fields must be filled in by the user and *“update” must be clicked before the user moves on to another page.* If the user moves off the screen without clicking “update,” the new information will be lost.

1. **Case Progress Number** - This field will automatically display the sequence number of the case progress note.
2. **Abuse Report Number** - Displays the associated abuse report number.
3. **Child’s County** - County where the client resides.
4. **Referral Date** - Date client was referred to the program.
5. **Referral Source** - Type of referral.
6. **CPI Name** - Identifies the name of the Child Protective Investigator assigned to the case, if one has been documented on the registration.
7. **Name** - Client name.
8. **DOB** - Client DOB.
9. **Client ID** - Client ID associated with the case note.
10. **Registration Sequence Number** - CPTIS automatically assigns the associated registration a sequence number and it displays in this field.
11. **Case Progress Number** - CPTIS automatically assigns the associated registration a case progress number and it displays in this field.
12. **Date of Activity** - Enter the date the activity took place.
13. **Time of Activity** - Enter the start time of the activity.
14. **Data Entry Date** - Enter the date the user created the case progress note.
15. **Case Activity** - Select the type of activity from the drop down menu show in figure 9-6
 - **Phone Call From** - Documents a call from someone associated with the case.
 - **Phone Call To** - Documents a call to someone associated with the case.
 - **Face to Face** - Documents a meeting that occurred in person.
 - **Assessment Activity** - Documents an assessment by a provider.
 - **Report Received** - Documents the receipt of a report by email or written correspondence.
 - **Report Sent** - Documents when a provider sends a report by email or written correspondence.
 - **Fax** - Documents receipt of a fax or when a provider sends a fax.
 - **Email** - Allows the user to copy and paste an email into the Case Activity Summary section.



- **Supervisor Review** - Documents a supervisor’s review of case progress notes for approval or feedback. Signature field available for CPTMAN and ADMIN users.
16. **Provider Name** - Depending on the type of Case Activity, a drop down list of providers will be available in this field.
 17. **Linked Registrations** - Checking the box in this field links this case progress note to other registrations under the same client ID.
 18. **Comments** - A maximum of 6000 characters allows the user to summarize the activity being documented in a narrative format.
 19. **Completed by** - An electronic signature assigned by CPTIS depending on the user log in. Clicking “sign” auto-populates this field.
 20. **Date** - Clicking “sign” auto-populates this field with the current date.
 21. **Updated by** - CPTIS auto-populates this field with the name of the user logged into the system when the note was created.
 22. **Created** - CPTIS auto-populates this field with the date the note was created.
 23. **Updated** - CPTIS auto-populates this field with the date the note was last updated.
- Users may click the spell check button  to correct spelling and grammar in the fields on the case note progress screen before clicking “update.”
 - Users must click “update” in order for CPTIS to save the new information entered.
 - Users may print the current case progress note, all notes for the associated client ID, or the associated client ID and abuse report number by selecting an option from the drop down menu and clicking “print” located at the bottom of screen.



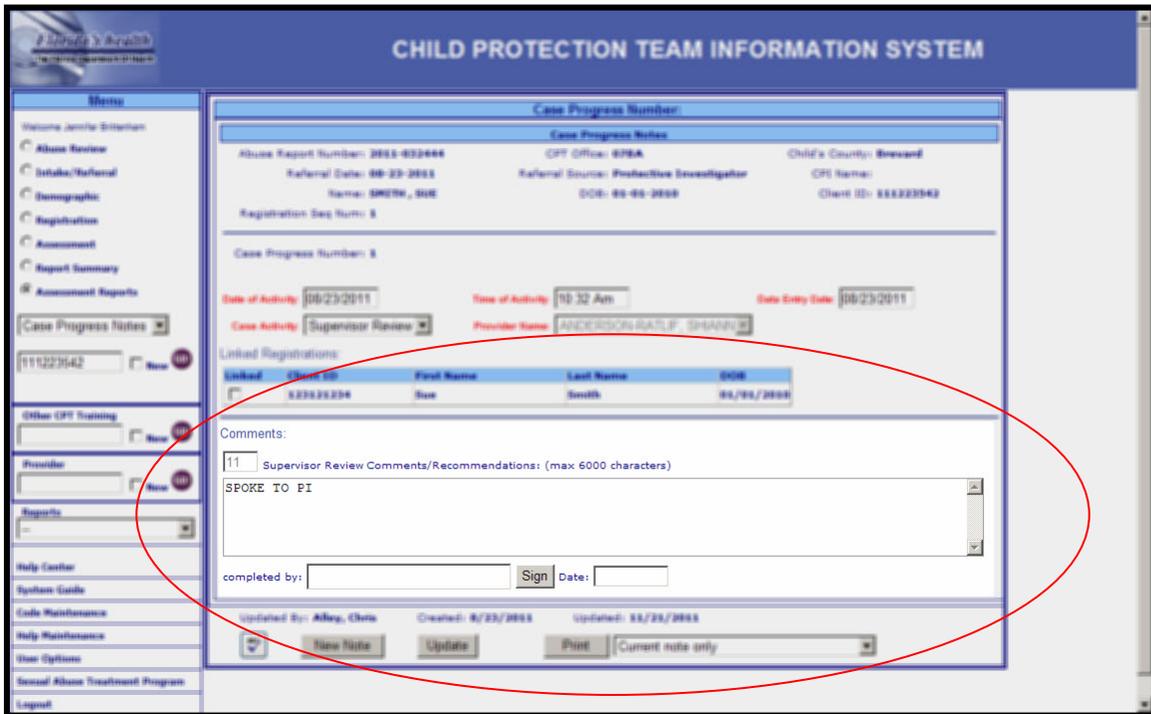
9.3 Supervisor Review of Case Progress Notes

When a supervisor or team coordinator logs into CPTIS and navigates to an existing case progress note, the system will allow them to select “supervisor review” from the drop down list in the case activity field. The title for narrative field then changes to “Supervisor Review Comments/Recommendations.” In a maximum of 6000 characters, this type of user can make a narrative reviewing the case progress note and leaving comments or recommendations. Figures 9-6 and 9-7 demonstrate these actions.

Figure 9-6 Case Activity Drop Down Menu



Figure 9-7 Supervisor Review Comment Box



After completing their review in the Comment Box, users with a log-in enabled with supervisor privileges can click the “Sign” button by the signature field, which will auto-populate with their electronic signature and the current date. *CPTIS will not save this action until the user clicks the “Update” button, which saves all new activity.* When the activity has been saved, CPTIS will show “Update successful” in the upper left hand corner of the Case Progress Note screen shown above.



SECTION 10: REPORT SUMMARY SCREEN

The Report Summary Screen captures information on the reason for referral, assessments provided, assessment of risk, and conclusions/recommendations in a case. The data fields are self-contained and specific to this CPTIS screen. Input to this screen is subsequent to the Assessment screen and is the introduction screen to data entry screens for each of the three reports; Interim Case Summary, Final Case Summary, and the Addendum Report. Users can access the Report Summary screen by searching on the main menu with the abuse report #, client ID or client name, or clicking the “Report Summary Screen” button on the Registration screen.

10.1 Report Summary Search Screen

Once a search is submitted by the user, search results are returned in the format noted in figure 10-1. Please note that if you enter the client ID, and click “New” and “Go,” the system will remind you to that you cannot create a new report summary from the main menu.

Figure 10-1 Report Summary Search Results

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like Abuse Review, Intake/Referral, Demographic, Registration, Assessment, Report Summary (selected), and Assessment Reports. Below the menu are search fields for 'Other CPT Training' and 'Provider', and a 'Reports' dropdown. The main area shows 'Report Summary Search Results for Client 2011-032444' with a table of results. At the bottom right, it says 'CPT Version (1.1.1.3) Florida Department of Health - CMS'.

Abuse Report #	Client ID	Reg.#	Last Name	First Name	Mid. Initial	DOB	CPT Office	County
2011-032444	111223542	1	SMITH	SUE		1-01-2010	07BA	Brevard
2011-032444	123121234	1	Smith	Sue		1-01-2010	01AA	Brevard

- 1. Abuse Report #** - A link to the report summary record for that client ID and registration number.
- 2. Client ID** - A link to the demographic record for that client ID.

3. **Registration #** - Ordinal automatically generated by CPTIS to distinguish registrations under a single client with same abuse report #.
4. **Last Name** - Client last name.
5. **First Name** - Client first name.
6. **Middle Initial** - Client middle initial.
7. **Date of Birth** - Client DOB.
8. **CPT Office Code** - CPT Office where registration was generated.
9. **County** - County of child's residence at the time the case was open.

10.2 Accessing the Report Summary Create/Update Screen

To create a report summary record for a registration it is necessary first to select the correct registration record. You may locate a registration by using the search ability on the main menu with the abuse report #, client ID or name. You can also locate a specific registration by going through the Abuse Report Search screen, or Demographic screen. Once you get the registration screen, a user will be able to select a Report Summary Screen button at the bottom of the screen.

Clicking on the button will bring you to the Report Summary screen that is related to the select registration record as shown in figure 10-2.

Figure 10-2 Report Summary Create/Update Screen

CHILD PROTECTION TEAM INFORMATION SYSTEM		
REPORT SUMMARY		
Abuse Report Number: 2011-032444	CPT Office: 07BA	Child's County: Brevard
Referral Date: 8/23/2011	Referral Source: Protective Investigator	CPI/CBC Name:
Name: SMITH, SUE	Date of Birth: 1/1/2010	Client ID: 111223542
Linked Abuse Report Numbers:		
<input type="button" value="Interim Case Summary"/>	<input type="button" value="Final Case Summary"/>	<input type="button" value="Addendum"/>

The first section of this screen will be automatically populated from the demographic record (client ID, last name, first name and DOB), and from the registration record (abuse report #, CPT office, child's county, date of referral, referred by and PI/unit). There are three fields that link the user to other related screens.

1. **Abuse Report #** - Will bring you to the Abuse Report Review screen.
2. **Client ID** - Will link you to the Demographic screen.
3. **Client Name** - Will take you directly back to the Registration screen.

The buttons labeled Interim Case Summary, Final Case Summary or Addendum (if any service has been provided after the case was terminated) are displayed right under this section. Clicking on each of the buttons will navigate you to that report screen.

To update or access existing records, you may search on the main menu with the abuse report #, client ID or client name. Enter the abuse report #, client ID or client name, and check the option box of the Report Summary. Click "Go." It will return the Report Summary Search screen if there are multiple results from the search. Click on the abuse report # to access a specific report summary. If there is only one report summary under that client ID, it will take you directly to the report summary create/update screen.

You can also access an existing report summary by going through the Registration, the Abuse Report Search, or Demographic screens.

10.3 Instructions for Creating a Report Summary

There are three command buttons on the Report Summary Screen. Each button leads to a separate report summary; Interim Case Summary, Final Case Summary or Addendum input screens.

10.4 Interim Case Summary

To access this optional report, click on the Interim Case Summary button on the Report Summary Screen. You will see a screen that looks like figure 10-3. Interim Case Summary is displayed on the title bar of the screen as an identifier.

Figure 10-3 Interim Case Summary Create/Update Screen

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CHILD PROTECTION TEAM INFORMATION SYSTEM

INTERIM CASE SUMMARY

Abuse Report Number: 2013-123580 CPT Office: 01AA Child's County: Escambia
 Referral Date: 5/24/2013 Referral Source: DCF/Other CPI/CBC Name:
 Name: Case, Fake Date of Birth: 10/31/2010 Client ID: 112223334

Linked Abuse Report Numbers:

25 Reason for Referral: (max 10,000 characters)
 Text Entry for User Guide

Assessments Provided	Date Completed	Date Report Sent
Del	Assessments Pending	Pending
<input type="checkbox"/>	--	<input type="checkbox"/>

0 Interim Assessment of Risk: (max 10,000 characters)

CPT Case Coordinator: TRAVIS MCLANE
 Date Report Sent:
 CC: (max 250 characters)

Prepared By: Sign Date:
 Reviewed By: Sign Date:
 Updated By:
 Updated Date:

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Interim Case Summary is displayed on the title bar of the screen as an identifier. While this report is no longer mandatory, users can always use this report template.

The case specific information on the top section will be auto populated. You can print out the report any time by clicking the "Print" button at the bottom of the screen. The fields of the screen are as follows:

Data field descriptions and parameters (i.e. drop-down choices) for the Interim Case Summary screen are as follows.

- 1. Reason for Referral** - (10,000 characters). This is a text field that will auto populate from the Intake/Referral Screen. Additional narrative information may be added. The field will allow you to add, but not edit additional information. It is a summary of allegations, a list of agreed upon assessment services needed, and identifies the source of the referral.
- 2. Assessments Provided – Date Completed – Date Report Sent** - This section will auto populate the completed team assessments from the assessment screens attached to the registration. It is therefore important that the assessment screens be completed on all assessment activities.

If “Assessment Provided” does not have a “Date Report Sent,” it will prompt the user with “Please ensure all Assessment data is entered,” but will allow user to save change.

3. **Assessments Pending** - This section allows users to identify assessments that have been scheduled but not yet completed.
4. **Interim Assessment of Risk** - (10,000 characters for ICS and FCS report) (5000 characters for Addendum report). This is a text field that requires narrative information regarding the team’s interim assessment of the level of risk to the child(ren). This is based on the information provided to the team by the referral source and information obtained through completed assessment activities.
5. **CC Completing Intake (CPT Case Coordinator)** - This field will auto populate from the registration screen, case coordinator field. In order for the report to reflect the correct case coordinator, supervisors and team coordinators must go in and update this screen when a case is reassigned. The supervisor/team coordinator can use the comment box to document the reassignment and date reassigned.
6. **Updated Date** - This is the date that the team coordinator/supervisor reviewed and approved the ICS report.
7. **Updated By** - This is the electronic signature for the case coordinator reviewing and approving the ICS report. These two fields will only be displayed on the print-out report.
8. **Date Report Sent** - This is the date the report was mailed to the PI. This field must be equal to or less than the Referral date located on the registration screen. Use the following format when entering the date: MM/DD/YYYY. Once the field is entered, data will be updated to the Date ICS sent to PI on the registration screen.

Important Note: Please do not use the Back button on the menu bar to return to the Registration screen. If you do, the registration screen will not capture the FCS date report sent. Use the client name on top of the FCS screen to get back to the Registration screen. The data in that field will then be successfully transferred from the FCS to the Registration screen. If “Assessments Provided” do not have a date, the system will prompt the user with “Assessment Data Required, and will not save changes until each assessment completed has been entered properly.

9. **CC** - (250 characters) Users can add or delete information from this field. Always press the Enter key before entering another agency name.
10. **Prepared By** – When the user clicks the “Sign” button next to the “Prepared By” field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID.
11. **Reviewed By** - When the user clicks the “Sign” button next to the “Reviewed By” field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID. Only users with supervisor privileges may review a report. CPTIS will not allow other users to sign this field.

Remember to click on the “update” button and confirm the successful update prior to going to a new screen, otherwise data entered will not be saved.



10.5 Final Case Summary

This report must be prepared and sent out prior to termination of the case. To access the report, click on the “Final Case Summary” button on the Report Summary Screen. Users will see a screen that looks like figure 10-4. Final Case Summary is displayed on the title bar of the screen as an identifier.

Figure 10-4 Final Case Summary Create/Update

The screenshot shows the 'FINAL CASE SUMMARY' form within the 'CHILD PROTECTION TEAM INFORMATION SYSTEM'. The interface includes a left-hand menu, a top header with the Florida Department of Health logo, and a main content area with various input fields and buttons.

Menu: Welcome Travis McLane, Abuse Review, Intake/Referral, Demographic, Registration, Assessment, Report Summary, Assessment Reports, Other CPT Training, Provider, Reports, Allocation Reports, Help Center, Training Videos, System Guide, Code Maintenance, Help Maintenance, User Options, Sexual Abuse Treatment Program, Logout.

FINAL CASE SUMMARY Header: Abuse Report Number: 2013-123580, Referral Date: 5/24/2013, Name: Case, Fake, CPT Office: 01AA, Referral Source: DCF/Other, Date of Birth: 10/31/2010, Child's County: Escambia, CPU/CBC Name: Client ID: 112223334.

Buttons: Interim Case Summary, Final Case Summary, Addendum.

Form Fields: Reason for Referral: (max 10,000 characters), Text entry for User Guide, Assessments Provided table, Final Assessment of Risk: (max 10,000 characters), Conclusion and Recommendations: (max 10,000 characters), CPT Case Coordinator: TRAVIS MCLANE, Date Report Sent, CC: (max 250 characters), Prepared By, Reviewed By, Updated By, Updated Date.

Assessments Provided	Date Completed	Date Report Sent
Forensic Interview	6-03-2013	
CPT Staffing	6-03-2013	6-04-2013

Buttons at Bottom: Update, Delete, Print.

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Case specific information, as indicated in the ICS instructions, will auto populate. Users may print out the report any time by clicking the “Print” button at the bottom of the screen. Data field descriptions and parameters (i.e. drop-down choices) for the Final Case Summary screen are as follows:

- 1. Reason for Referral** - (10,000 characters). This is a text field that will auto populate from the Intake/Referral Screen. Additional narrative information may be added to document services requested and completed. DO NOT write over the information auto populated from the Intake/Referral Screen. The field will allow the user to add any additional information. It is a summary of allegations, a list of agreed upon assessment services needed, and identifies the source of the referral.
- 2. Assessments Provided – Date Completed – Date Report Sent.** This section will auto populate the completed team assessments from the assessment screens attached to the registration. It is therefore important that the assessment screens be completed on all assessment activities. Edit Check: If “Assessment Provided” does not have a “Date Report Sent,” it will prompt the user with “Please ensure all Assessment data is entered,” but will allow user to save change.
- 3. Final Assessment of Risk** - (10,000 characters for ICS and FCS report) (5000 characters for Addendum report) This is a text field that requires narrative information regarding the team’s final assessment of the level of risk to the child(ren). This is based on the information provided to the team by the referral source and information obtained through completed assessment activities. This field will auto populate from the similar field in the ICS report and will allow additional information to be entered.
- 4. Conclusions and Recommendations** - (10,000 characters). This is a text field that requires narrative information regarding the team conclusions and recommendations related to the case, based on information provided to the team.
- 5. CC Completing Intake (CPT Case Coordinator)** - This field will auto populate from the registration screen, case coordinator field. In order for the report to reflect the correct case coordinator, supervisors and team coordinators must go in and update this screen when a case is reassigned. The supervisor/team coordinator can use the comment box to document the reassignment and date reassigned.
- 6. Updated Date** - This is the date that the team coordinator/supervisor reviewed and approved the FCS report.
- 7. Updated By** - This is the electronic signature for the case coordinator reviewing and approving the FCS report. These two fields will only be displayed on the print-out report.
- 8. Date Report Sent** - This is the date the report was mailed to the PI. This field must be equal to or less than the termination date field located on the registration screen. Use the following format when entering the date: MM/DD/YYYY. Once the field is entered, data will be updated to the Date FCS sent to PI on the registration screen. **Note:** Please do not use the Back button on the menu bar to return to the Registration screen. If you do, the registration screen will not capture the FCS date report sent. Use the client name on top of the FCS screen to get back to the Registration screen. The data in that field will then be successfully transferred from the FCS to the Registration screen. If “Assessments Provided” do not have a date, the system will prompt the user with “Assessment Data Required, and will not save changes until each assessment completed has been entered properly.

9. **CC** - (250 characters) The information will be auto populated from the ICS (if one has been completed). You can always add or delete information from this field. Always press the Enter key to before you enter another agency name.
10. **Prepared By** – When the user clicks the “Sign” button next to the “Prepared By” field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID.
11. **Reviewed By** - When the user clicks the “Sign” button next to the “Reviewed By” field, CPTIS auto-populates their electronic signature and the current date, based on the users log-in ID. Only users with supervisor privileges may review a report. CPTIS will not allow other users to sign this field.



Remember to click on the “update” button and confirm the successful update prior to going to a new screen, otherwise data you have entered will not be saved.

10.6 Addendums

Users may create an addendum to any report by clicking the “Addendum” button on the Report Summary Screen. On this screen, users can fill out a maximum 10,000 character comment box detailing the assessment and the addendum information. Fields are included for the “Date Report Sent”, as well as “Updated By” and “Updated Date”, which are the electronic signature as discussed in the last two subsections on Report Summaries. The figure below demonstrates the Addendum screen.

Figure 10-5 Addendum Create/Update


CHILD PROTECTION TEAM INFORMATION SYSTEM

Menu

Welcome Travis McLane

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

--

2013-123580

Other CPT Training

Provider

Reports

--

Allocation Reports

Help Center

Training Videos

System Guide

Code Maintenance

Help Maintenance

User Options

Sexual Abuse Treatment Program

Logout

ADDENDUM

Abuse Report Number: 2013-123580	CPT Office: 01AA	Child's County: Escambia
Referral Date: 5/24/2013	Referral Source: DCF/Other	CPI/CBC Name:
Name: Case, Fake	Date of Birth: 10/31/2010	Client ID: 112223334

Linked Abuse Report Numbers:

Assessments Provided	Date Completed	Date Report Sent
Forensic Interview	6-03-2013	
CPT Staffing	6-03-2013	6-04-2013

0 Addendum: (max 10,000 characters)

CPT Case Coordinator: **TRAVIS MCLANE**

Date Report Sent:

0 CC: (max 250 characters)

Prepared By:

Date:

Reviewed By:

Date:

Updated By:

Updated Date:

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SECTION 11: OTHER CPT TRAINING SCREEN

11.1 Other CPT Training Search Screen

The Other CPT Training screen tracks contractually mandated training provided or attended by team members. It includes self-contained data fields specific to this CPTIS screen. Input is independent from the other CPTIS screens and not specific to an abuse case or client registration. The Other CPT Training search box allows users to search provider training entries by CPT office code and provider's name. Users can enter the applicable four digit CPT office code under "Other CPT Training" search box on the main menu. Once a search is submitted the results are returned in the format noted in figure 11-1.

Figure 11-1 Other CPT Training Search Results

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like Abuse Review, Intake/Referral, Demographic, Registration, Assessment, Report Summary, and Assessment Reports. A search input field contains '2011-032444'. Below it is the 'Other CPT Training' search box. The main area shows search results for provider ABCD,EFGH in a table format.

Presenter/Attendee	Name	Training	Hours	CPT Office	Date
2070	ABCD, EFGH	ST - Staff	11	01AA	4-02-2012
2072	abcd, efgh	PT - Physician		01AA	4-02-2012
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010
2070	ABCD, EFGH	PT - Physician		01AA	2-01-2010

If a search criteria results in only one record being returned the user will be taken directly to that activity record.

The following columns of information are returned for each record to help identify it:

10. Presenter/Attendee - Links to the training record for associated Provider ID.

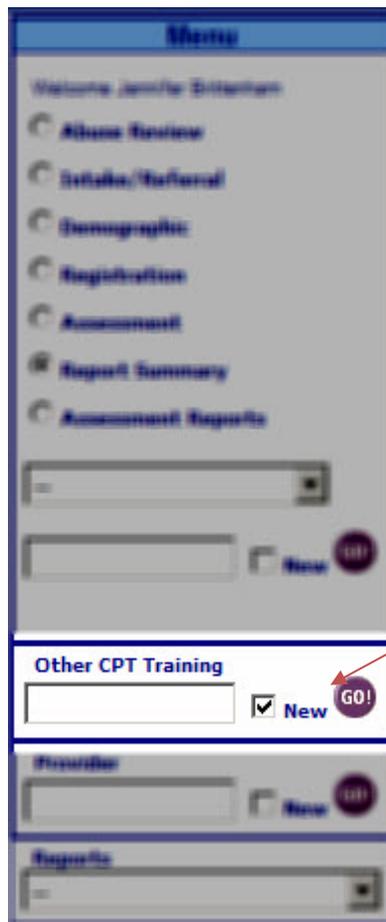
11. Name - Provider Name.

- 12. **Training** - Type of training.
- 13. **Hours** - Displays hours for the trainings that the staff members attended.
- 14. **CPT Office** - Associated CPT office.
- 15. **Date** - Training date.

11.2 Create New CPT Training

To enter new Other CPT Training, users should check the new box on the main menu and click the “Go” button.

Figure 11-2 Access New Other CPT Training



The screenshot displays the CPTIS main menu. At the top, it says 'Menu' and 'Welcome Jennifer Brittenham'. Below this are several menu items with radio buttons: 'All Case Review', 'Details/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary' (which is selected), and 'Assessment Reports'. There are two input fields below these items, each with a 'New' checkbox and a 'GO!' button. The 'Other CPT Training' section is highlighted with a blue border, and its 'New' checkbox is checked. A red arrow points to the 'GO!' button in this section. Below this are sections for 'Prescriber' and 'Reports', each with an input field and a 'New' checkbox.

This will take the user to a new screen to enter a new CPT training. This is the screen where CPT activities unrelated to a specific registered case are documented. A training report is available for management purposes through the “Reports” section of CPTIS.

Figure 11-3 New Other CPT Training Screen

Users can enter data on this screen to save a new training activity. After clicking “Insert” a “successful update” message notified the user that the information has been entered and saved. Users can continue to add additional activities by clicking on the “New Other Activity” button. Remember to click on the “update” button and confirm the successful update prior to going to a new screen, otherwise data you have entered will not be saved.



Data field descriptions and parameters for the Other CPT Training screen are as follows. Mandatory input fields are identified in red.

1. **CPT Office** - The CPT office code of the individual completing the activity. Select code from drop-down box (See Appendix D, CPT Office Codes).
2. **Presenter/Attendee Provider Name** - If the training is conducted by a CPT physician or CPT team member, this field will capture the name of the presenter(s). If the CPT staff members attend the training, this field will capture the name of the attendee.
 - The drop-down will only display the providers from your team. It shows the provider ID, name and type of provider.

- This drop-down box allows you to select multiple presenters/attendees. If you would like to select presenter/attendees in a consecutive order, you may hold down the **Shift** key on your keyboard, and use the cursor to highlight multiple presenters or attendees. Otherwise, you may hold down the **Ctrl** key, and select the presenters/attendees in an interrupted order. An individual record will then be created for each presenter or attendee that you select.

3. Type of Training - Select type of training from drop-down box.

- Physician - Indicates a CPT Physician or other medical personnel providing training to emergency room and other non-team medical personnel in the detection of abuse and neglect.
- Staff - CPT staff members attending training.
- CPT - CPT providing training to non-CPT members.

4. Training Date - Captures the date training completed. Use format MM/DD/YYYY.

- CPTIS will accept MMDDYY date field entries and automatically format them with date slashes. CPTIS will automatically format any YY entry less than 81 as a year 2000 date (i.e. 010180 would be formatted 01/01/2080 and 010181 would be formatted 01/01/1981).
- To avoid error messages enter dates prior to 1981 as MMDDYYYY.

5. CE - Continued Educational Credit (Optional)

- This field will be enable only when the Type of Training is “Staff”
- When this field is selected, the field of Hours will be enabled to capture the credit hours of this training.

6. Hours - Continued Educational Credit hour, or if CE not selected, the training hours completed by the staff.

7. Audience - Field will be enabled if the Type of Training is “Physician and Team.”

- ER Medical Person
- Other Child Protection Services - This includes DCF and SI child protection investigators, and other local agencies responsible for child protection services)
- Other Non-Team Medical Personnel - This includes Health Department personnel, Children’s Medical Services medical personnel, or private physicians or physician groups to name a few.

8. Comments - (300 characters) Enter comments as appropriate and necessary. If the “Type of Training” selected is “Staff,” you are required to enter a brief description of the training that you attended.

9. Updated By - The signature field for the CPT user that has input data to this screen.

10. Updated Date - The date field for when the CPT user input data to this screen.

SECTION 12: PROVIDER SCREEN

12.1 Provider Search Screen

The Provider screen contains information regarding individuals (such as psychologists, attorneys, medical providers, case coordinators, and team coordinators) who provide team services. This screen will include data fields self-contained to this specific CPTIS screen. A user is able to search for provider information records by CPT Office Code and the Provider Name (last name, last name,first name, or team #).

Figure 12-1 Provider Search

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Menu

Welcome Jennifer Brittenham

- Abuse Review
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports

--

New **GO!**

Other CPT Training

New **GO!**

Provider

New **GO!**

Reports

--

Help Center

System Guide

Code Maintenance

Help Maintenance

User Options

Sexual Abuse Treatment Program

Once a search is submitted in the field on the menu bar the results are returned in the format as illustrated in figure 12-2.

Figure 12-2 Search Results

The screenshot shows the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options like 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary', and 'Assessment Reports'. The main area displays 'Provider Search Results for Provider ABCD,EFGH' in a table format.

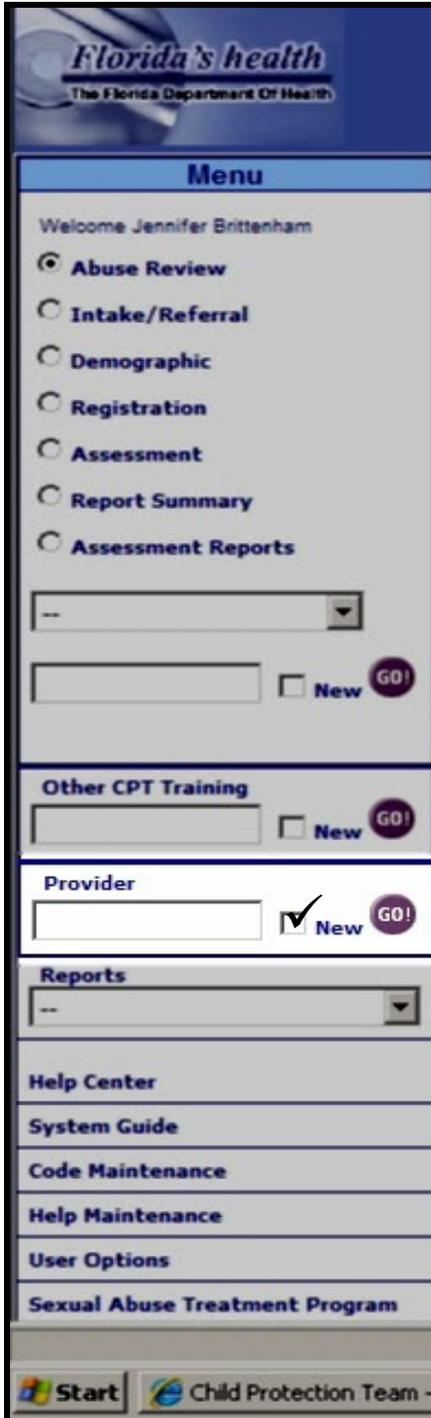
Provider ID	Name	Address	City	State	Phone	CPT Office	Active
2072	abcd, efgh	1234 abcd		FL		01AA	Y
2070	ABCD, EFGH	1234 ABCD		FL		01AA	Y
2073	abcd, efgh	1234 abcd		FL		01AA	Y
2076	abcd, efgh	1234 fisher ln	tallahassee	FL	1232456463	01AA	Y

The following columns of information are returned for each record to help identify it:

1. **Provider ID** - Four digit numeric ID automatically assigned by CPTIS when provider record is created.
2. **Name** - Formatted last name, first name.
3. **Address** - Street address of provider business.
4. **City** - Of provider business
5. **State** - Of provider business
6. **Phone** - Telephone number of provider business.
7. **CPT Office** – Code for the CPT office the provider is associated with.
8. **Active** - Identifies the provider status with team. “Y” indicates an active provider, “N” indicated an inactive provider. If the provider active status is “N”, that provider’s name will not appear in the respective drop down boxes.

In order to add a new provider, go to the menu bar on the left, and check the “new” box and click on go as indicated in figure 12-3 below.

Figure 12-3 CPTIS Menu



√The screen to enter new provider data is demonstrated in figure 12-4.

Figure 12-4 New Provider Screen

CHILD PROTECTION TEAM INFORMATION SYSTEM

PROVIDER

Provider ID: <input type="text" value="2070"/>	Last Name: <input type="text" value="ABCD"/>	First Name: <input type="text" value="EFGH"/>	
Address: <input type="text" value="1234 ABCD"/> <input type="text"/>	CPT Office: <input type="text" value="01AA"/>	Type: <input type="text" value="AR - Advanced Registered Nurse Practitioner"/>	
City: <input type="text"/>	State: <input type="text" value="Florida"/>	Zip: <input type="text"/>	
Phone: <input type="text" value="() - -"/>	County: <input type="text" value="--"/>	Active: <input checked="" type="checkbox"/>	CMS Approval Expiration Date: <input type="text"/>

Updated by: **REYNOLDS, JERRY** Created: **5/27/2009** Updated:

This is the screen used to initially enter all providers, including case coordinators, to the database. Data field descriptions and parameters for the Provider screen are as follows. Mandatory input fields are identified in red. The “Active” field will automatically contain the value “Y”.

1. **Provider ID** - Input the Provider ID for the specific provider. This is a system generated ID.
2. **Last Name** - Input the last name of provider. This field holds a maximum of 20 characters.
3. **First Name** - Input the first name of provider. This field holds a maximum of 16 characters.

4. **Type** - Select provider type code from drop-down box (See Appendix C: Provider Type and Codes).
5. **CPT Office** - The code for the CPT office the provider is associated with. Select code from drop-down box (See Appendix D: CPT Office Codes).
6. **Address1** - Enter the street address of provider's business location. This field holds a maximum of 22 characters. Please also use Address2 if the address includes more than 22 characters.
6. **Address2** - Enter the continuation of the street address of provider business location from Address 1.
7. **City** - Enter the city of provider business location.
8. **State** - Enter the state of provider's business location. Select choices from drop-down box if different from FL-Florida, which populates automatically. This field holds a maximum of 2 characters.
9. **Zip** - Enter the zip code of provider's business location.
10. **Phone** - Telephone number of provider's business location. Use format (999)999-9999.
11. **County** - Enter the county of provider's business location. Select from drop-down box:
 - Standard county codes 01-67
 - 00 – Out of State
12. **Active** (provider's status) - Indicates whether the provider is active in CPTIS.
 - Checked – Yes
 - Not Checked – No
 - New Provider Records default to Yes.

Important Note: It is important to keep this field up to date since this field determines who will be displayed in the provider drop-down throughout the system. Providers no longer active with the team should be deactivated by clicking on the active check box.

13. **CMS Approval Expiration Date** - Mandatory under specific conditions. Indicates the date the CMS approval will expire in system. This field is only accessible by program office staff.
14. **Updated By** - The signature field for the CPT user that has input data to this screen.
15. **Updated Date** – Enter date the CPT user input data to this screen.

Remember to click on the “update” button and confirm the successful update prior to going to a new screen, otherwise data you have entered will not be saved.



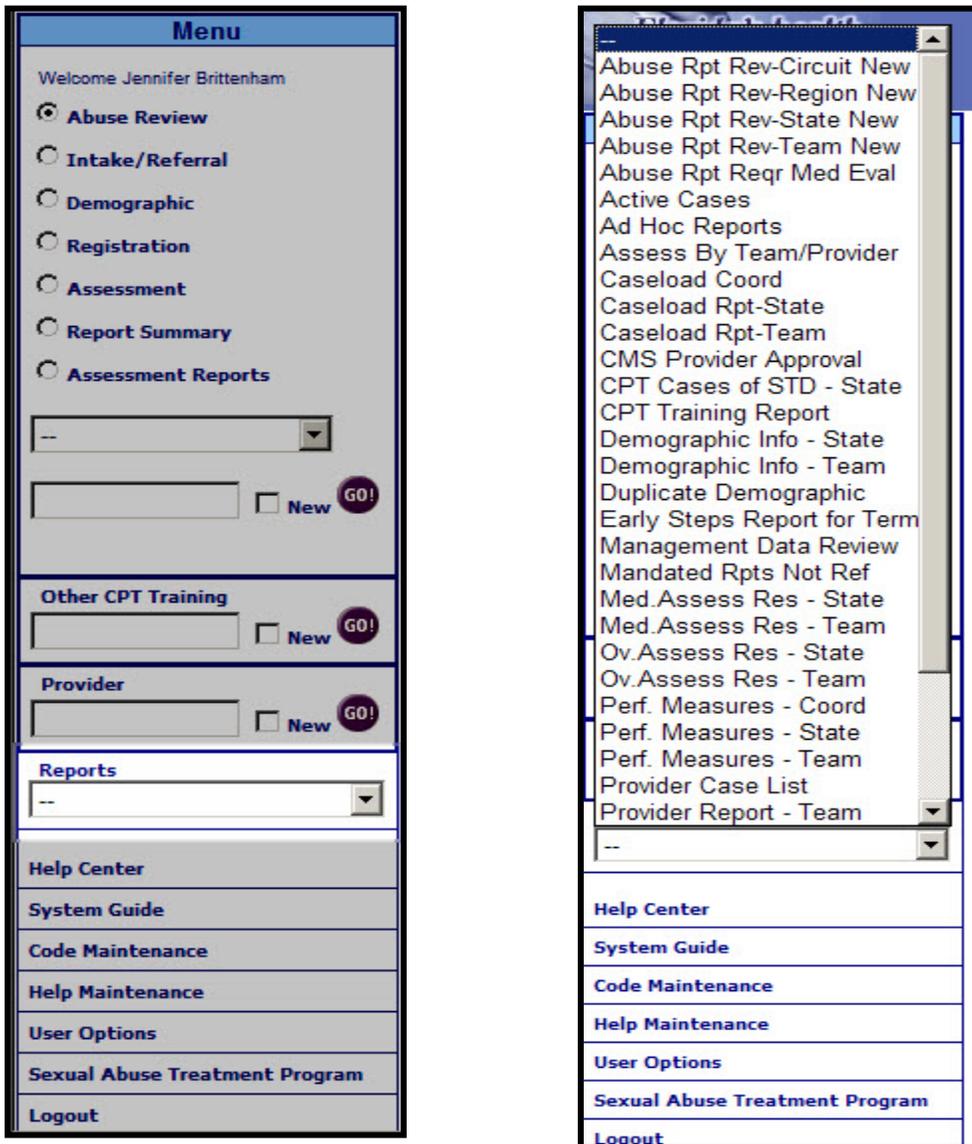
SECTION 13: MANAGEMENT REPORTS

13.1 CPTIS Management Reports Overview

CPTIS has the capability to generate management and performance reports based on the individual team and statewide data available in the system. Each team is responsible for ensuring that their data is accurate and up to date in CPTIS. Team coordinators and case coordinators are expected to review information entered in the system and ensure its quality and accuracy for CPTIS reports.

There are over 20 management reports available in CPTIS. After a quick overview of the reports menu, this section will review how to access each report.

Figure 13-1 & Figure 13-2 CPTIS Report Menu



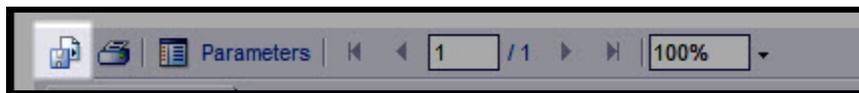
Specific management reports can be selected from the drop down field on the main menu. All reports in the drop down are listed alphabetically. Depending on the report selected, users will be required to enter criteria for the reporting data range, specific CPT team, provider name, and other applicable parameters. Once a user inputs the desired criteria, they can click the “Report” button to generate the report.

13.2 Exporting, Printing, & Saving Management Reports

Once the specified report is successfully generated and displayed, the user can save the report in a different file format, print the report, and/or close the report and re-run the report with different criteria.

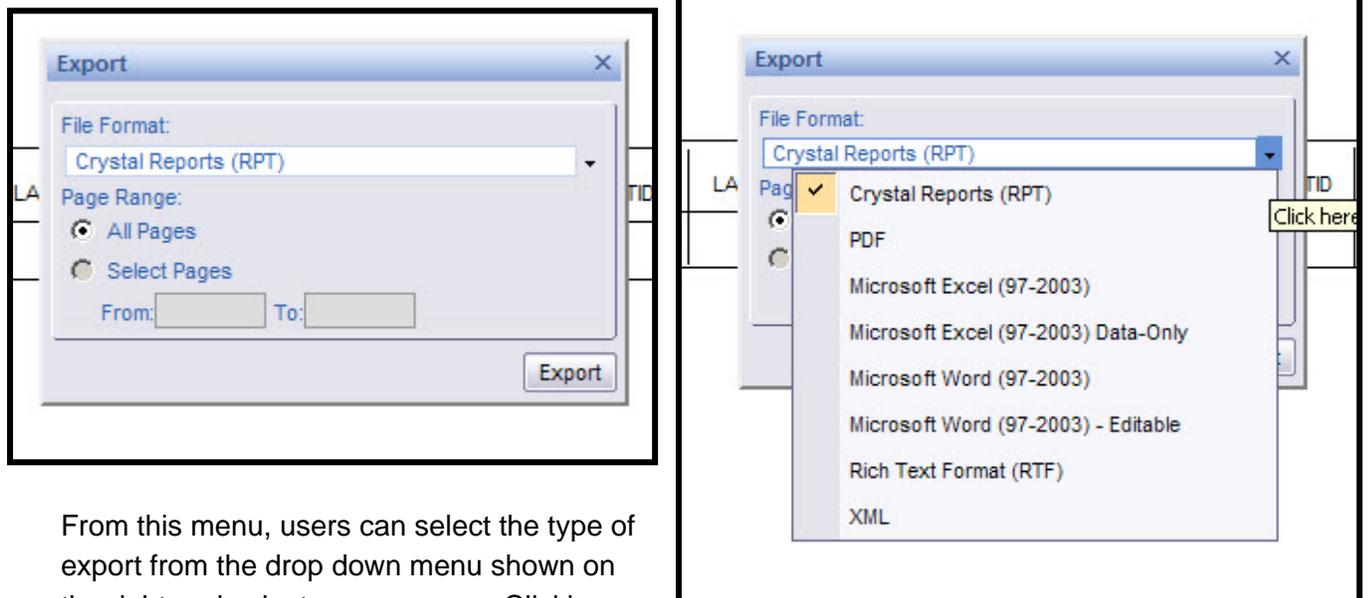
Each report form has a small menu in the upper left-hand corner as displayed below in figure 13-3.

Figure 13-3 Management Reports Menu



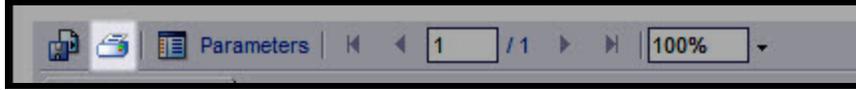
The first icon on this menu, a small floppy disk, controls the export function. Clicking the export icon, will allow the user to access a pop-up menu as shown in figures 13-4 and 13-5 below.

Figure 13-4 & 13-5 Management Reports Export Menu



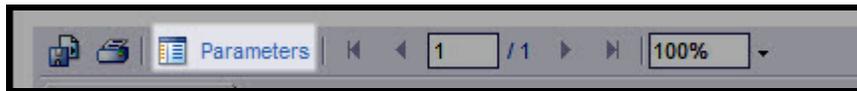
From this menu, users can select the type of export from the drop down menu shown on the right and select a page range. Clicking “Export” will allow the user to access MS Word’s file download menu, from which the report can be saved or opened, or the user can cancel the export and go back to the menu.

Figure 13-6 Management Reports Print Icon



The second icon on this menu is the print icon. Clicking the print icon allows the user to access MS Word's traditional print set up menu. From here, users can print to any networked printer.

Figure 13-7 Management Reports Parameters Icon



The parameters icon controls a menu within each report that links the user to related reports of the same type. Figure 13-8 below demonstrates the report pane where related reports will be displayed, if they exist. To access a related report, users simply point the cursor on the report name in the pane and click.

Figure 13-8 Parameters Report Pane

The screenshot shows a report titled "CHILD PROTECTION TEAMS: 02PC Performance Measures Report". The report includes the following sections and data tables:

Case Coordinator:

CaseLoad Status

Interim Case Summary (90%)			
within 20 days		over 20 days	
#	%	#	%

Positive Findings

Verbal Notification (90%)			
within 1 days		over 1 days	
#	%	#	%

Reports

(90%)				(90%)				(90%)				(90%)			
within 10 days		over 10 days		within 10 days		over 10 days		within 10 days		over 10 days		within 10 days		over 10 days	
#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%

Assessment Activities

Total Number Assessments	Assessments over 20 days		
	within 20 days	NE	over 20 days RFD
#	%	#	%

Staff Training

Number of Training (100%)	
Physician Training	Other/Team Training

Overall Report Compliance (90%)

#	%

Page 1 of 1

The highlighted area, titled “Main Report,” would contain the names of related reports if any existed. Clicking the “parameters” icon on the reports menu will hide or show this menu, depending on the user’s preference.

To quickly move through the pages of any management report, users can employ the page selection icon on the preferred reports menu shown below in figure 13-9.

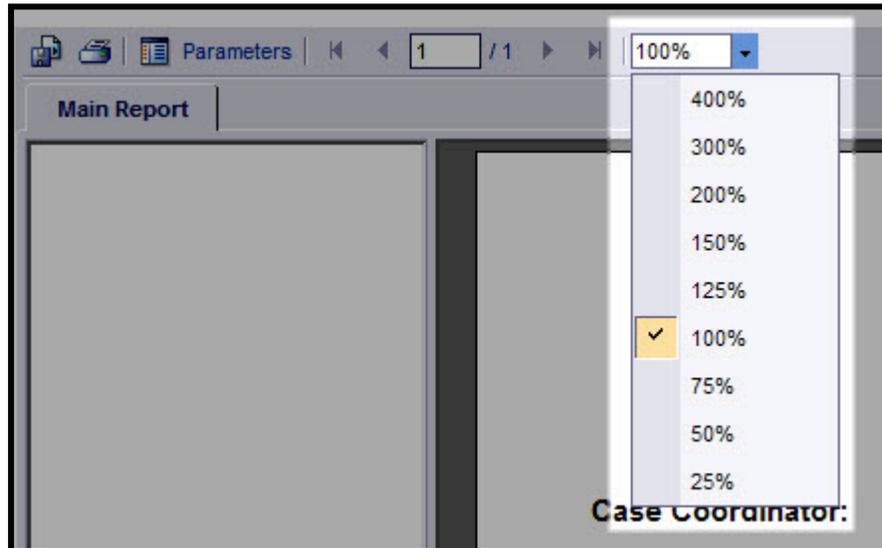
Figure 13-9 Page Selection Icon



Users can move back and forth through the report by clicking on the small arrows on either side of the page number field, or by entering page number into the field and hitting “enter” on the keyboard.

The final icon on this menu is the zoom icon. As demonstrated below in figure 13-10, users can select the size of the report on the screen by clicking the preferred zoom percentage in the drop down menu.

Figure 13-10 Zoom Selection Icon



The correct way to exit out of any management report is to click “file” and then “exit.” Users are asked not to click the “x” at the top right hand corner of the screen to exit from a report.

Each of the management reports is addressed in the following manual sections, including information on how to access the report and the data it contains.

13.3 Abuse Report Reviews

The Abuse Report Reviews that CPTIS generates apply to new abuse reports on and after 10/1/2009. CPTIS offers five different types of Abuse Report Reviews:

- Abuse Report Reviews by Circuit.
- Abuse Report Reviews by Region.
- Abuse Report Reviews by State.
- Abuse Report Reviews by Team.
- Abuse Reports Requiring a Medical Evaluation.

Each of these reports is accessed by selecting the report by name from the drop down menu on the main menu. When the user clicks the name of the report, CPTIS directs to the search screen for that report. All of the Abuse Report Reviews have the same data criteria to pull a report. Figure 13-11 below demonstrates this screen.

Figure 13-11 Abuse Report Review Search Criteria



The screenshot shows a web application interface for searching abuse reports. The title bar is blue and contains the text "Abuse Report By Circuit -- New, on/after 10/1/2009". Below the title bar, there are two date input fields: "From Date:" followed by a text box, and "End Date:" followed by a text box. At the bottom of the form, there are two buttons: "Clear" and "Report".

The search criteria for these reports are limited to the date range, with the exception of Abuse Reports Requiring a Medical Review. This report also requires that users select a CPT office from a drop down menu. Users can click in the field for the date to pull up a calendar from which to select dates. This calendar moves back and forth through the months, allowing users to select the correct year, month, and day for the needed report. Users can also type the date into the field using a MMDDYYYY format. No dashes or forward slashes are required.

Figure 13-12 Calendar Option

After selecting a date range, users can click “report” to pull the report or “clear” to start over and enter a different date range.

Clicking “report” will access the report, which will be pulled up in a separate window. All of the Abuse Report Reviews have the same appearance and data fields. An example is shown in Figure 13-13 below.

Figure 13-13 Example Abuse Report Review

CHILD PROTECTION TEAM -- 01AA

ABUSE REPORT REVIEW - BY COUNTY

From: 7/1/2011 - 12/31/2011

Printed 7/3/2012 / 8:05:56AM

County	Abuse Reports Received	CPT Abuse Reports Reviewed		Reports Meeting Mandatory Criteria		Of the Reports Meeting Mandatory Criteria															
				Yes		No		Referral / Intake		Closed at Intake		Ref. for Services		Open Intake		Linked		Referred/ Declined		Not Referred	
				#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Alachua	11	11	100	11	100	0	0	11	100	0	0	9	82	2	18	0	0	0	0	0	0
Baker	1	1	100	1	100	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	100
Columbia	1	1	100	1	100	0	0	1	100	0	0	1	100	0	0	0	0	0	0	0	0
Dade	1	1	100	1	100	0	0	1	100	0	0	1	100	0	0	0	0	0	0	0	0
Flagler	1	1	100	1	100	0	0	1	100	0	0	1	100	0	0	0	0	0	0	0	0
Franklin	3	3	100	3	100	0	0	1	33	0	0	1	33	0	0	0	0	0	0	2	67
Gadsden	2	2	100	2	100	0	0	1	50	0	0	1	50	0	0	0	0	0	0	1	50
Okaloosa	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	21	20	95	20	95	0	0	16	80	0	0	14	88	2	13	0	0	0	0	4	20

Data is represented in the following fields:

- 1. Circuit/Region/State/County** - Area from which report data was received. This field will vary based on the type of Abuse Report Review selected.
- 2. Abuse Reports Received** - Number of abuse reports the area received during the specified date range.
- 3. CPT Abuse Reports Reviewed** - Number of abuse reports which were reviewed by the team in that area. Data includes both the number of abuse reports reviewed and the percentage of reports received which were reviewed.

4. **Reports Meeting Mandatory Criteria** - Number of abuse reports meeting the mandatory criteria for referral to CPT program. This data is pulled from the "Mandatory Referral Criteria" field on the Abuse Report Review screen in CPTIS.
5. **Of the Reports Meeting Mandatory Criteria** - This data applies only to those abuse reports which did meet the mandatory criteria. Of those reports that did:
 - **Referral/Intake** - Number and percentage of reports meeting the mandatory criteria which were referred for an intake.
 - **Closed at Intake** - Number and percentage of reports meeting the mandatory criteria that were closed after the referral/intake. This is a subset of those referrals/intakes which were accepted.
 - **Referred for Services** - Number and percentage of reports meeting the mandatory criteria that were referred for services.
 - **Open Intake** - Number and percentage of reports meeting the mandatory criteria which, at the time of the report, were neither closed nor had a registration created.
 - **Linked** - Number and percentage of intakes linked to other registrations.
 - **Referred/Declined** - Number and percentage of intakes referred or declined.
 - **Not Referred** - Number and percentage of reports meeting the mandatory criteria which were not referred to CPT.

Important Note: Currently the number of abuse reports received that were reviewed by CPT is based on the date of the medical review in the abuse report screen.

13.3.1 Abuse Reports Requiring a Medical Evaluation

This report provides a list of abuse reports which required a medical evaluation within the specified time frame. These abuse reports do not meet the mandatory referral criteria. However, the medical staff determines that medical evaluation is needed. Figure 13-14 demonstrates an example of this report.

For each report listed, information includes:

Figure 13-14 Abuse Reports Requiring a Medical Evaluation

CHILD PROTECTION TEAM: 05AA							
LIST OF ABUSE REPORTS REQUIRING MEDICAL EVALUATION (Non-Mandatory that CPT determined Needed Evaluation)							
1/1/2005 - 1/31/2005							
Printed 4/26/2005 / 10:46:29AM							
Abuse Report County	DAU	Abuse Report #	Review #	Hotline Date	CPT Received Date	CPT Review Date	Cross Team Case
Pinellas		2005-301793	1	01/04/2005	01/05/2005	01/06/2005	
Pinellas		2005-305659	1	01/11/2005	01/11/2005	01/12/2005	
Pinellas		2005-306244	2	01/11/2005	01/12/2005	01/13/2005	
Pinellas		2005-306290	1	01/11/2005	01/12/2005	01/13/2005	
Pinellas		2005-306364	1	01/12/2005	01/12/2005	01/13/2005	
Pinellas		2005-307557	1	01/13/2005	01/14/2005	01/14/2005	
Pinellas		2005-308045	1	01/18/2005	01/18/2005	01/19/2005	
Pinellas		2005-311914	1	01/21/2005	01/21/2005	01/24/2005	
Pinellas		2005-315128	1	01/26/2005	01/27/2005	01/28/2005	
Pinellas		2005-316133	1	01/27/2005	01/28/2005	01/31/2005	
Sub Total		10					
TEAM TOTAL		10					

Data is reported in the following fields:

- 1. Abuse Report County** - County of service.
- 2. DAU** - District, Area and Unit assigned by DCF or sheriff's office responsible for child protective investigations.
- 3. Abuse Report Number** - Number assigned by the FL Abuse Hotline when a report is accepted for investigation.
- 4. Sequence Number** - Sequence number of reports received related to same client/case.
- 5. Hotline Date** – Date hotline received report.
- 6. CPT Received Date** – Date CPT received referral from hotline.
- 7. Cross Team Case** – Indicates whether more than one team is involved in the referral.

13.4 Active Cases

The Active Case reports show a list of active CPT cases by team code and provider. Users can access this data by clicking on “Active Cases” in the “Reports” drop down menu. A search screen will allow users to select their criteria as shown in figure 13-15 below.

The report indicates the Child Protection Team by code and the total cases open at the top. It also indicates when the report was “printed.” This indicates when CPTIS generated the report, not when it was printed to a hard copy.

Cases are listed by Case Coordinator for each CPT or just by the provider. Under each Case Coordinator is a list of open cases assigned to them. The report provides data for each case according to the following parameters:

1. **Abuse Report #** - Case abuse report #.
2. **Client Name** - First and last name of client.
3. **DOB** - Client DOB.
4. **Initiation date** - CPT case initiation date.
5. **ICS/Verbal Notification Date Due** - Will only populate if ICS information is filled out on the Registration.
6. **ICS Sent/Verbal Notification Date** - Will only populate if ICS information is filled out on the Registration.
7. **Alleged Maltreatment(s), and Type** - Maltreatment noted on Registration.
8. **Assessment Activity, Completion Date, Report Due Date and Date Report Sent** - For each case, the report identifies any assessment activities and their individual completion and report dates.

13.5 Ad Hoc Reports

Ad Hoc reports list records that have not met CPT Performance Measures based on at least one criterion. There are seven types of Ad Hoc Reports:

- Abuse Reports - Provides a list of abuse reports not reviewed in a timely manner.
- Abuse Reports Not Reviewed - List of abuse reports received but not reviewed.
- Abuse Reports Reviewed Late – List of abuse reports reviewed late.
- Assessment Activities - List of assessment activities not completed.
- Assessment Reports - List of assessment reports not timely.
- Assessment Reports Not Sent To DCF - List of assessment reports not sent.
- Early Steps Ad Hoc Report For Terminated Cases – List of children seen but not screened and those screened/meeting criteria but not referred.
- Open Intakes - List of intakes with no termination date or registration.
- Verbal Notification - List of assessments with positive findings and verbal notifications which are not timely.

Users can access these reports by selecting “Ad Hoc” from the “Reports” drop down box on the main menu. Figure 13-17 demonstrates the Ad Hoc Reports search criteria screen.

Figure 13-17 Ad Hoc Reports Search

The screenshot shows the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' with options: Abuse Review (selected), Intake/Referral, Demographic, Registration, Assessment, Report Summary, and Assessment Reports. Below the menu are input fields for 'Other CPT Training', 'Provider', and 'Reports', each with a 'New' button and a 'GO!' button. The main area is titled 'Ad Hoc Reports' and contains search criteria: 'From Date: 05/01/2011', 'End Date: 06/30/2011', 'CPT: 02PC', 'Provider: --', and 'Report Type: --'. A dropdown menu for 'Report Type' is open, showing options: Abuse Reports, Abuse Reports Not Reviewed, Assessment Activities, Assessment Reports, Assessment Reports Not Sent To Open Intakes, and Verbal Notification. A 'Report' button is located to the right of the dropdown.

User's select a date range, CPT, provider, and report type. CPTIS will generate the report based on the selected criterion. Users have the option of selecting to organize data by CPT or provider or both, as well as any date range and any report type.

13.6 Assessments by Team/Provider

This report provides the type of assessment activities on terminated cases by each CPT and/or provider for a specific date range. Figure 13-18 demonstrates the search screen for this report.

Figure 13-18 Assessments by Team/Provider Search

Users can enter a date range and select the CPT from the drop down menu and click “report.” CPTIS will generate a report as shown in figure 13-19.

Figure 13-19 Assessments by Team/Provider

CHILD PROTECTION TEAM: 01AA
 Assessments By Team/Provider
 From: 6/1/2005 - 6/30/2005

Printed 7/7/2005 / 11:54:33AM

ABUSE EPORT #	REGSEQ NUM	LAST NAME	FIRST NAME	CLIENTID	INITIAL DATE	TERM DATE	COORD CODE	ME	PE	PEC	PEQ	NA	FI	SA	SI	SIC	SIO	MS	TS	MC
05-391286	1	TESTER	NICKI	592123456	6/1/05	6/10/05	1781													1018
05-391424	1	TESTER	WISE	592099999	5/31/05	6/10/05	1758	1018												
05-391575	1	TESTER	HONEY	111991111	5/31/05	6/10/05	1780	1018												
05-392889	1	TESTER	PAUL	000110000	5/31/05	6/10/05	1757	1018												
05-392889	1	TESTER	JOY	777997777	5/31/05	6/10/05	1757	1018												
05-392889	1	TESTER	BEAUTY	888998888	5/31/05	6/10/05	1757	0155												
05-395251	1	TESTER	WATER	666996666	6/6/05	6/10/05	1757	1018									0952			
05-888888	1	TESTER	SALLY	592138888	6/1/05	6/21/05	1781			1757							1760			
TOTAL								18	0	1	0	0	1	0	0	0	3	0	0	5

The date range at the top of the report will match the date range the user selected. Data within the report applies to all cases terminated within the selected date range. CPTIS pulls the termination date from the registration. As with all the management reports, the print date indicates the date and time CPTIS generated the report. The following data is represented on this report:

1. **Abuse Report number** - Abuse report number that applies to the case.
2. **Registration number** - Sequence number of related registration.
3. **Client Name** - First & last name of client.
4. **Client ID** - Client ID number which populates from the Demographic screen.

5. **Initial date** - Date case was accepted for CPT services.
6. **Termination date** - Date case was closed.
7. **Coordinator code** – Assigned case coordinator by code.
8. **Type of assessment activities** – The types of assessment activities are shown by code across the report by provider. There is a key for these codes in the Appendix.

13.7 Caseload Report by Coordinator, State, or Team

This set of reports provides a summary of caseload data based on different parameters. The information provided in these reports is intended to track CPT's performance measures. These parameters include a date range, CPT team, provider, and a statewide search for data. There are three screens from which users can pull Caseload Reports: by Coordinator, by State, or by Team. The figure below shows the screen to search by coordinator. The screen to pull caseload reports by state only has fields for a date range and the screen to pull caseload reports by team has fields for CPT and date range.

Figure 13-20 Caseload by Coordinator Search

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. On the left is a 'Menu' sidebar with options: Abuse Review, Intake/Referral, Demographic, Registration (selected), Assessment, Report Summary, and Assessment Reports. Below the menu is a search bar containing '111223542' and a 'New' button. The main content area is titled 'Caseload by Coordinator' and contains the following search criteria: 'From Date:' and 'End Date:' (both empty text boxes), 'CPT: 01AA' (a dropdown menu), and 'Provider: --' (a dropdown menu). At the bottom of the search area are 'Clear' and 'Report' buttons.

When the user enters criteria and clicks “report,” CPTIS will generate a report based on the criterion selected by the user, including a date range, CPT, and/or provider. The figure below demonstrates a sample of this report.

Figure 13-21 Caseload by Coordinator

The report shown was generated by selecting a CPT office and a date range. If the user had selected a date range and a provider, the report would show case data for that case coordinator only. The statewide report shows CPT caseload for the entire state during the

CHILD PROTECTION TEAM COORDINATOR CASELOAD REPORT															
From: 1/1/2010 - 12/31/2010 for 01AA															
Printed 1/26/2011 / 10:43:08AM															
Case Coordinator	Open beginning of period	Initiated	Terminated	Open end of period	Cases Open				Terminated Cases						
					Over 45 Days		Over 60 days		Total Number	Over 30 Days		Over 45 Days		Over 60 Days	
					#	%	#	%		#	%	#	%	#	%
BARBARA VALLETTO	15	0	0	15	0	0	15	100	0	0	0	0	0	0	0
CHRISTINE SHERMAN	15	1	1	15	0	0	15	100	1	0	0	0	0	0	0
John Doe	1	1	0	2	0	0	2	100	0	0	0	0	0	0	0
KIRSTEN BUCEY	27	35	12	50	1	2	48	96	12	0	0	0	0	1	8
LINDA KAHL	19	2	2	19	0	0	19	100	2	0	0	0	0	0	0
PHYLLIS GONZALEZ	1	3	1	3	0	0	3	100	1	0	0	0	0	0	0
SALLY SMTH	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0
VU LAUREN	0	2	1	1	0	0	1	100	1	0	0	0	0	0	0
Total	78	45	18	105	1	1	103	98	18	0	0	0	0	1	6

date range selected. The caseload by team report shows the same information as the coordinator report but for the entire CPT team. The following data is represented in these reports:

1. **Case Coordinator** - Name of assigned case coordinator.
2. **Open beginning of period** - Number of cases open at the beginning of the period.
3. **Initiated** - Number of new cases assigned within the date range.
4. **Terminated** - Number of cases terminated within the date range.
5. **Open end of period** - Number of cases open at the end of the period.
6. **Cases Open** - Number of cases open over 45 and 60 days.
7. **Terminated Cases** - Number of terminated cases that were closed within 30, 45, and 60 days.

13.8 CMS Provider Approval

This report lists, by team, the status of active medical or other professional providers that have been approved by Children's' Medical Services.

Figure 13-22 CMS Provider Approval Search

When the user selects a CPT office and clicks “report,” CPTIS generates the report. A sample of the CMS Provider Approval report is shown in figure 13-23.

Figure 13-23 CMS Provider Approval Report

CMS Approved Provider Report : 01AA

CPT OFFICE	PROVIDER NAME	PROVIDER TYPE	APPROVAL EXPIRATION DATE	STATUS
01AA	EFGH ABCD	Nurse Practitioner		[NO INFORM.]
01AA	efgh abcd	Nurse Practitioner	Monday, January 1, 1900	[OVERDUE]
01AA	efgh abcd	Nurse Practitioner	Tuesday, June 2, 2009	[OVERDUE]
01AA	efgh abcd	Nurse Practitioner	Monday, January 1, 1900	[OVERDUE]
01AA	TERESA GREENQUIST	Nurse Practitioner		[NO INFORM.]
01AA	FKLASDJFKL SHARATH	Nurse Practitioner	Thursday, June 11, 2009	[OVERDUE]
01AA	johnson smith	Nurse Practitioner		[NO INFORM.]
01AA	SHARATH TIGULLA	Nurse Practitioner	Tuesday, June 9, 2009	[OVERDUE]
01AA	RANDALL REESE	Medical Director		[NO INFORM.]
01AA	PAMELA KLEIN	Other Doctor		[NO INFORM.]
01AA	Thomas Mignerey	Other Doctor	Sunday, January 1, 2012	341 DAYS
01AA	Patrick Murray	Other Doctor	Sunday, January 1, 2012	341 DAYS

This report has the following data:

1. **CPT Office** - CPT office to which the provider is assigned.
2. **Provider Name** - First and last name of the provider.
3. **Provider Type** - Shown by job title or profession.

4. **Approval Expiration Date** - The date the provider’s active status will expire.
5. **Status** - The provider’s status with CMS.

13.9 CPT report of STD treatment - Statewide

Using the search screen demonstrated below, users can access statewide data concerning clients receiving STD prophylactic treatment.

Figure 13-24 CPT Report of STD Treatment - Statewide Search

Users only need to enter the date range and click “report” to access this data. The report is shown in the figure below.

Figure 13-25 CPT Cases of STD - Statewide Report

CPT Cases of Sexually Transmitted Disease - State							
1/1/2011 - 12/31/2011							
Printed 5/18/2012 / 1:17:39PM							
CPT Office	Total MEs	MEs with Sexual Abuse Finding		STD Treated		Referral for Follow-Up	
		#	%	#	%	#	%
01AA	1	1	100.00%	0	0.00%	0	0.00%
01BA	2	1	50.00%	5	500.00%	1	20.00%
02AA	8	0	0.00%	0	0.00%	0	0.00%
04AA	2	0	0.00%	0	0.00%	0	0.00%
05AA	1	0	0.00%	0	0.00%	0	0.00%
07AA	1	0	0.00%	0	0.00%	0	0.00%
11AA	1	0	0.00%	0	0.00%	0	0.00%
14AA	1	0	0.00%	0	0.00%	0	0.00%
313A	1	1	100.00%	0	0.00%	0	0.00%
Total	18	3	16.67%	5	166.67%	1	20.00%

This report has the following data:

1. **CPT Office** - CPT office to which the provider is assigned.
2. **Total MEs** - Shows total number of Medical Exams (MEs) for the date range shown on the report for that office.
3. **MEs with Sexual Abuse Finding** - Shows total number of medical exams with a sexual abuse finding for the date range shown for that office
4. **STD Treated** - Shows total number of STDs diagnosed during medical exams for the date range shown for that office.
5. **Referral for Follow-up**- Shows total number of cases referred for a follow up appointment related to an STD diagnosis for the date range shown for that office.

13.10 CPT Training Report

CPTIS will generate reports regarding physician, team, and staff trainings offered by CPT providers. This assists CPT staff and related personnel with tracking training opportunities and requirements. The search screen is shown below.

13-26 CPT Training Search Screen

The screenshot shows a search form titled "Other CPT Training". The form contains the following fields and controls:

- From Date:
- End Date:
- CPT:
- Providers:
- Type of Training:
- Audience:
- CE:
- Hours:
- Clear button
- Report button

Search criteria includes:

1. **Date range** - Time period of data shown.
2. **CPT** - Child Protection Team office by code from a drop down menu.
3. **Providers** - Drop down list of the team providers providing training. Users should select this parameter when searching for a specific provider report.
4. **Type of Training** - Options from the drop down list are Physician, Staff, or Team.
5. **Audience** - Options from the drop down list are ER Medical Person, Other Child Protection Services, or Other Non-Team Medical Personnel. Identifies the type of audience for physician and team trainings.
6. **CE** - Options include "Y" for yes and "N" for no. This field filters trainings that do or do not offer education credits for professionals.

- 7. **Hours** - Allows users to filter by the number of education credit hours a training activity offers.

The following figure is an example of a CPT Training report.

13-27 CPT Training Report

CHILD PROTECTION TEAM: 01AA					
CPT TRAINING REPORT					
From: 01/01/2010 To: 12/31/2010					
Printed 1/26/2011 / 10:57:53AM					
CPT Office: 01AA					
Provider: 1868 - GONZALEZ, PHYLLIS					
<u>Training Date</u>	<u>Activity</u>	<u>CE</u>	<u>Hours</u>	<u>Audience</u>	<u>Comments</u>
01/19/2010	Staff	N	3		Strengthening Families for Childwelfare workers
Provider: 1935 - GREENQUIST, TERESA					
<u>Training Date</u>	<u>Activity</u>	<u>CE</u>	<u>Hours</u>	<u>Audience</u>	<u>Comments</u>
07/09/2010	Physician	N		ER Medical Person	
Provider: 2027 - KAHL, LINDA					
<u>Training Date</u>	<u>Activity</u>	<u>CE</u>	<u>Hours</u>	<u>Audience</u>	<u>Comments</u>
04/28/2010	Staff	N	8		2010 CAC Conference in Niceville, FL
04/29/2010	Staff	N	8		2010 CAC Conference in Niceville, FL

Data provided includes:

1. **CPT Office** - Office the provider is assigned to.
2. **Provider** (if provider specific) - Team individual provider.
3. **Training Date** - Date of the training activity.
4. **Type of Training** - Physician, team, or staff.
5. **CE** - Number of continuing education credits the training activity offers.
6. **Hours** - Number of CE hours the activity offers.
7. **Audience** - Type of professional the training is intended for.
8. **Comments** - Any comments the provider may have included when entering this training into the system.

13.11 Demographic Information by State or by Team

This set of reports is available by state or by team, utilizing two different screens. Both are accessible from the report drop down list on the main menu. CPTIS generates aggregate demographic data for CPT cases which were initiated during the selected date range. The Demographic Information by Team screen allows users to filter demographic information by CPT, as well. Both screens are demonstrated below.

13-28 Demographic Information by State Search Screen

Demographic Information By State	
From Date: <input type="text"/>	End Date: <input type="text"/>
<input type="button" value="Clear"/>	<input type="button" value="Report"/>

13-29 Demographic Information by Team Search Screen

Demographic Information By Team	
From Date: <input type="text"/>	End Date: <input type="text"/>
CPT: <input type="text" value="01AA"/>	
<input type="button" value="Clear"/>	<input type="button" value="Report"/>

To generate a report, enter search criteria and click “report.” A sample Demographic report is shown below. It was pulled using the statewide option. Reports pulled using the team option will only show demographic data for cases assigned to the CPT office selected.

The figure below is a sample of a duplicate demographic report.

13-32 Duplicate Demographic Report

CHILD PROTECTION TEAM Duplicate Demographic Report						
ClientID	Name	DOB	Sex	Fahisnum	Regseqnum	CPT Office
789899090	Tester, Kay	2/1/2000	Female	2010-091010	1	01AA
789899090	Tester, Kay	2/1/2000	Female	2010-110910	1	01AA
789899090	Tester, Kay	2/1/2000	Female	2010-303038	1	01AA
789899090	Tester, Kay	2/1/2000	Female	2010-345345	1	01AA
789899090	Tester, Kay	2/1/2000	Female	2010-345345	2	01AA
789899090	Tester, Kay	2/1/2000	Female	2010-404089	1	01AA
789899090	Tester, Kay	2/1/2000	Female	2010-592138	1	01AA
123456789	Tester, Kay a	2/1/2000	Female	2009-987654	1	01BA
123456789	Tester, Kay a	2/1/2000	Female	2010-000022	1	01BA
123456789	Tester, Kay a	2/1/2000	Female	2010-015264	1	313A

The report provides all client ID numbers in CPTIS with the same name and shows the date of birth, sex, registration sequence number, and CPT office associated with the record.

13.13 Early Steps (ES) Report

This report provides data regarding which terminated clients that met criteria for ES screening received a screening and, if appropriate, were referred to Early Steps. As shown below, the search criterion provides the ability to generate the report by Terminated date or Initial date.

13-33 Early Steps Report Screen

Early Steps Report for Terminated Cases - Statewide

From Date: End Date:

Type of Date: --
--
Termination Date
Initial Date

The report is shown below and includes the following data:

1. **CPT Office** - Indicates CPT office by code.
2. **Total Served** - Total number of clients served by the office, which met age criteria.
3. **Early Steps Enrolled** - Number of clients already enrolled in the Early Steps program.

- 4. **Remaining Clients to be Screened** - Number of clients who either did not receive an assessment or received a medical consult. This # is omitted from the total.
- 5. **Screened** - Number of clients screened by the based on the total clients and percentage.
- 6. **Meets referral criteria/Referred** - Number clients meeting the referral criteria for Early Steps and the percentage this represents of the total number clients served. Also, the number referred to Early Steps and the percentage this represents of the total number clients served.

13-34 Early Steps Report

Early Steps Report for Terminated Cases - Statewide

1/1/2012 - 6/27/2012

Printed: 6/27/2012 / 10:42:38AM

CPT Office	Total Served	Early Steps Enrolled	Remaining Clients to be Screened	Screened		Meets referral criteria		Referred	
				Number Screened	% of Served	Yes			
						#	%	Referred	%
02AA	2	0	2	1	50.00%	1	100.00%	1	100.00%
Total	2	0	2	1	50.00%	1	100.00%	1	100.00%

13.14 All Intakes/Referrals

This report can be generated by Team or State and will display total number of Intakes, Open and Closed.

The search criteria are shown in the figure below.

Figure 13-35 All Intakes/Referrals

All Intakes/Referrals

From Date: End Date:

CPT: 01AA ▾

Report Type: State ▾

The date range indicates the CPT Receive Date. The user can then select to generate the report by Report Type: of State or Team. If 'Team' is selected, the user's CPT Office value will display for the CPT: field. When 'State' is selected, the CPT: field will be ignored on the selection screen.

Figure 13-36 Intakes/Referrals

CHILD PROTECTION TEAM -- 01AA

Intakes/Referrals - BY TEAM

From: 1/1/2013 - 12/31/2013

Printed 8/6/2014 / 1:20:30PM

County	Abuse Reports Received	CPT Abuse Reports Reviewed	Total Intakes	Mandatory						NonMandatory							
				Total	Closed at Intake		Referred for Services		Open		Total	Closed at Intake		Referred for Services		Open	
					#	%	#	%	#	%		#	%	#	%		
Escambia	24	14	23	4	0	0	4	100	0	0	19	2	11	15	79	2	11
Santa Rosa	1	1	1	1	0	0	0	0	1	100	0	0	0	0	0	0	0
Total	25	15	24	5	0	0	4	1	1	19	2	15	2	15	2	2	

13.15 Mandated Reports Not Referred

CPTIS generates a list of cases which meet the mandatory referral criteria but have not been referred to the Child Protection Team. These cases have no CPT “decline for referral” documented. As shown below, the report is pulled according to the date range selected and CPT office.

Figure 13-37 Mandated Reports Not Referred Search Screen

Mandated Reports Not Referred

From Date: End Date:

CPT:

The report, shown below, provides data on each case according to abuse report number.

Figure 13-38 Mandated Reports Not Referred Report

CHILD PROTECTION TEAM: 01BA LIST OF ABUSE REPORTS REQUIRING REFERRAL OR EXCEPTION (MANDATED REPORTS NOT REFERRED) 1/1/2005 - 1/31/2005 Printed 4/26/2005 / 10:39:49AM							
Abuse Report County	DAU	Abuse Report #	Review #	Hotline Date	CPT Received Date	CPT Review Date	Cross Team Case
Okaloosa	013SI4	2005-300214	1	01/01/2005	01/03/2005	01/03/2005	
Okaloosa	013CAC	2005-307254	2	01/14/2005	01/18/2005	01/18/2005	
Okaloosa	013CAC	2005-308194	1	01/14/2005	01/18/2005	01/18/2005	
Okaloosa	013X06	2005-308217	1	01/14/2005	01/18/2005	01/18/2005	
Okaloosa	013X06	2005-308645	1	01/15/2005	01/18/2005	01/18/2005	
Okaloosa	013X06	2005-309477	1	01/18/2005	01/19/2005	01/20/2005	
Okaloosa	013X06	2005-309705	1	01/18/2005	01/19/2005	01/20/2005	
Okaloosa	013SI4	2005-313425	1	01/24/2005	01/25/2005	01/25/2005	
Okaloosa	013CAC	2005-313942	1	01/24/2005	01/26/2005	01/26/2005	
Okaloosa	013SI4	2005-316064	1	01/27/2005	01/28/2005	01/28/2005	
Sub Total		10					
Walton	014X04	2005-305042	1	01/10/2005	01/11/2005	01/11/2005	
Sub Total		1					
TEAM TOTAL		11					

The data in this report includes:

- 1. Abuse Report County** - The county in which the abuse report was assigned for investigation by DCF/SO. (The number of abuse reports which were not referred is subtotaled by county.)
- 2. DAU** - District, Area and Unit assigned by DCF or sheriff's office responsible for child protective investigations.
- 3. Abuse Report #** - Number assigned by the hotline.
- 4. Review #** - Sequence # assigned by CPTIS.
- 5. Hotline Date** - Indicates day on which the abuse hotline received the call.
- 6. CPT Received Date** - Indicates the day on which CPT received the report.
- 7. CPT Review Date** - Indicates the day on which CPT reviewed the report.
- 8. Cross Team Review** - Indicates another team's review.

Important Note: There is a field on the Abuse Review screen labeled "Link to Intake." Please check that field if the other reviews under the same abuse report # have also been referred for intake. This will prevent duplication of cases on this report.

13.16 Medical Assessment Results by State and by Team

This set of reports provides data on terminated cases, specific to the date range specified by the user. Two screens offer CPTIS users access to this information. Both are shown in

the figures below. The search criterion for a statewide report is only the date range. The criteria for the results by team also include the CPT office.

Figure 13-39 Medical Assessment By State Search Screen

Medical Assessment By State

From Date: End Date:

Clear Report

Figure 13-40 Medical Assessment By Team Search Screen

Medical Assessment By Team

From Date: End Date:

CPT: 01AA

Clear Report

The figure below shows a sample of these reports. Both types contain the same information fields.

Figure 13-41 Medical Assessment Results Report

CHILD PROTECTION TEAM									
STATEWIDE MEDICAL RESULTS FOR TERMINATED CASES									
11/1/2011 - 11/30/2011									
Printed 5/1/2012 / 5:34:03PM									
	MEDICAL EXAM RESULTS								
	Number of Medical Exams	FINDINGS							
		Findings		Indeterminate		Subtotal: Findings/Indeterminate		No Findings	
#	#	%	#	%	#	%	#	%	

The information provided includes:

1. **CPT Office by code.**
2. **Number of medical exams completed for the date range.**
3. **Number of exams resulting in physical findings.**
4. **Number of exams resulting in indeterminate findings.**
5. **Subtotal of findings and indeterminate.**
6. **Number of exams resulting in no findings.**

13.17 Overall Assessment Results by State and by Team

These reports provide a summary of assessment results on terminated cases for a specific date range. The reports are generated from two different screens, both accessible from the reports drop down list on the main menu. The figures below demonstrate the search screens. The statewide report search only requires a date range, while the report by team also requires the team be selected from the drop down menu.

13-42 Overall Assessment Results by State Search Screen

Overall Assessment By State	
From Date: <input style="width: 80%;" type="text"/>	End Date: <input style="width: 80%;" type="text"/>
<input type="button" value="Clear"/> <input style="margin-left: 200px;" type="button" value="Report"/>	

13-43 Overall Assessment Results by Team Search Screen

Overall Assessment By Team

From Date: End Date:

CPT:

An example of the report is shown below.

Figure 13-44 Overall Assessment Results Report

CHILD PROTECTION TEAM
STATEWIDE OVERALL TEAM ASSESSMENT
RESULTS FOR TERMINATED CASES
11/1/2011 - 11/30/2011
 Printed 5/1/2012 / 5:44:45PM

CPT	OVERALL TEAM ASSESSMENT RESULTS										
	Number of Overall CPT Assmnts	FINDINGS								No Assessments	
		Abuse/Neglect Indicated		Abuse/Neglect Some Indication		Subtotal: Indicated/Some Indication		Abuse/Neglect Not Indicated			
#	#	%	#	%	#	%	#	%	#	%	

These reports include the following data:

1. CPT office code
2. Number of overall CPT assessments completed during the given time period
Findings:
 3. Number and percent of overall assessments where abuse/ neglect were indicated.
 4. Subtotal # and %age of overall assessments which had some indication of abuse and neglect.
 5. Subtotal # and %age of overall assessments in which abuse/neglect were not indicated.
 6. No Assessment - # of registrations closed during that time period with no assessment being completed.

13.18 Performance Measures by Coordinator, State, and Team

This set of reports provides the compliance rate for the contract performance standards and can be pulled by case coordinator, CPT team, or statewide using different screens accessed on the “reports” drop down list on the main menu.

13-45 Performance Measures Report - Search Criteria

Performance Measures By State	
From Date: <input style="width: 100px;" type="text"/>	End Date: <input style="width: 100px;" type="text"/>
<input type="button" value="Clear"/> <input type="button" value="Report"/>	

These reports contain data in five sections as shown below.

13-46 Performance Measures Report

CHILD PROTECTION TEAMS: 01AA

Performance Measures Report

(All are working days except interim case summary and total number of assessments)

From: 11/1/2011 - 11/30/2011

Printed 5/7/2012 / 10:46:38AM

Case Coordinator:

CaseLoad Status

Interim Case Summary (90%)			
within 20 days		over 20 days	
#	%	#	%

Positive Findings

Verbal Notification (95%)			
within 1 days		over 1 days	
#	%	#	%

Reports

(90%)		(90%)		(90%)		(90%)	
within 10 days		over 10 days		within 10 days		over 10 days	
#	%	#	%	#	%	#	%

(90%)		(90%)		(90%)		(90%)		(90%)	
within 10 days		over 10 days		within 10 days		over 10 days		within 20 days	
#	%	#	%	#	%	#	%	#	%

(90%)		(90%)		(90%)	
within 20 days		over 20 days		within 20 days	
#	%	#	%	#	%

Overall Report Compliance (90%)	
#	%

Assessment Activities

Total Number Assessments	Assessments over 20 days		
	within 20 days	over 20 days NE	over 20 days RFD
#	%	#	#

Staff Training

Number of Training (100%)	
Physician Training	Other/Team Training

Page 1 of 1

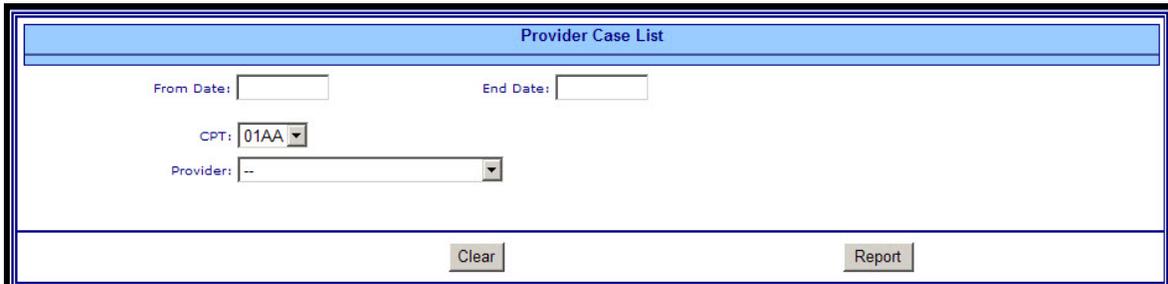
1. **Caseload Status** - This section pulls from the Abuse Report Screen. Abuse Report Review (100% compliance): The date the abuse report is received by the team and the date of the Medical review are compared and number of those reviewed within 4 working days and those reviewed after 4 working days are noted, with the percent of compliance. The report reads those abuse reports received by the team, within the date range selected.
2. **Positive Findings** - For all assessment activities completed within the date range that have positive findings indicated on the assessment screen. This section identifies the number of verbal notifications to DCF/SO within the required 24 hour period and those that were notified after the 24 hour period.
3. **Reports** - This section pulls from the assessment screen and identifies compliance of reports sent within required time frames by comparing the date of the assessment activity to the date the report was sent. Each type of report is identified and the number and percent of those sent within the time frames and those that were not is listed. It then calculates the number of working days and identifies those in and out of compliance by number and percent. Overall Report Compliance is based on the sum of all reports divided by the number of the reports that met the standards.

4. **Assessment Activities Completed within 20 days** - This section pulls from the registration screen and the assessment screen. The “Initiation Date” on the registration screen and the “Assessment Completion Date” on the Assessment screen are compared and the number of days calculated to determine the number of assessments completed within 20 days, over 20 days with a Reason for Delay and those completed after 20 days with No Exception (no reason for delay). The percentages provided, by contract language, compares those completed within 20 days to those completed over 20 days with no exception and provides percentages for both.
5. **Staff Training** - This section pulls from the “Other Activity” section on the menu bar and counts the number of training activities completed within the date range selected, based on the assessment activity date. This section only includes trainings for physician and team.

13.19 Provider Case List

This report lists the detailed information on all cases which had completed assessment activities during the time frame selected as shown in the figure below.

Figure 13-47 Provider Case List Report - Search Criteria



The screenshot shows a web form titled "Provider Case List". It contains the following fields and controls:

- From Date:** A text input field.
- End Date:** A text input field.
- CPT:** A dropdown menu with "01AA" selected.
- Provider:** A dropdown menu with "--" selected.
- Clear:** A button located at the bottom center.
- Report:** A button located at the bottom right.

When users enter the search criteria and click “Report,” CPTIS will generate a report as shown below.

Figure 13-48 Provider Case List Report

CHILD PROTECTION TEAM: 01AA																		
Provider Case List																		
From: 6/1/2005 - 6/30/2005																		
Printed 7/7/2005 / 12:45:31PM																		
1757 - TESSTA, AMY																		
ABUSE REPORT #	LAST NAME	FIRST NAME	INITIAL DATE	TERM DATE	TAS Date	ICS Date	Med Eval	Psych Eval	Nurs Asse	Social Asses	Spec Interv	Foren Interv	Mutil Agency Staff	Team Staff	Med Con	Psych Cons	Legal Cons	Court Act
2005-888888	TESTER	SALLY	6/1/05	6/21/05		6/13/05	0	1	0	0	0	0	0	0	0	0	0	0
TOTAL							0	1	0	0	0	0	0	0	0	0	0	0

This report shows each case by provider and the following fields are included:

1. **Date Range** - Based on date assessment service completed on the assessment screen.
2. **Abuse Report number** - Associated with the case.
3. **Client name** - Name of client who is the subject of the case.
4. **Initial date** - Initiation date on the registration screen.
5. **Termination date** - Termination date on the registration screen.
6. **TAS/ICS date** - TAS has been disabled. ICS-date if 20 day notification of case status.
7. **Type and number of the assessment activities** - Lists number of assessments activities completed for the case during the given date range.

13.20 Provider Report by Team

This report lists the number of assessment activities performed by each provider for the selected CPT, based on service date. The search screen is shown below.

Figure 13-49 Provider Report by Team Search Criteria

Provider By Team	
From Date: <input style="width: 100%;" type="text"/>	End Date: <input style="width: 100%;" type="text"/>
CPT: 01AA <input type="button" value="v"/>	
<input type="button" value="Clear"/>	<input type="button" value="Report"/>

The report generated is demonstrated below.

Figure 13-50 Provider Report by Team Search Criteria

CHILD PROTECTION TEAM: 01AA															
Provider Report															
From: 6/10/2005 - 6/30/2005															
Printed 7/7/2005 / 12:42:17PM															
Provider Name	Med Eval	Psych Eval	Nursing Assess	Social Assess	Spec Interv	Foren Interv	Multi Agency Staff	Team Staff	Court Act	Med Cons	Legal Cons	Psych Cons	Phys Train	Other Train	Total
AMY TESSTA	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
PAM TESTER	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MICHELLE TESTER	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
FUNNY TESTER	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Total	1	1	0	0	2	0	0	0	0	0	0	0	0	0	4

- 1. Date Range** - Based on the date the assessment activity was completed. This information is pulled from the assessment screen.
- 2. Provider Name** - Name of the provider who completed the assessment activities shown.
- 3. Type and number of assessment activities completed by the provider within the date range indicated** - Each type of assessment activity is shown with the number completed by the provider.

13.21 Sample - Case Work, Medical, Psychological

There are three sample reports available in CPTIS, which can be pulled from three different screens. They are accessed from the “Reports” drop down list on the main menu. The purpose of these reports is to assist the Quality Assurance team with desk and on-site reviews. The system uses the criteria show in the figures shown below to pull a random sample of cases.

Figure 13-51 Case Work Sample Report

The screenshot shows a web form titled "Case Work Sample Report -- New". It contains the following fields and controls:

- From Date:
- End Date:
- CPT:
- Provider:
- Sample Size:
- Service Type:
- Overall Finding:

At the bottom of the form are two buttons: "Clear" and "Report".

Figure 13-52 Medical Sample Report

The screenshot shows a web form titled "Medical Sample Report -- New". It contains the following fields and controls:

- From Date:
- End Date:
- CPT:
- Provider:
- Sample Size:
- Service Type:
- Medical Finding:

At the bottom of the form are two buttons: "Clear" and "Report".

Figure 13-53 Psychological Sample Report

The screenshot shows a web form titled "Psychological Sample Report -- New". It contains the following fields and controls:

- From Date:
- End Date:
- CPT:
- Provider:
- Sample Size:
- Service Type:

At the bottom of the form are two buttons: "Clear" and "Report".

Users can select from search criteria including date range, CPT office, provider, sample size, overall or medical findings, and service type. Drop down lists are provided for the user in most fields. Changing the criteria selected will affect the parameters of the sample generated in the report. The samples are completely random.

The report demonstrated below shows a typical Sample Report. It has been pulled using Case Work parameters.

Figure 13-54 Case Work Sample Report

CHILD PROTECTION TEAM CASE WORK												
From: 06/12/1910 To: 12/31/2010												
Sample Size: 150												
CPT Office: 01AA												
Printed 1/28/2011 / 2:15:12PM												
Team	HSn	ClientID	Init Date	Term Date	Overall Finding	Serv Type	Serv Date	Prov ID	Name	Other Serv Type	Coord ID	Coord Name
01AA	2000-019633	AXM010198	2/14/00	3/1/00	7 - Abuse - Not Indicated	FI	3/8/01	1221	CHRIS GEORGE	ME	0001	UNASSIGNED UNAS
01AA	2001-115437	591420200	7/25/01	8/1/01	1 - Abuse Indicated	FI	7/27/01	1025	Stephanie Broadnax		1025	Stephanie Broadnax
01AA	2001-116165	420436783	7/20/01	7/31/01	1 - Abuse Indicated	FI	7/27/01	1025	Stephanie Broadnax	TA	1025	Stephanie Broadnax
01AA	2001-179901	589379511	11/9/01	11/27/01	1 - Abuse Indicated	FI	11/13/01	1026	Sharyl Donnadieu		1026	Sharyl Donnadieu
01AA	2001-183131	593450774	11/14/01	11/19/01	7 - Abuse - Not Indicated	FI	11/19/01	1025	Stephanie Broadnax		1025	Stephanie Broadnax
01AA	2002-080087	591833642	5/16/02	5/17/02	7 - Abuse - Not Indicated	FI	5/17/02	1025	Stephanie Broadnax		1025	Stephanie Broadnax
01AA	2002-084474	436916813	6/11/02	7/5/02	1 - Abuse Indicated	FI	6/25/02	1025	Stephanie Broadnax	P1	1025	Stephanie Broadnax
01AA	2002-088555	055586719	5/31/02	7/5/02	1 - Abuse Indicated	FI	7/5/02	1275	Linda Rowe		1359	Sandra Lucassen
01AA	2002-139263	589830563	9/3/02	9/20/02	4 - Abuse - Some Indication	FI	9/5/02	1275	Linda Rowe	ME	0952	Linda Lee-Edwards

1. **Team** - Refers to the code for the team to which the case is assigned.
2. **FSFN** - Contains the abuse report number (FSFN).
3. **Client ID** - Refers to the client ID on the demographic screen.
4. **Init. Date** - Displays the date the case was initiated.
5. **Term. Date** - Displays the date the case was terminated.
6. **Overall/ Finding** - Shows the overall CPT finding if assessment completed.
7. **Serv. Type** - Demonstrates type of service provided to client.
8. **Serv. Date** - Contains the date the service was provided.
9. **Prov. ID** - Displays the ID number related to the service provider.
10. **Name** - Shows the name of the provider.
11. **Other Serv. Type** - Displays codes for other types of services provided to the client.
12. **Coord. ID** - Shows the ID number of the assigned case coordinator.
13. **Coord. Name** - Displays the name of the assigned case coordinator.

13.22 Summary of Team Activities by State and by Team

This report provides a summary of team assessment activities (and other CPT activities) completed for a specific date range. Report layouts include a statewide summary by child protection team and child protection team data by county. Search criteria is accessed by two screens-one for pulling activities by state and one for pulling activities by team. The only criteria are the date range and the CPT team as shown below.

Figure 13-55 Search Team Activities by State

Team Activities By State

From Date: End Date:

Figure 13-56 Search Team Activities by Team

Team Activities By Team

From Date: End Date:

CPT:

When users enter selection criteria and click “report,” CPTIS generates a report as shown in figure 13-57.

Figure 13-57 Team Activities Report

CHILD PROTECTION TEAM																		
STATEWIDE SUMMARY OF CHILD PROTECTION TEAM ACTIVITIES																		
From : 1/1/2006 - 12/31/2006																		
Printed 7/17/2007 / 5:24:50PM																		
CPT	ASSESSMENT ACTIVITIES													OTHER CPT TRAINING				
	Med Eval	Psych Eval	Nurs Assem	Social Assem	Spec Int	Foren Int	Med Cons	Legal Cons	Psych Cons	Staff Attend	CPT Staff	Court Act	TOTAL and % of State	Phys Train	Staff Train	Other/Team Train	TOTAL and % of State	
01AA #	5	1	0	0	5	0	1	0	0	1	0	0	13	2	17	3	5	
%	38	8	0	0	38	0	8	0	0	8	0	0	8	9	77	14	12	
01BA #	1	2	0	0	3	1	1	1	0	0	0	0	9	0	19	4	4	
%	11	22	0	0	33	11	11	11	0	0	0	0	5	0	83	17	10	
02AA #	2	1	0	0	2	3	0	0	0	1	0	1	10	3	3	0	3	
%	20	10	0	0	20	30	0	0	0	10	0	10	6	50	50	0	7	
02BA #	0	0	0	0	1	0	1	0	0	0	0	2	4	0	3	0	0	
%	0	0	0	0	25	0	25	0	0	0	0	50	2	0	100	0	0	
313A #	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100	2	
313B #	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
04AA #	10	3	0	1	10	8	1	1	0	1	0	3	38	0		0	0	
%	26	8	0	3	26	21	3	3	0	3	0	8	22	0	0	0	0	
05AA #	2	1	1	1	7	1	0	0	0	0	0	0	13	0	4	0	0	
%	15	8	8	8	54	8	0	0	0	0	0	0	8	0	100	0	0	
05BA #	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

The report demonstrates the number of assessment activities and other CPT training activities reported by each team throughout the state of Florida. The value is shown as an actual number of activities, as well as their percentages.

13.23 Telemedicine Report

This report provides a summary of medical evaluations completed via telemedicine equipment for a specific date range. The figure below shows the search criteria screen, which is accessed from the “Reports” drop down list on the main menu.

Figure 13-58 Telemedicine Report Search

Entering a search criteria and clicking “report” generates the following report.

Figure 13-59 Telemedicine Report Search

CHILD PROTECTION TEAM
Telemedicine Report

From Date: 10/01/2010 To Date: 12/31/2010 CPT Office: 01AA

Page 1 of 1
01/28/2011
4:37 PM

COUNTY	# ME	# Telemedicine	% Telemedicine	# Telemedicine By Remote Site	# Telemedicine By Hub Site
ESCAMBIA	81	15	19		
SANTA ROSA	16	3	19		
<u>Remote Site</u> GULF BREEZE				13	
<u>Remote Site</u> MILTON				5	
<u>Hub Site</u> PENSACOLA					18
Totals for all counties	97	18	19	18	18

The report includes the number of medical evaluations and the number of those provided via telemedicine. The report also lists the number of medical evaluations done by telemedicine by remote site and by hub site. Information includes:

1. **Date range** - Based on the assessment completion date within the date range selected for the report.
2. **County** - Identifies the county in which the service was provided.

3. **# Medical Evaluations** - Total number of medical evaluations provided within the date range.
4. **# Telemedicine** - Number of medical evaluations provided via telemedicine
5. **% Telemedicine** - % of medical evaluations provided via telemedicine,
6. **# Telemedicine by Remote Site** - List the number of telemedicine, based on the remote site.
7. **# Telemedicine by Hub Site** - Lists the number of telemedicine, based on the hub site.

SECTION 14: HELP CENTER SCREEN

14.1 Help Center

The CPTIS Help Center allows users to type in data requests for specific ad hoc reports, questions, or concerns related to the website and its functioning. These questions or concerns may be either technical or programmatic. As soon as the request is submitted and received by the program office, it will be reviewed and assigned to the appropriate Child Protection Unit staff. The Help Center screen will be updated to reflect the date it was assigned and to whom. When the question or problem is answered or the data provided, a notification e-mail will be sent to the user.

Users can click on the “Help Center” link on the main menu, shown below, to access this section of the website.

Figure 14-1 CPTIS Help Center

The screenshot shows a web application menu titled "Menu". At the top, it says "Welcome Jennifer Brittenham". Below this are several radio button options: "Abuse Review" (selected), "Intake/Referral", "Demographic", "Registration", "Assessment", "Report Summary", and "Assessment Reports". There is a dropdown menu below these options. Below the dropdown is a text input field, a "New" checkbox, and a "GO!" button. The menu is divided into sections: "Other CPT Training" with a text input, "New" checkbox, and "GO!" button; "Provider" with a text input, "New" checkbox, and "GO!" button; and "Reports" with a dropdown menu. At the bottom of the menu are several links: "Help Center" (highlighted in blue), "System Guide", "Code Maintenance", "Help Maintenance", "User Options", "Sexual Abuse Treatment Program", and "Logout".

14.2 Help Center Search

By clicking on the Help Center link, users will access the Help Center Search screen shown below.

Figure 14-21 Help Center Search

The screenshot displays the 'SEARCH HELP CENTER' interface within the 'CHILD PROTECTION TEAM INFORMATION SYSTEM'. The interface includes a navigation menu on the left and a central search form. The search form contains the following fields and controls:

- Request ID:** A text input field.
- Category:** A dropdown menu with '[Select One]' as the current selection.
- Request Type:** A dropdown menu with '[Select One]' as the current selection.
- Screens/Reports Affected:** A dropdown menu with '[Select One]' as the current selection.
- Requested By:** A text input field auto-populated with 'Jennifer Brittenham'.
- Date Requested:** A range input field with 'To:' and a date selection box.
- Assigned To:** A text input field auto-populated with 'Jennifer Brittenham'.
- Priority:** A dropdown menu with '[Select One]' as the current selection.
- Status:** A dropdown menu with '[Select One]' as the current selection.

At the bottom of the search form are two buttons: 'Search' and 'New Help Request'. The left-hand menu includes options such as 'Abuse Review', 'Intake/Referral', 'Demographic', 'Registration', 'Assessment', 'Report Summary', 'Assessment Reports', 'Other CPT Training', 'Provider', 'Reports', 'Help Center', 'System Guide', 'Code Maintenance', 'Help Maintenance', 'User Options', 'Sexual Abuse Treatment Program', and 'Logout'.

The following search parameters are included on this screen:

1. **Request ID** - A number automatically generated by the system, and also used as a ticket number for the user's request. Note this number for future reference.
2. **Category** - Users can select from options in the drop down menu, including "Technical" and "Programmatic."
3. **Request Type** - Users can select characteristics of the request from the drop down menu, including Enhancement, Correction, Question Resolution, or Ad Hoc Request.
4. **Screens/Reports Affected** - Select a screen from drop down box. Only one screen can be selected.
5. **Requested By** - Field auto-populates based on user ID.
6. **Date Requested** - Enter the date of the request. If the problem is on-going, include a date range.
7. **Assigned to** - Field will auto-populate based on who is assigned the help request.
8. **Priority** - Users can assign a priority to the request from the drop down menu.
9. **Status** - Users can select a status from the drop down menu.

To review an existing record, enter a request ID and click "Search." This will bring you to a search result.

Figure 14-3 Help Center Search Results

The search results will appear, showing any information in the system on the request. If an authorized user, from the program office, has entered information following up on the request, it will show on this screen as well.

14.3 Help Center Screen Instructions for Data Entry

In order to add a new request, go to the menu bar on the left, and click on Help Center. Click the button “New Help Request” to access the screen below.

Figure 14-4 Help Center New Requests

Users can fill out the Help Center request. The basic information to generate a help request to the program office includes the following:

1. **Request ID** - A number automatically generated by the system, and also used as a Ticket No. for your request.
2. **Category** - Including Technical and Programmatic.
3. **Request Type** - Characteristics of the request, such as Enhancement, Correction, Question Resolution and Ad Hoc Request.
4. **Screens/Reports Affected** - Select from drop down box which screen(s) you are identifying for your Help request.

5. **Requested By** - The requestor's name.
6. **Date Requested** - Date of request.
7. **E-mail** - Requestor's email address.
8. **Description** - Short narrative of the requested data or problem experienced by the team.

When you finish, click the "Send Request" button. The request will be sent to the CMS program office where, once it is received, it will be assigned to the appropriate program office staff. You will receive a message at the top of the screen indicating the start date and time the request record was created as shown below.

Figure 14-5 Help Center New Requests

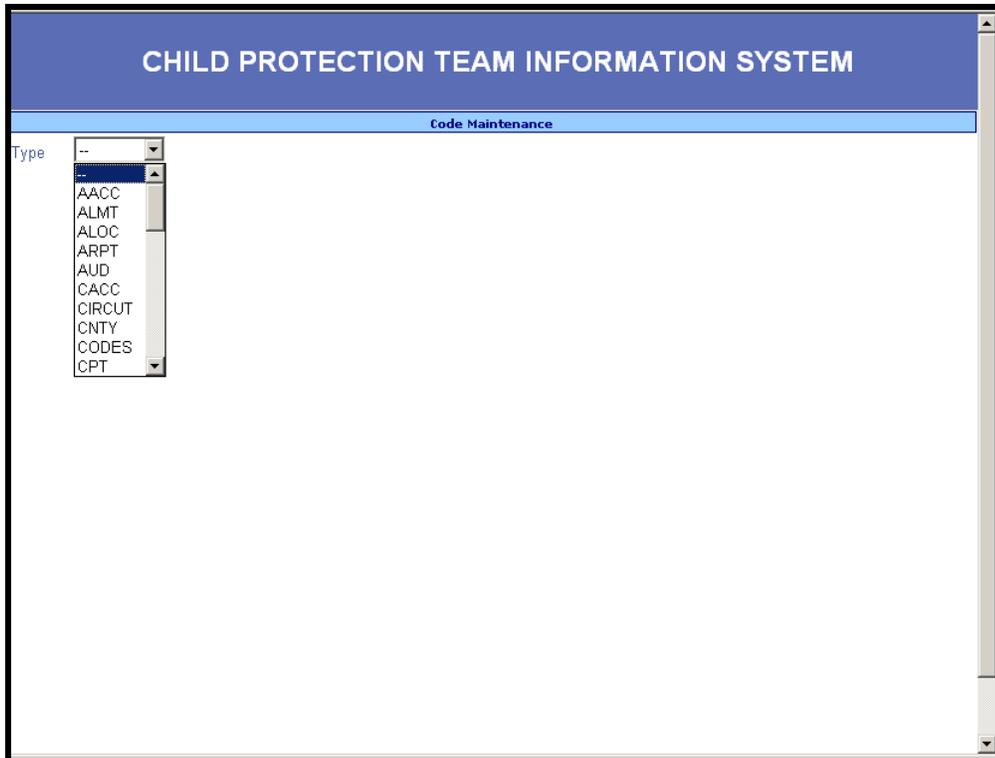


When the request is followed up on by the program office, authorized users will enter information into the bottom part of the New Request screen.

SECTION 15: CODE MAINTENANCE SCREEN

Code Maintenance allows authorized users, such as system administrators to edit existing or create new drop down options for the associated fields on each of the screens in CPTIS.

Figure 15-1



System administrators will receive specialized training on this section of CPTIS.

SECTION 16: HELP MAINTENANCE SCREEN

The Help Maintenance screen allows authorized users, such as system administrators to edit existing or create new “tool tips” for the associated fields on each of the screens that are contained in CPTIS. Tool tips are the field descriptions that automatically appear as a user “hovers” their cursor over a field label.

Figure 16-1 Help Maintenance Screen

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. At the top left is the 'Florida's Health' logo. The main header is blue with the text 'CHILD PROTECTION TEAM INFORMATION SYSTEM'. Below the header is a 'Menu' sidebar on the left with the following items: Welcome Jennifer Brittenham, Abuse Review (selected), Intake/Referral, Demographic, Registration, Assessment, Report Summary, Assessment Reports, Other CPT Training, Provider, Reports, Help Center, System Guide, Code Maintenance, Help Maintenance, User Options, Sexual Abuse Treatment Program, and Logout. The main content area is titled 'Help Maintenance' and contains a 'Table of Contents' dropdown menu, 'Screen Name:' and 'Field Name:' input fields, a large text area for 'Help Text: (max 1000 characters)', and three buttons: 'New', 'Update', and 'Delete'.

System administrators will receive special training on this section of CPTIS.

SECTION 17: TRAINING VIDEOS

The Training Videos menu link will navigate the user to a screen where training videos will be available based on the user's access level. The videos will be in .mp4 format and should play in most media players. An option to save the videos to the user's computer may also be provided. The videos will be updated periodically based on enhancements to CPTIS.

The screenshot displays the 'CHILD PROTECTION TEAM INFORMATION SYSTEM' interface. The top header includes the Florida Department of Health logo and the system title. The main content area is divided into two columns: 'Menu' and 'Training Videos'.

Menu Column:

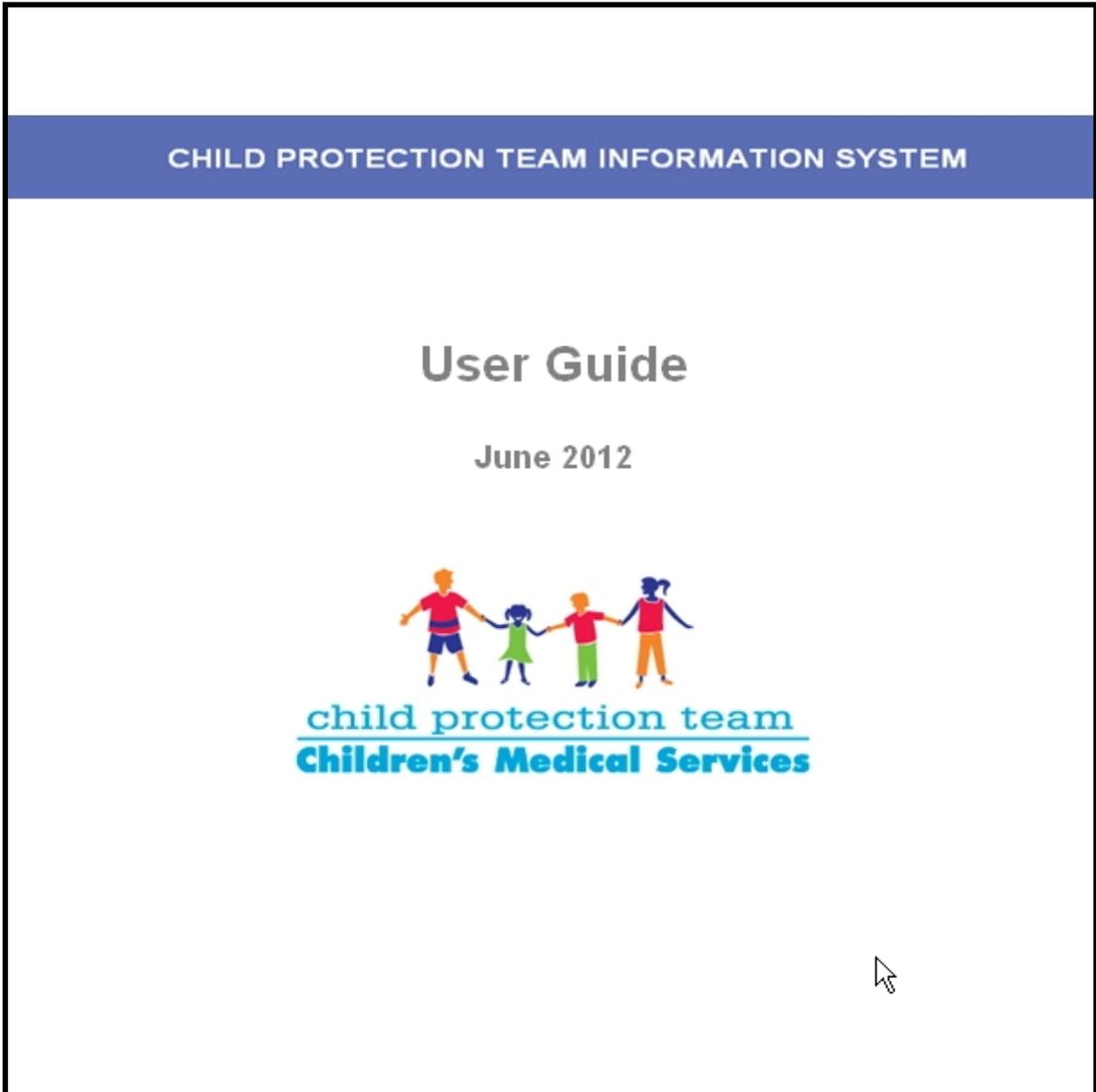
- Welcome Travis McLane
- Abuse Review (selected)
- Intake/Referral
- Demographic
- Registration
- Assessment
- Report Summary
- Assessment Reports
- Search dropdown: --
- Input field with 'New GO!' button
- Other CPT Training
- Input field with 'New GO!' button

Training Videos Column:

- CPT Videos
 - CPTIS_AbuseReportReview.mp4
 - CPTIS_Assessments.mp4
 - CPTIS_CaseProgressNotes.mp4
 - CPTIS_Demographic.mp4
 - CPTIS_FinalCaseSummary.mp4
 - CPTIS_IntakeReferral.mp4
 - CPTIS_Overview_2012.mp4
 - CPTIS_Registration.mp4
- SATP Videos
 - SATIS_Overview_2012
- DCF Videos
 - CPTIS_DCF_2012.mp4

SECTION 18: CPTIS USER MANUAL

The latest version of the CPTIS User Manual will launch into view when a user clicks on the “System Guide” link on the main menu. Users can save a copy of the manual as a PDF file and reference as needed.



Appendix I

Report Review Screen

_____	Review Number: _____
_____ (See Table Below)	Abuse Report County: _____ (Print County Name)
_____ (MM/DD/YYYY)	CPT Receive Date: _____ (MM/DD/YYYY)
_____ (MM/DD/YYYY)	Mandatory Referral Criteria: Yes No (Circle One)
	Non-Caretaker Report: <input type="checkbox"/> (Check if appropriate)
_____ (MM/DD/YYYY)	Medical Evaluation Required: Yes No M – Med. Needed (Circle One)
_____	Cross Team Review: _____ (CPT Office Code)
_____ (Check if applicable)	
Referral Declined: <input type="checkbox"/>	Date Referral Declined: _____ (MM/DD/YYYY)
_____ (Characters)	Linked To Abuse Review: _____ ADD
_____	(Abuse Rep.#) (Sequence #)

CPT Office Codes		
01AA	06AA	09AA
01BA	06BA	10AA
02AA	07AA	11AA
02BA	07BA	12AA
313A	05BA	13AA
313B	07CA	13BA
04AA	08AA	14AA
05AA	08BA	15AA
05BA	08CA	

Referral Declined Reason
Late Referral
PI Report Closed

Demographic Screen

Client ID: _____	Name: _____	Last	First	Mid. Init.
	AKA: _____			
Address: _____				
City: _____	State: _____ (Write State Name/Initials)	Zip: _____		
County: _____ (Write County)	Country: _____ (Country Initials)	Phone: (____) ____ - _____		
Date of Birth: _____ (MM/DD/YYYY)	Verification of DOB: _____ (See Table Below)	Date of Death: _____ (MM/DD/YYYY)		
Sex: _____ (See Table Below)	Race: _____ (See Table Below)	Ethnicity: _____ (See Table Below)		
Disability: _____ (See Table Below)				
Comments: (max. 255 characters)				

Verification
Declared
Estimated
Verified

Sex
Male
Female
Unknown

Race
Asian
Black
Bi-racial
Native American (American Indian or Alaskan Native)
Pacific Islander
Unknown
White

Ethnicity
Hispanic
Haitian
Other
Unknown

Disability
Yes
No
Unknown

Intake/Referral Screen

TEAM/CLIENT INFORMATION

Case Coordinator Completion Date: _____ **Case Coordinator:** _____

Referral Date: _____ **Referral Source:** _____ (See Table Below)

Law Enforcement Report #: _____ CPI/CBC Name: _____

Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ Sex: _____ Race: _____ Ethnicity: _____
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ Sex: _____ Race: _____ Ethnicity: _____
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ Sex: _____ Race: _____ Ethnicity: _____
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ Sex: _____ Race: _____ Ethnicity: _____

(See Tables Below)

Cross Team: 2nd CPT Office: _____
(See Table Below)

FAMILY INFORMATION

Client ID: _____ First Name: _____ Last Name: _____ Relationship: _____
Client ID: _____ First Name: _____ Last Name: _____ Relationship: _____
Client ID: _____ First Name: _____ Last Name: _____ Relationship: _____
Client ID: _____ First Name: _____ Last Name: _____ Relationship: _____

(See Table Below)

REASON FOR REFERRAL

ALLEGED MALTREATMENTS

Alleged Maltreatment: _____ Type: _____
Alleged Maltreatment: _____ Type: _____
Alleged Maltreatment: _____ Type: _____
Alleged Maltreatment: _____ Type: _____

(See Table with Registration Screen)

(See Table with Registration Screen)

IDENTIFIED ISSUES

Substance Misuse:

Domestic Violence:

Criminal History:

Mental Health:

Child 0-6 years:

Intake/Referral Screen
(CONTINUED)

MEDICAL

Medical Evaluation Needed:

Medical Evaluation Exception Reason: _____
(See Table Below)

Specify Reason for Exception to Medical Evaluation:

PRIORS

ASSESSMENT DECISION

Needed Assessment: _____

Schedule Date: _____ (MM/DD/YYYY)

Needed Assessment: _____

Schedule Date: _____ (MM/DD/YYYY)

Needed Assessment: _____

Schedule Date: _____ (MM/DD/YYYY)

(See Table Below)

Documentation of Intake/Referral Decision:

Physician Review Date: _____ Physician Concur: Supervisor Review Date: _____

Closure Date: _____

Closure Reason: _____

(See Table Below)

**Intake/Referral Screen
(CONTINUED)**

ADDENDUM	
Case Coordinator: _____	Referral Date: _____ Addendum Closure Date: _____
Documentation of Reason for Addendum:	
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ MI: _____ Sex: _____ Race: _____ Ethnicity: _____	
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ MI: _____ Sex: _____ Race: _____ Ethnicity: _____	
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ MI: _____ Sex: _____ Race: _____ Ethnicity: _____	
Client ID: _____ DOB: _____ First Name: _____ Last Name: _____ MI: _____ Sex: _____ Race: _____ Ethnicity: _____	

Referral Source
Description
CBC Case Manager
DCF/Other
Hospital
Protective Investigator
Law Enforcement
Other
Private Physician

Race
Asian
Black
Bi-racial
Native American (American Indian or Alaskan Native)
Pacific Islander
Unknown
White

Ethnicity
Hispanic
Haitian
Other
Unknown

Medical Eval Exception
Examined by Other Physician
DCF
SO
CPT Physician Exception

Relationship
Aunt
Father
Family Foster
Guardian
Grandfather
Grandmother
Mother
Other Relative
Other
Sibling
Stepfather
Stepmother
Unknown
Uncle

Activity Type	
Court Activities	Social Assessment
CPT Staffing	Spec. Int.(C) – Soc. Assess.
Forensic Interview	Spec. Int.(C) – Soc. Assess.
Legal Consultation	
Medical Consultation	
Medical Evaluation	
Nursing Assessment	
Psychological Consultation	
Psychological Eval - Child	
Psychological Eval. - Other	

Closure Reason
Child Not located
No Assessment Due to Late Referral
No Assessment Needed Closed After Intake
No Jurisdiction

Registration Screen

Client ID: _____

Abuse Report #: _____

CPT Office: _____ (See Table Below)

2nd CPT Office: _____ (See Table Below)

Child's County: _____ (Write County)

Early Steps Screened: Positive screen
(Check if completed)

Write Client ID and attach demographic sheet for each one

Client ID: _____
Client ID: _____
Client ID: _____
Client ID: _____

Alleged Maltreatment (See Attached Code Table)

#1 _____
#2 _____
#3 _____
#4 _____
#5 _____
#6 _____

Assessed Maltreatment (See Attached Code Table)

#1 _____
#2 _____
#3 _____
#4 _____
#5 _____

Referral Date: _____ (See Table Below) CPI/CBA Name _____

Coordinator: _____ (Write Name) Cross Team

2nd Coordinator: _____ (Write Name) Switch Team

Referral Source: _____ 2nd Referral Source _____
(See Table Below) (See Table Below)

Early Steps Referred: (Check if referred) Already enrolled in ES Program

Family Information

Relationship (See Table Below)

Maltreatment Type (See Table)

Termination Date: _____

Comments: (max. 500 characters)

Overall CPT Assessment: _____	_____
(See Table Below)	_____
Date ICS Sent to PI _____	_____

Date FCS Sent to PI _____	_____

Registration Screen (con't)

CPT Office Codes	
01AA	07CA
01BA	08AA
02AA	08BA
02BA	08CA
313A	09AA
313B	10AA
04AA	11AA
05AA	12AA
05BA	13AA
06AA	13BA
06BA	14AA
07AA	15AA
07BA	

Maltreatment Type	
Code	Description
1	Abuse
2	Neglect
3	Threatened Harm

Assessed Malt. Finding and Overall CPT Assessment	
Code	Description
1	Abuse Indicated
2	Neglect Indicated
3	Threat indicated
4	Abuse – Some Indication
5	Neglect – Some Indication
6	Threat – Some Indication
7	Abuse – Not Indicated
8	Neglect – Not Indicated
9	Threat – Not Indicated
10	Not Assessed

Relationship
Aunt
Father
Family Foster
Guardian
Grandfather
Grandmother
Mother
Other Relative
Other
Sibling
Stepfather
Stepmother
Unknown
Uncle

Referral Source
Description
CBC Case Manager
DCF/Other
Hospital
Protective Investigator
Law Enforcement
Other
Private Physician

Registration Screen (con't)

CPT Maltreatment Codes		
Codes	Category	Detail
011	Burns	Cigarette
012	Burns	Other Object
013	Burns	Scald Immersion
014	Burns	Scald Non-Immersion
019	Burns	Other
021	Bruises	Linear Marks/Indication of Strike by Object
022	Bruises	Hand Print
023	Bruises	Head (face, black eye, etc.)
029	Bruises	Other
030	Child – on - Child	Sexual Abuse Referral
031	Fracture	Skull
032	Fracture	Single Fracture Other Than Skull
033	Fracture	Multiple-Same Age
034	Fracture	Multiple-Different Age
039	Fracture	Other
041	Head Injury	Concussion
042	Head Injury	Epi or Sub-dural Hemotoma
043	Head Injury	Intraventricular Homorrhage
044	Head Injury	Retinal Hemorrhage
045	Head Injury	Whiplash-Shaking Syndrome
049	Head Injury	Other
050	Physical Injury	History only, Without Apparent Injury
061	Physical Injury	Cuts/Punctures/Bites
062	Physical Injury	Dislocation
063	Physical Injury	Internal Injuries
070	Physical Injury	Asphyxiation/Suffocation/Drowning
080	Physical Injury	Deadly Weapon
090	Physical Injury	Other
091	Physical Injury	Munchausen’s Syndrome by Proxy
112	Sexual Battery (Incest)	Penile Penetration, Vaginal
113	Sexual Battery (Incest)	Oral Penetration, Vaginal
114	Sexual Battery (Incest)	Digital Penetration
115	Sexual Battery (Incest)	Anal Penetration
116	Sexual Battery (Incest)	Anal/Vaginal Penetration, Object
118	Sexual Battery (Incest)	Veneral Disease
119	Sexual Battery (Incest)	Other
121	Sexual Exploitation	Solicitation
122	Sexual Exploitation	Sexual Exposure of Adult to Child
123	Sexual Exploitation	Exposing Child to Pornography
124	Sexual Exploitation	Participation in Pornography
125	Sexual Exploitation	Child Required to Witness Sexual Acts
129	Sexual Exploitation	Other
131	Sexual Abuse	Other Child Sexually Abused

Registration Screen (con't)

CPT Maltreatment Codes (continued)		
Code	Category	Detail
143	Sexual Molestation	Fondling
148	Sexual Molestation	Veneral Disease
149	Sexual Molestation	Other
152	Sexual Battery (Not Incest)	Penile Penetration, Vagina
153	Sexual Battery (Not Incest)	Oral Penetration, Penis
154	Sexual Battery (Not Incest)	Digital Penetration, Vagina
155	Sexual Battery (Not Incest)	Anal Penetration
156	Sexual Battery (Not Incest)	Anal/Vaginal Penetration, Object
158	Sexual Battery (Not Incest)	Veneral Disease
159	Sexual Battery (Not Incest)	Other
211	Mental Injury	Persistent Atmosphere of Humiliation
212	Mental Injury	Unrealistic Expectations
221	Mental Injury	Failure to Provide Caring Environment
222	Mental Injury	Inappropriate/Excessive Restraints (Facility)
223	Mental Injury	Inappropriate/Excessive Isolation (Facility)
224	Mental Injury	Confinement/Bizarre Punishment
229	Mental Injury	Other
241	Substance Abuse	Physically Drug Dependent Newborn
242	Substance Abuse	Substance Misuse
243	Substance Abuse	Substance Exposed Child
244	Substance Abuse	Poisoning
251	Inadequate Supervision	Hazardous Environment
252	Inadequate Supervision	Parent/Caretaker Absent
253	Inadequate Supervision	Parent/Caretaker Present
312	Inadequate Food	Lack of Proper Nutrition
313	Inadequate Shelter	Lack of Appropriate Living Conditions
314	Inadequate Clothing	Lack of Appropriate Clothing
319	Environmental Neglect	Conditions Hazardous to Health
321	Medical Neglect	Ignoring Recommended Treatment
322	Medical Neglect	Failure to Bring Child for Medical Attention
329	Medical Neglect	Other
350	Lack of Health Care	Malnutrition (diagnosed)
431	Failure to Thrive	Lack of Child Rearing Skills
432	Failure to Thrive	Improper Formula Preparation
433	Failure to Thrive	Psychogenic Etiology (Non-organic)
434	Failure to Thrive	Organic Etiology
439	Failure to Thrive	Other
440	Threatened Harm	Domestic Violence
450	Failure to Protect	From Inflicted Injury
480	Death	Death Due to Abuse/Neglect
481	Death	Other Child Dead Abuse/Neglect

Assessment Activity Screen

Client ID: _____ (Print client ID) CPT Office: _____ (See Table Below) Provider: _____ (Write Name) Completed Date: _____ (MM/DD/YYYY) Court Activity Type: _____ (See Table Below) Medical Exam/Consult Physical Findings: _____ Medical Exam/Consult Neglect Findings: _____ Date report sent to PI: _____ (MM/DD/YYYY) Positive Findings Date: _____ (MM/DD/YYYY) Handbook Requirement Not Met: <input type="checkbox"/> Comments: _____ _____ _____ _____ _____	Last Name: _____ First Name: _____ Assessment Type: _____ (Choose <u>Assessment</u> or <u>Link</u>) Activity Type: _____ (See Table Below) County of Service Provision: _____ Location: _____ (See Table Below) Wait Time: _____ (1 hour and then show 30 minute increments) Medical Exam/Consult Sexual Findings: _____ (See Table Below for Finding Codes) Reason for Delay: _____ (See Table Below) Verbal Notification Date: _____ (MM/DD/YYYY) Telemedicine: <input type="checkbox"/> Remote Site: _____ (See Table Below) Remote Provider: _____ (Write Name of Medical Provider at the Remote Site) Hub Site: _____ (See Table Below)
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Assessment Activity Screen (con't)

STD Assessment

Sexual Activity within 60 days	Signs and Symptoms
<input type="checkbox"/> Yes	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> No	<input type="checkbox"/> Discharge
<input type="checkbox"/> Undetermined	<input type="checkbox"/> Edema of genitals
	<input type="checkbox"/> Erythema of genitals
Presumptive Diagnosis	<input type="checkbox"/> Genital itching
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Genital odor
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Genital or anal bleeding
<input type="checkbox"/> Herpes	<input type="checkbox"/> Genital pain
<input type="checkbox"/> Other	<input type="checkbox"/> Genital ulcers or lesions
<input type="checkbox"/> Syphilis	<input type="checkbox"/> NONE
	<input type="checkbox"/> Urinary symptoms
Treatments	Pregnancy Test
<input type="checkbox"/> Azithromycin PO 1gram	<input type="checkbox"/> Administered – Positive Result
<input type="checkbox"/> Ceficime (Suprax) PO 400mg	<input type="checkbox"/> Administered – Negative Result
<input type="checkbox"/> Metronidazole (Flagyl) PO 2 grams	<input type="checkbox"/> Not Administered
<input type="checkbox"/> None	
Specimens Collected	Referred To:
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Community Health Center
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Community Health Department
<input type="checkbox"/> Herpes	<input type="checkbox"/> Private Doctor
<input type="checkbox"/> HIV	
<input type="checkbox"/> Other	Date/Time of Medical Services: _____
<input type="checkbox"/> Syphilis	

CPT Office Codes	
01AA	07CA
01BA	08AA
02AA	08BA
02BA	08CA
313A	09AA
313B	10AA
04AA	11AA
05AA	12AA
05BA	13AA
06AA	13BA
06BA	14AA
07AA	15AA
07BA	

Activity Type	
Court Activities	Psychological Eval - Child
CPT Staffing	Psychological Eval. - Other
Forensic Interview	Social Assessment
Legal Consultation	Spec. Int.(C) – Soc. Assess.
Medical Consultation	Spec. Int.(C) – Soc. Assess.
Medical Evaluation	Specialized Inter. - Child
Nursing Assessment	Specialized Inter. - Other
Psychological Consultation	Staffing Attended

Location
Attorney’s Office
County Health Unit
Court House
CPT Office
DCF/SO Office
Emergency Room
Hospital In-Patient
Other
Physician’s Office
Telemedicine Site

Medical Findings
Findings
Indeterminate
Not Applicable
No Findings

Court Activity Type
Court Testimony - Criminal
Court Testimony - Dependency
Disposition – Criminal
Deposition - Dependency
Subpoena and court wait of 1 hour or more

Reason for Delay
Additional Referral/Assessment
Assessment no-show
Late – No Exception
Medical No-show
Post-Termination
Waiting for Medical Records

Remote Site	
Bartow	Lecanto
Beverly Hills	Leesburg
Brooksville	Marathon
Bushnell	Milton
Defuniak Springs	Ocala
Gainesville	Palatka
Gulf Breeze	Sebring
Key West	Tavernier
Lake City	Tiger Point

Hub Site	
Bartow	Miami
Brooksville	Niceville
Gainesville	Ocala
Jacksonville	Pensacola

Provider Screen

Provider ID: _____ **Last Name:** _____ **First Name:** _____ **CPT Office:** _____
Address: _____ **Type:** _____ (See Table Below)
City: _____ **State:** _____ **Zip:** _____
Phone: _____ (###-###-####) **County:** _____ (Write County Name or Initials)
 (12 characters only) Active (Check if provider active/uncheck if provider not active)
CMS Approval Expiration Date: _____ (MM/DD/YYYY)

Provider Type			
Code	Description	Code	Description
AR	Advanced Registered Nurse Practitioner	OT	Other
AT	Attorney	PA	Physician's Assistant
CC	Case Coordinator	PS	MD, Psychiatrist
MD	Team Medical Director	PY	Psychologist
NU	Nurse	TC	Team Coordinator
OD	Other MD	TH	Therapist/Social Worker
VO	Volunteer		

CPT Office Codes		
01AA	06AA	09AA
01BA	06BA	10AA
02AA	07AA	11AA
02BA	07BA	12AA
313A	05BA	13AA
313B	07CA	13BA
04AA	08AA	14AA
05AA	08BA	15AA
05BA	08CA	

Other CPT Training Screen

CPT Office Code: _____ (See Table Below)	Presenter/Attendee: _____
Type of Training: _____	Training Date: _____ (MM/DD/YYYY)
CE: _____ Hours: _____	Audience: _____ (See Table Below)
Comments: (Please state the Specific Training Topic and Audience)	

CPT Office Codes	
01AA	07CA
01BA	08AA
02AA	08BA
02BA	08CA
313A	09AA
313B	10AA
04AA	11AA
05AA	12AA
05BA	13AA
06AA	13BA
06BA	14AA
07AA	15AA
07BA	

Type of Training
Physician
Staff
Team

AUDIENCE
ER Medical Person
Other Child Protection Services
Other Non-Team Medical Personnel

I. Purpose/General Description

- The purpose of this SOP is to outline the procedures for adding new non-FDOH user CPTIS accounts. These accounts will be limited, *read only* access.

II. Requirements

- Name and contact information for non-FDOH user.
- Access to SSO Database (Security Access Manager 2.0).
- Access to TRAIN Florida for non-FDOH user.
- FDOH Information Security and Privacy Awareness Training Certificate.

III. Procedure Operation

- CPT team staff coordinates the collection of contact information from their local, DCF counterpart.
- CPT team submits the following information to the Bureau of CPT/ST, CPTIS Help Desk for the non-FDOH user(s), currently *only* DCF.
 - Name and Contact information for each DCF user. Following information needed: Last Name, First Name, Middle Initial, DCF Email Account, Title, Department, Office, Phone#, Office Street Address, City, State, and Zip Code.
- CPTIS Help Desk representative will create TRAIN Florida accounts and reply to each DCF user(s) with their TRAIN Florida account information and directions for accessing and completing the required FDOH Information Security and Privacy Awareness Training.
- CPT team submits the following information to the Bureau of CPT/ST, CPTIS Help Desk for the non-DOH user(s), currently *only* DCF.
 - DOH Information Security Training form certifying user completed FDOH Information Security Training. See the following step regarding TRAIN Florida
- Once the required FDOH Information Security Training certificate(s) have been submitted, the CPTIS Help Desk representative will create the new Single Sign-On account for each new DCF user.

- **For DCF users...**Log-in to the Security Access Manager 2.0 application and add a new non_FDOH user SSO account for **Single Sign-On (SSO)** for CPTIS so that the user can access CPTIS. (**Note:** an email should be automatically sent to the DCF user from FDOH IT asking the user to confirm access to SSO. Once this has been completed, that account will be included in an overnight 'batch' job that will create the SSO/CPTIS link and allow the DCF user access to CPTIS. Follow-up with the DCF user the next day to confirm they can access CPTIS.)

IV. Reports/Data Delivery Points

- Local CPT follows up with their DCF counterpart in their area to confirm new user(s) can access CPTIS.
- At routine intervals (6 months, 12 months), CPTIS Help Desk staff will generate a list of active DCF user CPTIS accounts and submit to the local CPT to verify user(s) status with their local DCF counterpart.

V. Location of Other Supporting Documentation

- There is no other supporting documentation for this procedure

- VI. **Assessment Reports currently available to DCF users.** Note: access to an assessment report is only available once the report is complete. (Specialized Interview, Forensic Interview, CPT Staffing, Social Assessment, Nursing Assessment, Specialized Interview/Social Assessment, and *Medical Evaluation when available in Production*)

The screenshot displays the user interface for the CHILD PROTECTION TEAM INFORMATION SYSTEM. At the top left is the Florida's Health logo with the text 'The Florida Department Of Health'. The main header is a dark blue bar with the text 'CHILD PROTECTION TEAM INFORMATION SYSTEM' in white. On the left side, there is a 'Menu' section with a light blue header. Below the header, it says 'Welcome Travis McLane'. The menu items are: 'Abuse Review' (selected with a radio button), 'Intake/Referral', 'Demographic', 'Report Summary', and 'Assessment Reports' (highlighted in yellow). Below these is a dropdown menu with a list of options: 'Specialized Interview', 'Forensic Interview', 'CPT Staffing', 'Social Assessment', 'Nursing Assessment', 'Spec Int/Soc Assess.', and 'Medical Evaluation'. Further down are sections for 'Training Videos', 'System Guide', 'User Options', and 'Logout'. The main content area features a graphic of four children holding hands, with the text 'child protection team' in blue and 'Children's Medical Services' in bold blue below it. At the bottom right, there is a small text 'CPT Version ('.