

# **Home Based Primary Care User Manual**



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**Department of Veterans Affairs  
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Product Development**



## Revision History

Date	Patch #	Page	Description	Project Manager	Technical Writer
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# I. Introduction

## Overview

The Home Based Primary Care (HBPC) package formally known as Hospital Based Home Care (HBHC) is a VISTA application developed for use by the HBPC Programs at the medical centers. The software:

- Allows the entry and storage of information on all Evaluations/Admissions,
- Scans Outpatient Encounters for all HBPC visits and stores the visit data,
- Allows the entry and storage of HBPC Discharge information,
- Provides reports covering all aspects of the data,
- Informs the staff when incomplete records for transmission are found,
- Transmits the data to Austin using MailMan.

## Package Management

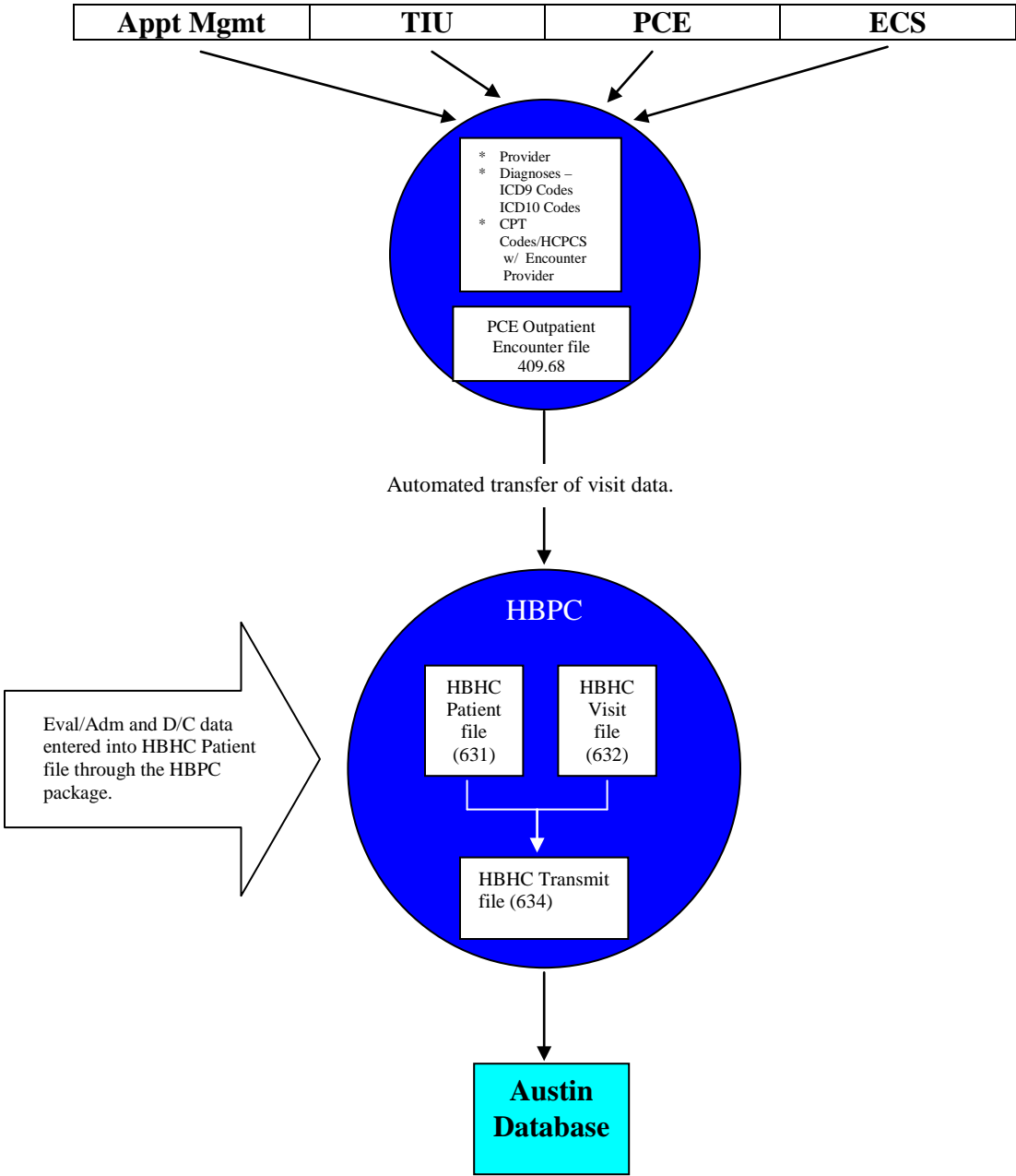
There are no known legal requirements associated with the HBPC software.

## Application Coordinator

The Application Coordinator sets up and maintains the data used by the package. At some sites, this same person may also be given the responsibility to assign menus and keys to new users. Generally, this person trains new users and troubleshoots any problems that arise with the software. (See [Implementing and Maintaining the Software](#))

Note: Some sites do not give users the ability to cancel an appointment or delete a checkout. At those sites, the Application Coordinator should assume that responsibility.

# HBPC Data Flow Chart



## II. Implementing and Maintaining the Software

This chapter is designed for the HBPC Application Coordinator who is responsible for the implementation and maintenance of the software. Implementation entails the compilation of specific information that will be added to the package's database after the package is installed. The information includes who will be using the package, which menus and keys they should own, and other data that is required for use in the package (clinics, teams, etc.).

### Installation Check List for the Application Coordinator

#### Prior to installation of the package:

- Determine the official startup date for HBPC package visit records to be electronically transmitted to Austin and give this information to the IRM (Information Resources Management) support person who will be installing the package.
- Review this chapter to get an overview of how menus and keys should be assigned and the types of data that you will need to implement the package.
- Complete the [Worksheets](#) at the end of this manual. The information will be used to complete the options System Parameters Edit, Clinic File Data Entry, Team File Data Entry and Provider File Data Entry. Look to those options for descriptions of the information you need for the worksheets.
- If you cannot assign menus and/or users to mail groups, give a copy of the Provider File Data Worksheet to the IRM support person who will be assigning the menus, keys, and mail group membership to users of the package.

#### After Installation of the package:

- Make sure you are assigned the HBPC Information System Menu.
- Make sure you are assigned the HBHC MANAGER and HBHC TRANSMIT keys.
- Set the system parameters using the System Parameters Edit option.
- Enter all Clinics used by the HBPC Program using the Clinic File Data Entry option.
- Enter all teams used by your HBPC Program using the Team File Data Entry option. Note: It is required that all providers for the program be assigned to a team.
- Add all HBPC providers using the Provider File Data Entry option utilizing the provider number scheme detailed in the help text.
- If not already done by IRM, assign menus and, where appropriate, keys to the users.
- Ask the IRM support person to set the Auto-queue File Update [HBHC AUTO-QUEUED FILE UPDATE] option to run daily, shortly after midnight.
- Ask IRM to assign members to the HBH mail group. These members receive messages concerning data errors and transmission confirmations.
- If not done by IRM, use VA FileMan to populate the Valid State Code file #631.8 with any state codes that are used by your site.
- Finally, ask IRM to assign file access.

## Assigning Menus and Keys

### HBPC Information System Menu

Assign this menu to the Application Coordinator and any users who will be adding/editing data in the package.

Any person assigned this menu who is also responsible for implementing and maintaining the package needs the HBHC MANAGER key to use the Manager Menu.

Any person assigned this menu who is also responsible for transmitting the data to Austin, needs the HBHC TRANSMIT key. (This key should be limited to only those few people who will transmit the data.)

### Reports Menu

There may be some users who will not be entering data but who need access to reports. Assign this menu to those users.

#### PCE Clinical Reports Menu

While the PCE Clinical Reports [PXRR CLINICAL REPORTS] menu is not a part of the HBPC software, the options can be useful in addition to the HBPC reports. See the PCE user manual for information on the use of these options.

Patient Activity by Location [PXRR PATIENT ACTIVITY BY LOC]  
Caseload Profile by Clinic [PXRR CASELOAD PROFILE BY CL]  
PCE Encounter Summary [PXRR PCE ENCOUNTER SUMMARY]  
Diagnosis Ranked by Frequency [PXRR MOST FREQUENT DIAGNOSES]  
Location Encounter Counts [PXRR LOCATION ENCOUNTER COUNTS]  
Provider Encounter Counts [PXRR PROVIDER ENCOUNTER COUNTS]

### <sup>1</sup>Auto-Queue File Update

[HBHC AUTO-QUEUED FILE UPDATE]

This option is not attached to any menu and is not assigned to anyone. The option should be queued to run every day. It performs the HBHC Visit file #632 update processing that is also found as part of the [Build/Verify Transmission File](#) option. The option runs against the Outpatient Encounter file #409.68 covering the previous 7 days of appointments and updates the HBHC Visit file with both additions and cancellations for encounters.

---

<sup>1</sup> Patch HBH\*1\*10 March 1998 New option.

If any errors are found during the Auto-queue File Update, the records with errors are placed in the HBHC Visit Error file #634.2 and members of the HBH mail group are sent a mail message containing the following:

Please run Form Errors Report option for HBHC errors to correct.

This gives you the opportunity to correct problems as they arise.

The HBHC Visit Error file is deleted and rebuilt as part of the scheduled auto-queued job. Therefore, the same record may be placed in the error file after each run over the 7 days if it is not corrected and you will receive a mail message each of those 7 days.

### **Assigning the HBH Mail Group**

Members of the HBH mail group receive data error messages after visit data is scanned. This group also receives any messages pertaining to the transmission of the data to Austin. Assign users to this mail group that will be responsible for correcting data or transmission errors.

## Using the Manager Menu in Implementation and Maintenance

This menu is used to set up and maintain the system and is described fully in the following pages:

<b>System Parameters Edit</b>	Contains data used to scan for records and print the Transmit History Report.
<b>Provider File Data Entry</b>	Contains all the HBPC providers.
<b>Clinic File Data Entry</b>	Contains all the HBPC clinics. Used when scanning for records to add to the HBHC Visit file. Note: These clinics must exist in the Hospital Location file #44. The clinics must also exist in the HBHC Clinic file #631.6 for visits to be automatically added to the HBHC Visit file #632.
<b>Team File Data Entry</b>	Contains all the HBPC teams. Note: There should be at least one team in this file.
<b>HBPC Provider File Report</b>	Prints the contents of the HBHC Provider file.
<b>Pseudo Social Security Number Report</b>	Displays invalid records containing pseudo (computer generated identification) SSNs.
<b>Re-Transmit File to Austin</b>	This option is used only if Austin determines that it is needed.

## System Parameters Edit

[HBHC EDIT SYSTEM PARAMETERS]

Use this option to edit data in the HBHC System Parameters file #631.9. You can enter or change:

- The number of days you want the package to scan back for appointments/encounters.
- The printer for the Transmit History Report.

**Number of Visit Days to Scan**      The entry in this parameter is used by the package to determine the number of days to scan back through Outpatient Encounters for HBPC Clinic visits. (E.g., If the parameter is set at 7, all HBPC clinic appointments for the previous 7 days are added to the HBHC VISIT file. This parameter must be a number between 7 and 365 inclusive. Set the parameter to the lowest number that accurately reflects the data timelines for appointment management (e.g., if appointments are entered daily, then 7 would be appropriate).

**<sup>1</sup>Transmit Report Printer**      This is the device that will print a copy of the Transmit History Report.

### System Parameters Edit Example:

```
NUMBER OF VISIT DAYS TO SCAN: 7
TRANSMIT REPORT PRINTER: (Enter or select a printer for the Transmit Report.)
```

---

<sup>1</sup> Patches HBH\*1\*6 July 1997 and HBH\*1\*8 January 1998 New field in file #631.9 (patch 6), added to System Parameters Edit (patch 8).

## Provider File Data Entry

[HBHC EDIT PROVIDER (631.4)]

To track the work done by providers, the software needs a list of all the providers for the HBPC Program. Use this option to set up and maintain that list of providers in the HBHC Provider file #631.4. The provider number creation scheme is detailed below and in the online help text.

### Before using this option:

- HBPC teams should be added using the [Team File Data Entry](#). Providers **must** belong to a team.
- All providers must first be members of the New Person file #200.

<sup>1</sup>**HBHC Provider Number** Assign a unique 3-4 digit number to each provider that has FTEE charged to HBPC. **This is a required entry.** Provider numbers are structured according to the following:

- The first digit should be 1 for non-students, 2 for students.
- The second digit (0-8) indicates the provider's discipline.
  - 0 RN
  - 1 LPN, LVN, Home Health Aide or Tech, Nursing Assistant
  - 2 Social Worker
  - 3 OT, PT, CT, Rehabilitation Therapist
  - 4 Dietitian, Nutritionist
  - 5 Physician
  - 6 Nurse Practitioner
  - 7 Clinical Pharmacist
  - 8 Other
- The third and fourth digits contain 0 – 99 indicating the provider as:
  - 0 First staff member in the discipline
  - 1 Second staff member in the discipline
  - 2 Third staff member in the discipline
  - 3 Etc.

---

<sup>1</sup> Patch HBH\*1\*6 July 1997 Provider number changed to 4 digits.



**Adding a tenth provider within a discipline:** When you need to add the 10th provider within a discipline, utilize the third and fourth digits.

Example: For adding the tenth RN, the number would change from 109 to 1010 instead of 110 since that would represent an LPN discipline.

**Adding providers who are not students:** A provider number is issued for each new non-student provider. Provider number "190" can be used as a catch-all category if the need arises.

**Adding students:** It is suggested that all students in a discipline share the same HBPC provider number (e.g., all RN students should be 200). HBPC is only concerned with the amount of work done by students for a discipline, not the individual who did it. However, if your site wants individual names, then each student name must be entered into the HBHC Provider file through this option and given a provider number.

**Reusing provider numbers:** It is not advisable to reuse non-student provider numbers even though the local system can distinguish between different provider names. Austin only uses provider numbers, not the names; so work done by two different providers with the same number will appear as if one person did the work.

**Are you adding ...**

After entering the provider number, answer Yes to the "Are you adding ..." prompt.

**HBHC Provider Name**

Enter the name of the provider (LAST NAME,FIRST NAME). **This is a required entry.**

**<sup>1</sup>HBHC Provider HBHC Team**

Enter the name of the team to which the provider is assigned. Every site should have at least one team. Enter ?? to see a list of teams for selection. **This is a required entry.** Teams are created using the option [Team File Data Entry](#).

The provider name is repeated as a default answer. Press the <RET> or <Enter> key to accept the default. (e.g., PROVIDER NAME: HBPCPROVIDER,ONE// <RET>)

---

<sup>1</sup> Patch HBH\*1\*6 July 1997 Provider Team field required.

<b>Degree</b>	This is a free text field (1-15 characters) for entry of the provider's degree.
<b>Grade/Step</b>	Enter the grade and step of the provider. Format the entry as nn/nn or xxx/nn where n is a number and x is a number or alphabetic character (e.g., 11/4 for grade 11, step 4. SR/11 for Senior grade, step 11.)
<b>FTEE on HBHC</b>	Enter 0 through 1. Can be up to 2 decimal points but not greater than 1.

The HBHC Team selected above is shown as a default. Press the <RET> or <Enter> key to accept the default. (e.g., HBHC TEAM: HINES TEAM 2// <RET>)

<sup>1</sup>**Inactive Provider Number** Providers should only have **one active** Provider Number. Use this field to distinguish between active and inactive numbers for a provider. Providers flagged as Inactive will not be selected when resolving provider numbers from PCE to the HBHC Visit file.

### Example: Adding a new nurse provider

```
Select HBHC PROVIDER NUMBER: 100
  Are you adding '100' as a new HBHC PROVIDER (the 7TH)? No// Y (Yes)
  HBHC PROVIDER PROVIDER NAME: HBPCPROVIDER,TWO      HPT      IRM FIELD OF
  FICE      IRM FIELD OFFICE
  HBHC PROVIDER HBHC TEAM: BLUE TEAM
  PROVIDER NAME: HBPCPROVIDER,TWO// <RET>
  DEGREE: BSN
  GRADE/STEP: III/3
  FTEE ON HBHC: 1
  HBHC TEAM: BLUE TEAM// <RET>
  INACTIVE PROVIDER NUMBER: <RET>
```

---

<sup>1</sup> Patch HBH\*1\*6 July 1997 New field in file #631.4.

Manager Menu ...

## **Clinic File Data Entry**

[HBHC EDIT CLINIC (631.6)]

This option allows you to add clinics in the HBHC Clinic file #631.6. When the program scans through Outpatient Encounters for visits, it looks for visits/appointments to the clinics in this file.

**Note: Clinics cannot be deleted from the file so care should be taken when adding clinics.**

### **Before using this option:**

- The clinics you want to add must be in the Hospital Location file #44.

### **Example: Adding a clinic**

Select HBHC CLINIC NAME: **ASSESSMENT CLINIC**

Are you adding 'ASSESSMENT CLINIC' as a new HBHC CLINIC (the 4TH)? No// **Y** (Yes)

NAME: ASSESSMENT CLINIC// **<RET>**

Manager Menu ...

## Team File Data Entry

[HBHC EDIT HBHC TEAM (633)]

This option allows you to enter new and edit existing HBPC teams in the HBHC Team file #633. There must be at least one team entry for each site. The team name is entered in a free text field of 1-30 characters. A team entry is **required** for each provider in the HBHC Provider file (see [Provider File Data Entry](#)).

### Example: Adding a new team

```
Select HBHC TEAM NAME: BLUE TEAM
  Are you adding 'BLUE TEAM' as a new HBHC TEAM (the 3RD)? No// Y (Yes)
NAME: BLUE TEAM// <RET>
```

### Example: Changing a team name

```
Select HBHC TEAM NAME: HINES ISC
NAME: HINES // GREEN TEAM
```

Manager Menu ...

## HBPC Provider File Report (132)

[HBHCRP8]

This option prints the contents of the HBHC Provider file. The report is sorted by Provider Name and includes: Provider Name, Provider Number, Degree, Grade/Step, FTEE, Team, and whether the provider number is Inactive. The report prints in 132 column format.

**Note: Send the report to a device that prints 132 columns.**

### Example:

```
Run Date: FEB 28, 2000                >>> HBPC Provider File Report <<<                Page: 1
```

Provider Name	Provider Number	Degree	Grade /Step	HBPC FTEE	HBHC Team	Inactive Prov #
HBPCPROVIDER,THREE	103	BS	SR/11	1.0	NUTRITIAN EVAL	
HBPCPROVIDER,FOUR	104	RN	11/9	1.0	NURSE EVAL/CARE	
HBPCPROVIDER,FIVE	104	MD	15/3	0.5	MED EVAL	
HBPCPROVIDER,SIX	106			0.0	MED EVAL	Inactive
HBPCPROVIDER,SEVEN	107	RN	11/2	1.0	NURSE EVAL/CARE	

```
==== End of Report ====
```

## <sup>1</sup>Pseudo Social Security Number Report (80)

[HBHXR14]

A pseudo Social Security Number (SSN) is a computer generated identification. Use this option to find any patient possessing a pseudo SSN. Patient records having pseudo SSNs are considered invalid. A patient that falls into one of the following categories will appear on this report:

- Wrong patient – a patient selected in error, or
- Invalid SSN – a patient not selected in error but whose SSN is invalid due to being a computer generated SSN (e.g., nnn-nn-nnnnP), or
- Collateral – a collateral patient should not be tracked in the HBPC program. If your site wants to track collateral patients, create a collateral clinic(s) in the Hospital Location file #44 but do not add it to the HBHC clinic file #631.6.

These records must be corrected in the MAS Patient file #2 prior to transmission to Austin.

### Alerting User to Patients with Pseudo SSNs

<sup>2</sup>When using the option Evaluation/Admission Data Entry, you will receive a message that the patient has a pseudo SSN and you will be required to select another patient. However, patients added to the HBHC Visit file from the outpatient encounter data may be considered errors when the [Build/Verify Transmission File](#) or Auto-queue File Update option is run. A message will be sent to the HBH mail group in this instance.

### Removing Records for Wrong Patients

- 1 Cancel all HBPC appointments for the wrong patient.
- 2 Use the [Edit Form Errors Data](#) option to clean up the HBHC Pseudo SSN Error(s) file.
- 3 Edit the Number of Visit Days to Scan in the Build/Verify Transmission File option to a value large enough to ensure all cancelled appointments will be processed.

### Removing Records with Invalid SSNs

- 1 Contact MAS to correct the SSN.
- 2 Use the [Edit Form Errors Data](#) option to clean up the HBHC Pseudo SSN Error(s) file.
- 3 Edit the Number of Visit Days to Scan in the Build/Verify Transmission File option to a value large enough to ensure all cancelled appointments will be processed.

### Removing Records for Collateral Patients

- 4 Cancel all HBPC appointments for the collateral patient.

---

<sup>1</sup> Patch HBH\*1\*2 May 1994 Added the option Pseudo Social Security Number Report.

<sup>2</sup> Patch HBH\*1\*2 May 1994 Software modified to recognize pseudo SSNs.

- 5 Use the [Edit Form Errors Data](#) option to clean up the HBHC Pseudo SSN Error(s) file.
- 6 Edit the Number of Visit Days to Scan in the Build/Verify Transmission File option to a value large enough to ensure all cancelled appointments will be processed.

**Example:**

```
>>> HBPC Pseudo SSN Report <<<                               Page: 1
Run Date: FEB 28, 2000
Patient Name                               SSN
=====
HBPCPSEUDOPATIENT,ONE                     000-000-0001P
=====
==== End of Report =====
```

Manager Menu ...

## **Re-Transmit File to Austin**

[HBHCRXMT]

**Use this option only if instructed to by Austin.**

Depending on the nature of the problem and/or reason for re-transmitting, your local IRM technical support person, and possibly Austin as well, should be involved whenever this option is used. For example, if a transmit was incomplete due to a hardware failure, Austin may need to delete the "partial" transmit file received prior to the re-transmit.

The Re-Transmit File to Austin option should only be used when something unforeseen happened to the last transmission (e.g., garbled file data due to network problems, incomplete transmit due to hardware failure, etc.). The option **re-sends the same HBPC data included in the last file transmitted** to Austin, (i.e., the option [Build/Verify Transmission File](#) has NOT been run again since the last transmission to Austin). This option should be used instead of running the Transmit File to Austin option a second time, since the Re-Transmit File option invisibly updates fields used by the software package.

After selecting the option, the following messages appear:

```
This option re-transmits the same data included in the last file created for
transmission to Austin. It should only be run under special circumstances and
should be coordinated with Austin. Do you wish to continue? NO//
```

Answering "No" or <RET> to this message returns the user to the Manager Menu with no transmission occurring.

If the user answers "Yes" to the "Do you wish to continue?" prompt, the following message indicates a background job has been initiated to re-transmit the file to Austin.

```
Re-transmission request has been queued.
```



## III. Package Operations

The following chapters describe the use of the HBPC package.

### Conventions Used in Examples

In examples demonstrating the use of the software, the following conventions will be used:

**<RET>**            press return or enter key  
**bolded** text        example response to a prompt

### Package Online Help

Online help is available for all fields and options in the software. It can be accessed by entering one or two question marks at any field and three question marks at any select option prompt.

### HBPC Information System Menu

Each option has an internal name. The internal name begins with HBHC and is shown in brackets following each option below. Whenever (80) or (132) follows a report name, the report requires a device that prints 80 columns or 132 columns respectively.

#### **HBPC Information System Menu ...**[HBHC INFORMATION SYSTEM MENU]

Evaluation/Admission Data Entry [HBHCADM]

Discharge Data Entry [HBHCDIS]

#### **Reports Menu ...** [HBHC REPORTS MENU]

Evaluation/Admission Data Report by Patient (80) [HBHCRP2]

Patient Visit Data Report (80) [HBHCRP3]

Discharge Data Report by Patient (80) [HBHCRP5]

Episode of Care/Length of Stay Report (80) [HBHCRP12]

Admissions/Discharges by Date Range Report (132) [HBHCRP7]

Rejections from HBPC Program Report (132) [HBHCRP16]

Visit Data by Date Range Report (80) [HBHCRP4]

CPT Code Summary Report (80) [HBHCRP17]

Provider CPT Code Summary Report (80) [HBHCRP22]

ICD Code/Dx Text by Date Range Report (80) [HBHCR19A]

Unique Patients by Date Range Summary Report (80) [HBHCRP20]

Total Visits by Date Range Report (80) [HBHCRP21]

Patient Days of Care by Date Range Report (80) [HBHCRP23]<sup>1</sup>  
**Census Reports Menu ...** [HBHC CENSUS REPORTS MENU]  
 Program Census Report (80) [HBHCRP10]  
 Address Included Program Census (132) [HBHCRP25]<sup>2</sup>  
 Expanded Program Census Report (80) [HBHCRP24]<sup>3</sup>  
 Active Census with ICD Code/Text Report (132) [HBHCRP18]  
 Team Census Report (80) [HBHCRP11]  
 Case Manager Census Report (132) [HBHCRP6]  
 Provider Census Report (132) [HBHCRP9]  
**Transmission Menu ...** [HBHC TRANSMISSION MENU]  
 Build/Verify Transmission File [HBHCFILE]  
 Form Errors Report (80) [HBHCRP1]  
 Edit Form Errors Data [HBHCUPD]  
 Transmit File to Austin [HBHCXMT] \*\* Locked with HBHC TRANSMIT \*\*  
 Print Transmit History Report (80) [HBHCR15A]  
**Manager Menu ...** [HBHC MANAGER MENU] \*\* Locked with HBHC MANAGER \*\*  
 (This menu is discussed under the section [Using the Manager Menu in Implementation and Maintenance.](#))  
 System Parameters Edit [HBHC EDIT SYSTEM PARAMETERS]  
 Provider File Data Entry [HBHC EDIT PROVIDER (631.4)]  
 Clinic File Data Entry [HBHC EDIT CLINIC (631.6)]  
 Team File Data Entry [HBHC EDIT HBHC TEAM (633)]  
 HBPC Provider File Report (132) [HBHCRP8]  
 Pseudo Social Security Number Report (80) [HBHXRP14]  
 Re-Transmit File to Austin [HBHCRXMT]

<sup>1</sup> Patch HBH\*1\*21 February 2005 – New option added to the Reports Menu

<sup>2</sup> Patch HBH\*1\*21 February 2005 – New option added to the Census Reports Menu

<sup>3</sup> Patch HBH\*1\*21 February 2005 – New option added to the Census Reports Menu

## IV. Adding and Editing Patient Data

### **Adding Evaluation/Admission, Discharge and Visit Data through HBPC**

There are three options for adding patient data into the HBPC package. These are discussed in depth later in this section.

**Appointment Management** Allows you to enter patient visit/appointment information. This data is stored in the Outpatient Encounter file #409.68 held by the Patient Care Encounter package. When it is complete, the data is added to the HBHC Visit file #632 through the Auto Queue HBHC File Update or the Build/Verify Transmission File option.

**Evaluation/Admission Data Entry** Allows you to document the patient's evaluation and admission information which adds the data to the HBHC Patient file #631. Once entered, and without errors, records are ready for transmission to Austin.

**Discharge Data Entry** Allows you to describe the patient at discharge to complete the record in the HBHC Patient file #631. Once entered, and without errors, records are ready for transmission to Austin.

### **Adding Visit Data through other Encounter Software**

Visit data entered through any of the following packages is also stored in the Outpatient Encounter file just as that entered using the option Appointment Management. Please see their respective manuals for use of the software.

**Text Integration Utility (TIU)** Allows you to enter encounter data via progress notes.

**Event Capture System (ECS)** Allows you to enter encounter procedures which are not handled in any other VISTA package.

**Automated Information Capture System (AICS)** Scans encounter data into the system.

## <sup>1</sup>Appointment Management

[SDAM APPT MGT]

This option utilizes the MAS Scheduling option, Appointment Management [SDAM APPT MGT] functionality, for entry of appointment data. Appointments entered **and** checked out via this option are added to the HBHC VISIT file #632, and then are ready for transmission to Austin.

Note: If appointments are entered after the visit has taken place, you will also be prompted for checkout information.

Note: The Appointment Management option, [HBHC APPOINTMENT], is being retired and no longer hangs off the HBPC Information System menu. This is due to the impending implementation of the new Resource Scheduling Application (RSA) that is to replace the legacy scheduling options. IRM should add the original Appointment Management Option, [SDAM APPT MGT], as a secondary menu option for HBPC users to use once patch HBH\*1\*24 is installed. After the RSA is nationally released, the Appointment Management option and other legacy Scheduling options will be replaced by usage of the new RSA application.

### Example: Making an Appointment for a Patient

The following example may differ from what you see when making an appointment depending on clinic parameter settings.

1. Entries can be made by selecting a patient or a clinic.
  - To make several entries for a clinic, enter the clinic name following "C." (e.g., C.ASSESSMENT CLINIC to enter appointments for the Assessment Clinic)
  - To make appointments for a specific patient, enter the patient's name following "P." (e.g., P.HBPCPATIENT,ONE)
2. At the Select Action prompt, choose MA to make an appointment.
3. Enter the name of the clinic.
4. Select an Appointment Type.
5. You may display the pending appointments or press the <RET> key.
6. Enter a date to display clinic availability.
7. Select a date and time for the appointment.
8. You may choose to bypass or accept prompts for test stops, other info, or x-rays.
9. You may then enter another clinic or the same clinic for another appointment for the same patient.

```
Select Patient name or Clinic name: P.HBPCPATIENT,ONE HBPCPATIENT,ONE 5-20-66
00000001 YES
Enrollment Priority: GROUP 1 Category: IN PROCESS End Date:
```

---

<sup>1</sup> Patch HBH\*1\*6 July 1997 Make Appointment option changed to call Appointment Management. Visit Data Entry and Cancel Appointment options were removed.

...OK? Yes// <RET> (Yes)

<b>Appt Mgt Module</b>		Mar 16, 2000 13:02	Page: 1 of 1
Patient: HBPCPATIENT,ONE (0001)			Outpatient
Total Appointment Profile		* - New GAF Required	02/15/00 thru 12/10/02
Clinic	Appt Date/Time	Status	
1 Med Clinic Harvey	Mar 09, 2000 10:45	Inpatient/Checked Out	11:30
2 Assessment	Mar 17, 2000 09:00	Future	
3 Phys Ther Bill	Mar 24, 2000 09:00	Future	
4 Phys Ther Bill	Mar 31, 2000 09:00	Future	
Enter ?? for more actions			

CI Check In	CL Change Clinic	PR Provider Update
UN Unscheduled Visit	CD Change Date Range	DX Diagnosis Update
MA Make Appointment	EP Expand Entry	DE Delete Check Out
CA Cancel Appointment	AE Add/Edit	CP Procedure Update
NS No Show	RT Record Tracking	PC PC Assign or Unassign
DC Discharge Clinic	PD Patient Demographics	TI Display Team Information
AL Appointment Lists	CO Check Out	
PT Change Patient	EC Edit Classification	

Select Action: Quit// **MA** Make Appointment

Patient: HBPCPATIENT,ONE (0001) Outpatient

Select CLINIC: **HBPCCLINIC1**  
 APPOINTMENT TYPE: REGULAR// <RET>

DISPLAY PENDING APPOINTMENTS: NO//<RET>  
 CURRENT ENROLLMENT: OPT  
 DISPLAY CLINIC AVAILABILITY STARTING WHEN: 3/31 (MAR 31, 2000)

**Note: Where a 1 appears below, there is an available clinic time. Where a 0 appears, the clinic time is taken.**

Diet Nancy									
Mar 2000									
TIME	8	9	10	11	12	1	2	3	4
DATE									
FR 31	[1 1 1 1]	[0 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
Apr 2000									
MO 02	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
FR 07	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
MO 09	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
FR 14	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
MO 16	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
FR 21	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
MO 23	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
FR 28	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
MO 30	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
May 2000									
FR 05	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		
MO 07	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]	[1 1 1 1]		[1 1 1 1]	[1 1 1 1]		

15 MINUTE APPOINTMENTS  
 DATE/TIME: **4/7@9A** (APR 07, 2000@09:00)  
 15-MINUTE APPOINTMENT MADE  
 WANT PATIENT NOTIFIED OF LAB,X-RAY, OR EKG STOPS? No// <RET> (No)

OTHER INFO: <RET>  
 WANT PREVIOUS X-RAY RESULTS SENT TO CLINIC? No// <RET> (No)  
 Select CLINIC: <RET>

<b>Appt Mgt Module</b>		Mar 16, 2000 13:02	Page: 1 of 1
Patient: HBPCPATIENT,ONE (0001)			Outpatient
Total Appointment Profile		* - New GAF Required	02/15/00 thru 12/10/02
Clinic	Appt Date/Time	Status	
1 Med Clinic Harvey	Mar 09, 2000 10:45	Inpatient/Checked Out	11:30
2 Assessment	Mar 17, 2000 09:00	Future	
3 Phys Ther Bill	Mar 24, 2000 09:00	Future	
4 Phys Ther Bill	Mar 31, 2000 09:00	Future	
5 <b>HBPCCLINIC1</b>	<b>Apr 07, 2000 09:00</b>	<b>Future</b>	
Enter ?? for more actions			

CI Check In	CL Change Clinic	PR Provider Update
UN Unscheduled Visit	CD Change Date Range	DX Diagnosis Update
MA Make Appointment	EP Expand Entry	DE Delete Check Out
CA Cancel Appointment	AE Add/Edit	CP Procedure Update
NS No Show	RT Record Tracking	PC PC Assign or Unassign
DC Discharge Clinic	PD Patient Demographics	TI Display Team Information
AL Appointment Lists	CO Check Out	
PT Change Patient	EC Edit Classification	
Select Action: Quit// <RET>	QUIT	

## Example: Using Check Out in Appointment Management

The HBHC Visit file holds the Patient Name, Visit Date, Clinic, Provider, Diagnoses, and CPT Code procedures and modifiers for the visit. Checking Out the patient visit in Appointment Management allows you to add this information to the file.

1. Entries can be searched for by patient or by clinic. Enter P. plus the patient's name or C. plus the clinic name.
2. At the "Select Beginning Date" and "Select Ending Date" accept the default dates or enter different dates.
3. For Action, select Check Out (CO).
4. If you want, you can make a follow-up appointment.
5. Enter a Check Out date and time.
6. If there is a known service connected condition or an exposure and the visit was related, give the appropriate answer(s).
7. Enter the provider for the appointment.
8. Enter diagnoses for the appointment.
9. Enter procedures and procedure modifiers for the appointment.

Select Patient name or Clinic name: **C.ASSESSMENT CLINIC**  
 Select Beginning Date: FEB 19, 2000// <RET> (FEB 19, 2000)  
 Select Ending Date: TODAY// <RET> (MAR 20, 2000)

<b>Appt Mgt Module</b>		Mar 20, 2000 15:23:23	Page: 1 of 1
Clinic: ASSESSMENT CLINIC			
No Action Taken/Action Required * - New GAF Required 02/19/00 thru 03/20/00			
Patient	Appt Date/Time	Status	
1 0002 HBPCPATIENT,TWO	Mar 17, 2000 09:00	No Action Taken	
2 0001 HBPCPATIENT,ONE	Mar 17, 2000 09:30	No Action Taken	
3 0003 HBPCPATIENT,THREE	Mar 17, 2000 10:00	No Action Taken	
Enter ?? for more actions			

CI Check In	CL Change Clinic	PR Provider Update
UN Unscheduled Visit	CD Change Date Range	DX Diagnosis Update
MA Make Appointment	EP Expand Entry	DE Delete Check Out
CA Cancel Appointment	AE Add/Edit	CP Procedure Update
NS No Show	RT Record Tracking	PC PC Assign or Unassign
DC Discharge Clinic	PD Patient Demographics	TI Display Team Information
AL Appointment Lists	CO Check Out	
PT Change Patient	EC Edit Classification	

Select Action: Quit// **CO** Check Out  
 Select Appointment(s): (1-6): **1**  
 1 0002 HBPCPATIENT,TWO Mar 17, 2000 09:00 No Action Taken  
 Do you wish to make a follow-up appointment? YES// NO  
 Check out date and time: NOW// **3/17@9:30A** (MAR 17, 2000@09:30)

--- Classification --- [Required]  
  
 Was treatment for SC Condition? **NO**  
 Was treatment related to Agent Orange Exposure? **NO**

<b>PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00 ASSESSMENT CLINIC</b>
PROVIDER: ...There are 0 PROVIDER(S) associated with this encounter.
<b>- - ENCOUNTER PROVIDERS - -</b>
No. PROVIDER PERSON CLASS ON MAR 17, 2000@09:00

**No PROVIDERS for this Encounter.**

Enter PROVIDER: **HBPCPROVIDER,TWO**  
 Is this the PRIMARY provider for this ENCOUNTER? YES// **<RET>**

<b>PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00 ASSESSMENT CLINIC</b>
PROVIDER: ...There are 0 PROVIDER(S) associated with this encounter.
<b>- - ENCOUNTER PROVIDERS - -</b>
No. PROVIDER PERSON CLASS ON MAR 17, 2000@09:00

1 HBPCPROVIDER,TWO\* PRIMARY Language/Audiologist

Enter PROVIDER: **<RET>**

<b>PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00 ASSESSMENT CLINIC</b>
ICD CODE: ...There are 0 ICD CODES associated with this encounter.

- - E N C O U N T E R D I A G N O S I S ( I C D 1 0 C O D E S ) - -			
No.	ICD	DESCRIPTION	PROBLEM LIST

No DIAGNOSIS for this Encounter.

Enter Diagnosis : 230.1

ONE primary diagnosis must be established for each encounter!  
Is this the PRIMARY DIAGNOSIS for this ENCOUNTER? YES// <RET>

PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00		ASSESSMENT CLINIC
ICD CODE: ...There is 1 ICD CODE associated with this encounter.		
Previous Entry: 230.1		

- - E N C O U N T E R D I A G N O S I S ( I C D 1 0 C O D E S ) - -			
No.	ICD	DESCRIPTION	PROBLEM LIST

1	230.1*	CA IN SITU ESOPHAGUS	PRIMARY
---	--------	----------------------	---------

Enter NEXT Diagnosis : <RET>

Enter PROVIDER associated with PROBLEM: WILLIAMS,CATHY // <RET>

PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00		ASSESSMENT CLINIC
PROVIDER: ...Enter the provider associated with the CPT'S....		
CPT: ...There are 0 PROCEDURES associated with this encounter.		

- - E N C O U N T E R P R O C E D U R E S ( C P T C O D E S ) - -				
No.	CPT CODE	QUANTITY	DESCRIPTION	PROVIDER

Enter '+' for next page, '-' for last page.  
Enter PROCEDURE (CPT CODE): nnnnn

Select CPT MODIFIER: <RET>

PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00		ASSESSMENT CLINIC
PROVIDER: ...Enter the provider associated with the CPT'S....		
CPT:		

- - E N C O U N T E R P R O C E D U R E S ( C P T C O D E S ) - -				
No.	CPT CODE	QUANTITY	DESCRIPTION	PROVIDER

1	nnnnn*		DIAGNOSTIC ...	
---	--------	--	----------------	--

How many times was this procedure performed: 1// <RET>

Enter PROVIDER associated with PROCEDURE: HBPCPROVIDER,TWO// <RET>

PAT/APPT/CLINIC: HBPCPATIENT,TWO MAR 17, 2000@09:00		ASSESSMENT CLINIC
PROVIDER: ...Enter the provider associated with the CPT'S....		
CPT: ...There is 1 PROCEDURE associated with this encounter.		

- - E N C O U N T E R P R O C E D U R E S ( C P T C O D E S ) - -				
No.	CPT CODE	QUANTITY	DESCRIPTION	PROVIDER

1	nnnnn*	1	DIAGNOSTIC ...	HBPCPROVIDER,TWO
---	--------	---	----------------	------------------



Enter '+' for next page, '-' for last page.  
 Enter NEXT PROCEDURE (CPT CODE): <RET>

- - - - S o r r y   A b o u t   T h e   W a i t - - - -  
 This information is being stored or monitored by Scheduling  
 Integrated Billing, Order Entry, Registration, Prosthetics  
 PCE/Visit Tracking and Automated Med Information Exchange.

Do you wish to see the check out screen? NO// <RET>

Appt Mgt Module	Mar 20, 2000 15:59:45	Page:	1 of 1
Clinic: ASSESSMENT			
No Action Taken/Action Required * - New GAF Required      02/19/00 thru 03/20/00			
Patient	Appt Date/Time	Status	
No appointments meet criteria.			
Enter ?? for more actions			

- |                       |                         |                             |
|-----------------------|-------------------------|-----------------------------|
| CI Check In           | CL Change Clinic        | PR Provider Update          |
| UN Unscheduled Visit  | CD Change Date Range    | DX Diagnosis Update         |
| MA Make Appointment   | EP Expand Entry         | DE Delete Check Out         |
| CA Cancel Appointment | AE Add/Edit             | CP Procedure Update         |
| NS No Show            | RT Record Tracking      | PC PC Assign or Unassign    |
| DC Discharge Clinic   | PD Patient Demographics | TI Display Team Information |
| AL Appointment Lists  | CO Check Out            |                             |
| PT Change Patient     | EC Edit Classification  |                             |
- Select Action: Quit// <RET>

## Evaluation/Admission Data Entry

[HBHCADM]

Use this option to enter or edit evaluation and admission data (Form 3) for a patient. This data is stored in the HBHC Patient file #631. A patient must already exist in the MAS Patient file #2 before being entered into the HBPC package.

### Complete Episode of Care

A "complete" episode of care consists of both an admission and a discharge, with each episode comprising a separate HBHC Patient file record. A "reject" also represents an episode of care. Therefore, a patient can have more than one episode of care record. The package will NOT allow the creation of an additional episode of care until the patient has been discharged from the previous episode.

A complete episode of care record should ONLY be edited if data correction is needed. Selection of an existing record is inappropriate if your intention is to create an additional episode of care. A message is displayed to remind you that the record may have been selected in error.

\*\*\* Record contains Discharge data indicating a Complete Episode of Care \*\*\*

### Creating an Additional Episode of Care for a Patient

To create another episode of care for the same patient, enclose the patient's name in double quotes at the "Select HBHC PATIENT NAME" prompt (e.g., "HBPCPATIENT,FOUR" or "S0004"). This informs the package that you want to create a new record in the HBHC Patient file for the same patient.

### Patient Demographic Information

Patient demographic information <sup>1</sup>(Birth Year and Sex,) is pulled from the MAS Patient file #2. If this data is incorrect, contact MAS to correct the data. It cannot be edited by HBPC personnel.

State Code, County Code, ZIP Code, Eligibility @ Evaluation, Period of Service, and Marital Status @ Evaluation come from the MAS Patient file and are displayed as default values. Press the <RET> or <ENTER> key if the default is valid, or type in the correct field information. Illinois is the default value in the following example:

```
STATE CODE: ILLINOIS// <RET>           Accept the default or
STATE CODE: ILLINOIS// WISCONSIN       type in the correct information.
```

---

<sup>1</sup> Patch HBH\*1\*19 January 2003 Removed Race: O Race: Obsolete Field 2003bsolete Field

## Exiting and Field Jumping

You may ^ exit from the data entry process and return to the menu at any field prompt. Field jumping is not allowed due to branching logic contained within the data entry process.

### HBHC Patient Name

**New Entry:** Enter the name of a new patient to the HBHC Patient file:

Last name,First name (e.g., HBPCPATIENT,FOUR)

First initial of last name plus last 4 digits of the SSN (e.g., S0004)

**Creating Additional Episode of Care:** Enter the name of a patient who has a previous complete episode of care or a reject record in HBPC:

Enter name in quotes ("HBPCPATIENT,FOUR" or "S0004")

Answer Yes to the "Are you adding..." prompt.

If you choose a record that already contains discharge data, then the following message will appear:

```
*** Record contains Discharge data indicating a Complete Episode of Care ***
```

This message is a reminder that the record is considered to be complete and may have been selected in error. This record should only be edited if correction of existing data is needed. Selection of this record is inappropriate if your intention is to create an additional episode of care. If you want to start a new record, then “^” out at the next prompt and reenter the patient’s name in quotation marks “NAME,PATIENT”. If you want to edit a complete record, then continue.

### <sup>1</sup>HBHC Patient Date

Enter the date the patient was evaluated for or admitted to the HBPC Program.

The date is repeated as a default. Press the <RET> key to accept the date.

```
HBHC PATIENT DATE: 2/29/2000
```

```
DATE: FEB 29,2000// <RET>
```

---

<sup>1</sup> Patch HBH\*1\*8 January 1998 Field required.

<b>State Code</b>	This is the state in which the patient resides. Either press the <RET> key to accept the default, or change the code.
<b>County Code</b>	This is the county in which the patient resides. Either press the <RET> key to accept the default, or change the code.
<b>ZIP Code</b>	This is the ZIP Code for the patient's address. Either press the <RET> key to accept the default, or change the code.
<b>Eligibility @ Evaluation</b>	This is the patient's eligibility.
<b>Birth Year</b>	This is the year the patient was born. If it is incorrect, contact MAS.
<b>Period of Service</b>	This is the period of time the patient served in the military.
<b>Sex</b>	This is the patient's sex. If it is incorrect, contact MAS.
<b><sup>1</sup>Race</b>	This is the patient's race. If it is incorrect, contact MAS.
<b>Race</b>	This is the patient's race. If it is incorrect, contact MAS.
<b>Marital Status @ Evaluation</b>	This is the patient's marital status. Either press the <RET> key to accept the default, or change the status.
<b>Living Arrangements @ Eval</b>	Enter one of the following numeric codes (1-5, 9) that best defines the patient's living arrangements: 1 Alone 2 With Spouse 3 With Relatives 4 With Non-Relatives 5 Group Quarters, Not Health Related 9 Not Determined
<b>Last Agency Providing Care</b>	Enter one of the following codes (1-3) that best describes the last agency providing care for the patient: 1 VA Provided Care 2 Non VA Care 3 VA Fee Basis/Contract

---

<sup>1</sup> Patch HBH\*1\*19 January 2003 Race: Obsolete Field January 2003

<b>Type of Last Care Agency</b>	<p>Enter one of the following codes (1-7, 9) that best describes the type of care provided by the last agency:</p> <ol style="list-style-type: none"> <li>1 General Hospital</li> <li>2 Specialty Hospital</li> <li>3 Nursing Home</li> <li>4 Residential Care Facility</li> <li>5 Hospice</li> <li>6 Community-Based Services</li> <li>7 Self/Family, No Regular Source</li> <li>9 Not Determined</li> </ol>
<b>Admit/Reject Action</b>	<p>Enter the code for either admitted to or rejected from the HBPC program.</p> <ol style="list-style-type: none"> <li>1 Admit to HBHC</li> <li>2 Reject from HBHC</li> </ol> <p>If 1, skip to Primary Diagnosis @ Admission.</p>
<b>Reject/Withdraw Reason</b>	<p>Enter the 2 digit code that represents the reason the patient was rejected/withdrawn from the HBPC program.</p> <ol style="list-style-type: none"> <li>10 Referral Withdrawn Due to Death</li> <li>11 Other</li> <li>01 Not Located in Service Area</li> <li>02 Program Slot Not Available</li> <li>03 Patient or Caregiver Refused HBHC</li> <li>04 Suitable Caregiver Not Available</li> <li>05 Home Environment Unsuitable</li> <li>06 Referral Withdrawn (excludes death)</li> <li>07 Patient's Condition Necessitates Institutional Care</li> <li>08 Patient Can Be Effectively Treated as Outpatient</li> </ol>
<b>Reject/Withdraw Disposition</b>	<p>Enter the code that represents the patient's disposition.</p> <ol style="list-style-type: none"> <li>1 Referred Back to Referral Source</li> <li>2 Disposition Made by HBHC</li> </ol> <p>Skip to Person Completing Evl/Adm Form.</p>
<b>Primary Diagnosis @ Admission</b>	<p>Enter the ICD9 or ICD10 diagnosis code for the patient's primary diagnosis.</p>
<b>Secondary Diagnosis @ Adm</b>	<p>Enter a secondary diagnosis. This is a free text field (1-30 characters). This information is not transmitted to Austin.</p>
<b>Vision @ Admission</b>	<p>Enter the code that best represents the patient's vision.</p> <ol style="list-style-type: none"> <li>1 Normal or Minimal Loss</li> <li>2 Moderate Loss</li> <li>3 Severe Loss</li> <li>4 Total Blindness</li> </ol>

9 Not Determined

**Hearing @ Admission**

Enter the code that best represents the patient's hearing.

- 1 Normal or Minimal Loss
- 2 Moderate Loss
- 3 Severe Loss
- 4 Total Deafness
- 9 Not Determined

**Expressive  
Communication @ Adm**

Enter the code that best describes the patient's ability to communicate with others.

- 1 Speaks and is Usually Understood
- 2 Speaks But is Understood Only with Difficulty
- 3 Uses Only Sign Language, Symbol Board or Writing
- 4 Uses Only Gestures, Grunts, or Primitive Symbols
- 5 Does Not Convey Needs
- 9 Not Determined

**Receptive Communication  
@ Adm**

Enter the code that best describes the patient's ability to understand others.

- 1 Usually Understands Oral Communication
- 2 Has Limited Comprehension of Oral Communication
- 3 Understands by Depending on Lip Reading, Written Material, or Sign Language
- 4 Understands Primitive Gestures, Facial Express., Pictograms, and/or Env. Cues
- 5 Does Not Understand
- 9 Not Determined

**Bathing @ Admission**

Enter the code that describes how much help the patient requires bathing.

- 1 No Help
- 2 Receives Help
- 3 Not Done or Done Without Patient Participation
- 9 Not Determined

<b>Dressing @ Admission</b>	<p>Enter the code that describes how much help the patient requires dressing.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Toilet Usage @ Admission</b>	<p>Enter the code that describes how much help the patient requires using the toilet.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Transferring @ Admission</b>	<p>Enter the code that describes how much help the patient requires transferring.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Eating @ Admission</b>	<p>Enter the code that describes how much help the patient requires eating.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Walking @ Admission</b>	<p>Enter the code that describes how much help the patient requires walking.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Bowel Continence @ Admission</b>	<p>Enter the code that describes the patient's bowel continence.</p> <ul style="list-style-type: none"> <li>1 Continent or Ostomy/Catheter Self Care</li> <li>2 Incontinent Occasionally</li> <li>3 Incontinent or Ostomy/Catheter Not self Care</li> <li>9 Not Determined</li> </ul>

<b>Bladder Continence @ Admission</b>	<p>Enter the code that describes the patient's bladder continence.</p> <ol style="list-style-type: none"> <li>1 Continent or Ostomy/Catheter Self Care</li> <li>2 Incontinent Occasionally</li> <li>3 Incontinent or Ostomy/Catheter Not Self Care</li> <li>9 Not Determined</li> </ol>
<b>Mobility @ Admission</b>	<p>Enter the code that describes the patient's mobility.</p> <ol style="list-style-type: none"> <li>1 Goes Outdoors Without Help</li> <li>2 Goes Outdoors With Help</li> <li>3 Confined Indoors, Not Bed Disabled</li> <li>4 Bed Disabled</li> <li>9 Not Determined</li> </ol>
<b>Adaptive Tasks @ Admission</b>	<p>Enter the code that describes the patient's ability to perform adaptive tasks.</p> <ol style="list-style-type: none"> <li>1 No Help</li> <li>2 Requires Help</li> <li>9 Not Determined</li> </ol>
<b>Behavior Problems @ Admission</b>	<p>Enter the code that describes whether or not the patient has behavior problems.</p> <ol style="list-style-type: none"> <li>1 Does Not Exhibit This Characteristic</li> <li>2 Exhibits This Characteristic</li> <li>9 Not Determined</li> </ol>
<b>Disorientation @ Admission</b>	<p>Enter the code that describes whether or not the patient is disoriented.</p> <ol style="list-style-type: none"> <li>1 Does Not Exhibit This Characteristic</li> <li>2 Exhibits This Characteristic</li> <li>9 Not Determined</li> </ol>
<b>Mood Disturbance @ Admissison</b>	<p>Enter the code that describes whether or not the patient has a mood disturbance.</p> <ol style="list-style-type: none"> <li>1 Does Not Exhibit This Characteristic</li> <li>2 Exhibits This Characteristic</li> <li>9 Not Determined</li> </ol>
<b>Caregiver Limitations @ Adm</b>	<p>Enter the level of limitations for the caregiver.</p> <ol style="list-style-type: none"> <li>1 Minimal or None</li> <li>2 Moderate</li> <li>3 Moderately Severe</li> <li>4 No Caregiver</li> <li>9 Not Determined</li> </ol>



**Person Completing  
Evl/Adm Form**

Enter the person's name that completed the form. Entering ?? brings up a list of choices. If you do not see the person who completed the form, that person must be entered into HBHC Provider file # 631.4. Use the option [Provider File Data Entry](#) to add the person to the file. This information is not transmitted to Austin.

**Date Eval/Adm Form  
Completed**

Enter the date the form was completed. This information is not transmitted to Austin.

**Case Manager**

Enter the person that is responsible for the case. Entering ?? brings up a list of choices. If you do not see the case manager's name, that person must be entered into HBHC Provider file # 631.4. Use the option [Provider File Data Entry](#) to add the person to the file. This information is not transmitted to Austin.

**Messages**

Transmit Status Flag must be reset before editing this record is allowed. Do you wish to reset the Flag? NO//

This message is displayed if the record has previously been transmitted to Austin. Resetting the flag allows you to edit any data in the record. Answering “Yes” to the “Do you wish to reset the Flag?” prompt automatically generates a Form 6 Correction record behind the scenes. The Transmit Status Flag will be reset to “Needs to be Transmitted” status, and the record will be included in the next transmission to Austin. In short, answering “Yes” tells Austin to delete the previously transmitted record because this is a corrected replacement.

\*\*\* Record contains Discharge data indicating a Complete Episode of Care \*\*\*

This message is a reminder that the record is considered to be complete and may have been selected in error. This record should only be edited if correction of existing data is needed. Selection of this record is inappropriate if your intention is to create an additional episode of care.

**Example of an admission**

```
Select HBHC PATIENT NAME:      HBPCPATIENT,FIVE          1-1-40      000000005
YES  SC VETERAN
Enrollment Priority: GROUP 2    Category: IN PROCESS      End Date:

Are you adding 'HBPCPATIENT,FIVE' as a new HBHC PATIENT (the 9TH)? No// Y
(Yes)
HBHC PATIENT DATE: T (FEB 29, 2000)
DATE: FEB 29,2000// <RET>
STATE CODE: ANYSTATE // <RET>
COUNTY CODE: ANYCOUNTY (031)// <RET>
ZIP CODE: 66611// <RET>
```

ELIGIBILITY @ EVALUATION: Service Connected Less Than 50% (03)// <RET>

BIRTH YEAR: 1940  
 \*\*\* Contact MAS if value is incorrect. \*\*\*

PERIOD OF SERVICE: Vietnam (07)// <RET>

SEX: Male (1)  
 \*\*\* Contact MAS if value is incorrect. \*\*\*

RACE: White (1)  
 \*\*\* Contact MAS if value is incorrect. \*\*\*

MARITAL STATUS @ EVALUATION: Married (1)// <RET>

LIVING ARRANGEMENTS @ EVAL: 1 Alone (1)

LAST AGENCY PROVIDING CARE: 1 VA Provided Care (1)

TYPE OF LAST CARE AGENCY: 5 Hospice (5)

ADMIT/REJECT ACTION: 1 Admit to HBHC (1)

PRIMARY DIAGNOSIS @ ADMISSION: 157.1 MAL NEO PANCREAS BODY  
 COMPLICATION/COMORBIDITY

SECONDARY DIAGNOSES @ ADM: <RET>

VISION @ ADMISSION: 2 Moderate Loss (2)

HEARING @ ADMISSION: 2 Moderate Loss (2)

EXPRESSIVE COMMUNICATION @ ADM: 1 Speaks and is Usually Understood (1)

RECEPTIVE COMMUNICATION @ ADM: 1 Usually Understands Oral Communication (1)

BATHING @ ADMISSION: 2 Receives Help (2)

DRESSING @ ADMISSION: 2 Receives Help (2)

TOILET USAGE @ ADMISSION: 2 Receives Help (2)

TRANSFERRING @ ADMISSION: 2 Receives Help (2)

EATING @ ADMISSION: 2 Receives Help (2)

WALKING @ ADMISSION: 3 Not Done or Done Without Patient Participation (3)

BOWEL CONTINENCE @ ADMISSION: 2 Incontinent Occasionally (2)

BLADDER CONTINENCE @ ADMISSION: 3 Incontinent or Ostomy/Catheter Not Self Care (3)

MOBILITY @ ADMISSION: 3 Confined Indoors, Not Bed Disabled (3)

ADAPTIVE TASKS @ ADMISSION: 2 Requires Help (2)

BEHAVIOR PROBLEMS @ ADMISSION: 1 Does Not Exhibit This Characteristic (1)

DISORIENTATION @ ADMISSION: 1 Does Not Exhibit This Characteristic (1)

MOOD DISTURBANCE @ ADMISSION: 2 Exhibits This Characteristic (2)

CAREGIVER LIMITATIONS @ ADM: 1 Minimal or None (1)

PERSON COMPLETING EVL/ADM FORM: 100 HBPCPROVIDER,TWO HINES ISC  
 ...OK? Yes// <RET> (Yes)

DATE EVAL/ADM FORM COMPLETED: T (FEB 29, 2000)

CASE MANAGER: 100 HBPCPROVIDER,TWO HINES ISC  
 ...OK? Yes// <RET> (Yes)

## Discharge Data Entry

[HBHCDIS]

This option allows you to enter and edit the discharge data (also known as Form 5) in the HBHC Patient file #631.

## Complete Episode of Care

A “complete” episode of care consists of both an admission and a discharge or a reject, with each episode being a separate HBHC Patient file record. An admission must exist before a discharge is allowed. The package will **NOT** allow the creation of an additional episode of care until the patient has been discharged from the last episode. This is the message you receive if you attempt to do this using the Evaluation/Admission Data Entry option.

```
Select HBHC PATIENT NAME: "HBPCPATIENT,SIX"  HBPCPATIENT,SIX      12-1-12
000000006      YES      MILITARY RETIREE
Are you adding 'HBPCPATIENT,SIX' as a new HBHC PATIENT (the 13TH)? No//Y (Yes)
HBHC PATIENT DATE: T (MAR 09, 2000)
```

Patient must be discharged from last episode of care before new episode  
can be entered. Current episode not created.

## Default Values

Default values for the discharge data fields are pulled from the corresponding admission record data whenever possible to simplify data entry. Simply press the <RET> or <ENTER> key if the default answer is valid, or type in the correct field information.

## Exiting and Field Jumping

You may ^ exit from the data entry process and return to the menu at any field prompt. Field jumping is not allowed due to branching logic contained within the data entry process. (Example: If “Died on HBHC (4)” is entered at the “Discharge Status” prompt, the software goes directly (branches) to the “Cause of Death” prompt and no Discharge data field prompts are displayed.)

<b>HBHC Patient Name</b>	Enter the name of a patient in the HBHC Patient file: Last name,First name (e.g., HBPCPATIENT,FOUR) First initial of last name plus last 4 digits of the SSN (e.g., S0004)
<b>Discharge Date</b>	Enter the date the patient was discharged from the HBPC Program.
<b>Eligibility @ Discharge</b>	This is the patient's eligibility.
<b>Marital Status @ Discharge</b>	Enter one of the following for the patient's marital status: 1 Married 2 Widowed 3 Separated 4 Divorced 5 Never Married 9 Not Determined
<b>Living Arrangements @ D/C</b>	Enter one of the following numeric codes (1-5, 9) that best defines the patient's living arrangements: 1 Alone 2 With Spouse 3 With Relatives 4 With Non-Relatives 5 Group Quarters, Not Health Related 9 Not Determined
<b>Discharge Status</b>	Enter one of the following for the status of the patient at discharge: 1 Transferred to Other Provider 2 Anticipated Institutionalization 3 Family or Self Care/No Regular Source 4 Died on HBHC 5 Moved Away/Lost to Contact 9 Not Determined

The Discharge Status field value controls which field prompts are displayed for data entry. If you change the value of the Discharge Status field after other fields have been filled in, you may receive messages stating a particular type of data exists and no longer coincides with what you just selected.

Depending on your selection for Discharge Status, you will branch to prompts appropriate for the status. All records end with the two prompts: Person Completing D/C Form and Date Discharge Form Completed.

<u>If Discharge Status Code =</u>	<u>Branches to</u>
1 Transferred to Other Provider	Transfer Destination Type of Destination Agency
2 Anticipated Institutionalization	Transfer Destination Type of Destination Agency
3 Family or Self Care/No Regular Source	Primary Diagnosis @ Discharge ↓ Caregiver Limitations @ Discharge
4 Died on HBHC	Cause of Death
5 Moved Away/Lost to Contact	Primary Diagnosis @ Discharge ↓ Caregiver Limitations @ Discharge
9 Not Determined	Primary Diagnosis @ Discharge ↓ Caregiver Limitations @ Discharge

<b>Transfer Destination</b>	Enter the code that best describes the patient's transfer destination. This field is only prompted for when the Discharge Status field contains either 1 (Transferred to Other Provider) or 2 (Anticipated Institutionalization). <ul style="list-style-type: none"> <li>1 VA Provided Care</li> <li>2 Non VA Care</li> <li>3 VA Fee Basis/Contract</li> </ul>
<b>Type of Destination Agency</b>	Enter the code that best represents the patient's type of destination agency. This field is only prompted for when the Discharge Status field contains either 1 (Transferred to Other Provider) or 2 (Anticipated Institutionalization). <ul style="list-style-type: none"> <li>1 General Hospital</li> <li>2 Specialty Hospital</li> <li>3 Nursing Home</li> <li>4 Residential Care Facility/Domiciliary</li> <li>5 Hospice</li> <li>6 Community-Based Services</li> <li>9 Not Determined</li> </ul>
<b>Cause of Death</b>	Enter the patient's cause of death. This is a free text field (1 – 30 characters). This field is only prompted for when Discharge Status field contains 4 (Died on HBHC). This information is not transmitted to Austin.
<b>Primary Diagnosis @ Discharge</b>	Enter the ICD9 or ICD10 diagnosis code for the patient's primary diagnosis.
<b>Secondary Diagnosis @ D/C</b>	Enter the secondary diagnosis. This is a free text field (1 – 30 characters). This information is not transmitted to Austin.
<b>Vision @ Discharge</b>	Enter the code that best represents the patient's vision. <ul style="list-style-type: none"> <li>1 Normal or Minimal Loss</li> <li>2 Moderate Loss</li> <li>3 Severe Loss</li> <li>4 Total Blindness</li> <li>9 Not Determined</li> </ul>
<b>Hearing @ Discharge</b>	Enter the code that best represents the patient's hearing. <ul style="list-style-type: none"> <li>1 Normal or Minimal Loss</li> <li>2 Moderate Loss</li> <li>3 Severe Loss</li> <li>4 Total Deafness</li> <li>9 Not Determined</li> </ul>
<b>Expressive</b>	Enter the code that best describes the patient's ability to

<b>Communication @ D/C</b>	<p>communicate with others.</p> <ol style="list-style-type: none"> <li>1 Speaks and is Usually Understood</li> <li>2 Speaks But is Understood Only with Difficulty</li> <li>3 Uses Only Sign Language, Symbol Board or Writing</li> <li>4 Uses Only Gestures, Grunts, or Primitive Symbols</li> <li>5 Does Not Convey Needs</li> <li>9 Not Determined</li> </ol>
<b>Receptive Communication @ D/C</b>	<p>Enter the code that best describes the patient's ability to understand others.</p> <ol style="list-style-type: none"> <li>1 Usually Understands Oral Communication</li> <li>2 Has Limited Comprehension of Oral Communication</li> <li>3 Understands by Depending on Lip Reading, Written Material, or Sign Language</li> <li>4 Understands Primitive Gestures, Facial Express., Pictograms, and/or Env. Cues</li> <li>5 Does Not Understand</li> <li>9 Not Determined</li> </ol>
<b>Bathing @ Discharge</b>	<p>Enter the code that describes how much help the patient requires bathing.</p> <ol style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ol>
<b>Dressing @ Discharge</b>	<p>Enter the code that describes how much help the patient requires dressing.</p> <ol style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ol>
<b>Toilet Usage @ Discharge</b>	<p>Enter the code that describes how much help the patient requires using the toilet.</p> <ol style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ol>

<b>Transferring @ Discharge</b>	<p>Enter the code that describes how much help the patient requires transferring.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Eating @ Discharge</b>	<p>Enter the code that describes how much help the patient requires eating.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Walking @ Discharge</b>	<p>Enter the code that describes how much help the patient requires walking.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Receives Help</li> <li>3 Not Done or Done Without Patient Participation</li> <li>9 Not Determined</li> </ul>
<b>Bowel Continence @ Discharge</b>	<p>Enter the code that describes the patient's bowel continence.</p> <ul style="list-style-type: none"> <li>1 Continent or Ostomy/Catheter Self Care</li> <li>2 Incontinent Occasionally</li> <li>3 Incontinent or Ostomy/Catheter Not Self Care</li> <li>9 Not Determined</li> </ul>
<b>Bladder Continence @ Discharge</b>	<p>Enter the code that describes the patient's bladder continence.</p> <ul style="list-style-type: none"> <li>1 Continent or Ostomy/Catheter Self Care</li> <li>2 Incontinent Occasionally</li> <li>3 Incontinent or Ostomy/Catheter Not Self Care</li> <li>9 Not Determined</li> </ul>
<b>Mobility @ Discharge</b>	<p>Enter the code that describes the patient's mobility.</p> <ul style="list-style-type: none"> <li>1 Goes Outdoors Without Help</li> <li>2 Goes Outdoors With Help</li> <li>3 Confined Indoors, Not Bed Disabled</li> <li>4 Bed Disabled</li> <li>9 Not Determined</li> </ul>
<b>Adaptive Tasks @ Discharge</b>	<p>Enter the code that describes the patient's ability to perform adaptive tasks.</p> <ul style="list-style-type: none"> <li>1 No Help</li> <li>2 Requires Help</li> <li>9 Not Determined</li> </ul>



<b>Behavior Problems @ Discharge</b>	<p>Enter the code that describes whether or not the patient has behavior problems.</p> <ul style="list-style-type: none"> <li>1 Does Not Exhibit This Characteristic</li> <li>2 Exhibits This Characteristic</li> <li>9 Not Determined</li> </ul>
<b>Disorientation @ Discharge</b>	<p>Enter the code that describes whether or not the patient is disoriented.</p> <ul style="list-style-type: none"> <li>1 Does Not Exhibit This Characteristic</li> <li>2 Exhibits This Characteristic</li> <li>9 Not Determined</li> </ul>
<b>Mood Disturbance @ Discharge</b>	<p>Enter the code that describes whether or not the patient has a mood disturbance.</p> <ul style="list-style-type: none"> <li>1 Does Not Exhibit This Characteristic</li> <li>2 Exhibits This Characteristic</li> <li>9 Not Determined</li> </ul>
<b>Caregiver Limitations @ D/C</b>	<p>Enter the level of limitations of the caregiver.</p> <ul style="list-style-type: none"> <li>1 Minimal or None</li> <li>2 Moderate</li> <li>3 Moderately Severe</li> <li>4 No Caregiver</li> <li>9 Not Determined</li> </ul>
<b>Person Completing D/C Form</b>	<p>Enter the person's name that completed the form. Entering?? brings up a list of choices. If you do not see the person who completed the form, that person must be entered into HBHC Provider file # 631.4. Use the option <a href="#">Provider File Data Entry</a> to add the person to the file. This information is not transmitted to Austin.</p>
<b>Date Discharge Form Completed</b>	<p>Enter the date the form was completed. This information is not transmitted to Austin.</p>

## Example: Discharging a patient to another institution

Select HBHC PATIENT NAME: **HBPCPATIENT, SEVEN**      5-20-66      000000007

Enrollment Priority: GROUP 1      Category: IN PROCESS      End Date:  
01-03-00

DISCHARGE DATE: **T** (FEB 29, 2000)

ELIGIBILITY @ DISCHARGE: Service Connected 50% or More (01)  
// **<RET>** Service Connected 50% or More (01)

MARITAL STATUS @ DISCHARGE: **1** Married (1)

LIVING ARRANGEMENTS @ D/C: **2** With Spouse (2)

DISCHARGE STATUS: **2** Anticipated Institutionalization (2)

TRANSFER DESTINATION: **2** Non VA Care (2)

TYPE OF DESTINATION AGENCY: **3** Nursing Home (3)

PRIMARY DIAGNOSIS @ DISCHARGE: **102.2** EARLY SKIN YAWS NEC

SECONDARY DIAGNOSES @ D/C: **<RET>**

VISION @ DISCHARGE: **3** Severe Loss (3)

HEARING @ DISCHARGE: **3** Severe Loss (3)

EXPRESSIVE COMMUNICATION @ D/C: **4** Uses Only Gestures, Grunts, or Primitive Symbols (4)

RECEPTIVE COMMUNICATION @ D/C: **5** Does Not Understand (5)

BATHING @ DISCHARGE: **3** Not Done or Done Without Patient Participation (3)

DRESSING @ DISCHARGE: **3** Not Done or Done Without Patient Participation (3)

TOILET USAGE @ DISCHARGE: **3** Not Done or Done Without Patient Participation (3)

TRANSFERRING @ DISCHARGE: **3** Not Done or Done Without Patient Participation (3)

EATING @ DISCHARGE: **3** Not Done or Done Without Patient Participation (3)

WALKING @ DISCHARGE: **3** Not Done or Done Without Patient Participation (3)

BOWEL CONTINENCE @ DISCHARGE: **3** Incontinent or Ostomy/Catheter Not Self Care (3)

BLADDER CONTINENCE @ DISCHARGE: **3** Incontinent or Ostomy/Catheter Not Self Care (3)

MOBILITY @ DISCHARGE: **3** Confined Indoors, Not Bed Disabled (3)

ADAPTIVE TASKS @ DISCHARGE: **2** Requires Help (2)

BEHAVIOR PROBLEMS @ DISCHARGE: **1** Does Not Exhibit This Characteristic (1)

DISORIENTATION @ DISCHARGE: **2** Exhibits This Characteristic (2)

MOOD DISTURBANCE @ DISCHARGE: **2** Exhibits This Characteristic (2)

CAREGIVER LIMITATIONS @ D/C: **3** Moderately Severe (3)

PERSON COMPLETING D/C FORM: **100**      HBPCPROVIDER,TWO      HINES ISC  
...OK? Yes// **<RET>** (Yes)

DATE DISCHARGE FORM COMPLETED: **T** (FEB 29, 2000)

## V. Using the Reports Menu

Use of these reports is discussed in the following pages:

- Evaluation/Admission Data Report by Patient (80) [HBHCRP2]
- Patient Visit Data Report (80) [HBHCRP3]
- Discharge Data Report by Patient (80) [HBHCRP5]
- Episode of Care/Length of Stay Report (80) [HBHCRP12]
- Admissions/Discharges by Date Range Report (132) [HBHCRP7]
- Rejections from HBPC Program Report (132) [HBHCRP16]
- Visit Data by Date Range Report (80) [HBHCRP4]
- CPT Code Summary Report (80) [HBHCRP17]
- ICD Code/Dx Text by Date Range Report (80) [HBHCR19A]
- Unique Patients by Date Range Summary Report (80) [HBHCRP20]
- Total Visits by Date Range Report (80) [HBHCRP21]
- <sup>1</sup>Patient Days of Care by Date Range Report (80) [HBHCRP23]
- Census Reports Menu ... [HBHC CENSUS REPORTS MENU]
  - Program Census Report (80) [HBHCRP10]
  - <sup>2</sup> Address Included Program Census (132) [HBHCRP25]
  - <sup>3</sup> Expanded Program Census Report (80) [HBHCRP24]
  - Active Census with ICD Code/Text Report (132) [HBHCRP18]
  - Team Census Report (80) [HBHCRP11]
  - Case Manager Census Report (132) [HBHCRP6]
  - Provider Census Report (132) [HBHCRP9]

---

<sup>1</sup> Patch HBH\*1\*21 February 2005 – New option added to the Reports Menu

<sup>2</sup> Patch HBH\*1\*21 February 2005 – New option added to the Census Reports Menu

<sup>3</sup> Patch HBH\*1\*21 February 2005 – New option added to the Census Reports Menu

Reports Menu ...

## Evaluation/Admission Data Report by Patient (80)

[HBHCRP2]

This report is useful for displaying all admission data fields for a particular patient, or for locating information on a specific episode of care. The report format mimics the Evaluation/Admission (Form 3) pre-printed form layout. Data entry accuracy can be verified by comparing the report printout to the original Form 3.

### Example:

```
Select HBHC PATIENT NAME: HBPCPATIENT,FIVE      1-1-40      000000005  YES  SC VETERAN
  Enrollment Priority: GROUP 2      Category: IN PROCESS      End Date: 02-29-00
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

>>> HBPC Patient Evaluation/Admission Data Report <<<

Run Date: FEB 29, 2000

```

=====
Patient Name: HBPCPATIENT,FIVE                Last Four: 0004
=====
1. Hospital Number:          499 | 20. Primary Diagnosis @ Adm:    157.1
-----
2. Date:                     02-29-00 | 21. Secondary Diagnoses @ Adm:
-----
3. State Code:               17 | 22. Vision @ Admission:          2
-----
4. County Code:              031 |   Hearing @ Admission:          2
-----
5. ZIP Code:                 60611 | 23. Expressive Communication @ Adm: 1
-----
6. Eligibility @ Evaluation:  03 | 24. Receptive Communication @ Adm:  1
-----
7. Birth Year:                1940 | 25. Bathing @ Admission:         2
-----
8. Period of Service:        07 |   Dressing @ Admission:         2
-----
9. Sex:                       1 |   Toilet Usage @ Admission:      2
-----
110. Race:                    1 |   Transferring @ Admission:      2 |
-----
11. Marital Status @ Evaluation: 1 |   Eating @ Admission:            2
-----
12. Living Arrangements @ Eval:  1 |   Walking @ Admission:           3
-----
13. Last Agency Providing Care:  1 | 26. Bowel Continence @ Admission:  2
-----
14. Type of Last Care Agency:    5 |   Bladder Continence @ Admission: 3
-----
15. Referred While Inpatient:    1 | 27. Mobility @ Admission:         3
-----
16. Admit/Reject Action:         1 | 28. Adaptive Tasks @ Admission:   2
-----
17. Reject/Withdraw Reason:      | 29. Behavior Problems @ Admission: 1
-----
18. Reject/Withdraw Disposition: | 30. Disorientation @ Admission:   1
-----
19. SSN:                        000-00-0004 | 31. Mood Disturbance @ Admission:  2
-----
                                     | 32. Caregiver Limitations @ Adm:   1
-----
                                     | 33. Person Completing Eval/Adm:  100
-----
                                     |   Date Eval/Adm Completed: 02-29-00
-----
                                     |   Case Manager:                100
=====

```

<sup>1</sup> Patch HBH\*1\*19 January 2003 Race: Obsolete Field January 2003

Reports Menu ...

## <sup>1</sup>Patient Visit Data Report (80)

[HBHCRP3]

Use this option to obtain a list of visit dates for a patient over a selected date range. The report prints the Visit Date, Provider Name and Number, Diagnosis(es), CPT codes and CPT modifiers.

If there are no visits for the patient you select, the following message is displayed:

This patient has no visits on file.

### Example:

Select PATIENT NAME: **HBPCPATIENT**,SEVEN      5-20-66      000000007      YES      ACTIVE DUTY  
Enrollment Priority: GROUP 1      Category: IN PROCESS      End Date:

Beginning Report Date: **2/1/00** (FEB 01, 2000)  
Ending Report Date: **T** (FEB 29, 2000)  
DEVICE: HOME// (Enter a device)

```
>>> HBPC Patient: HBPCPATIENT,SEVEN 000-00-0007 Visit Data Report <<< Page: 1
Run Date: FEB 29, 2000                               Date Range: FEB 01, 2000 to
                                                         FEB 29, 2000
=====
Visit Date: 02-10-2000   Prov No.: 102   Prov Name: HBPCPROVIDER,TWO
Diagnosis:  161.3      MAL NEO CARTILAGE LARYNX
CPT Code:   92502      EAR AND THROAT EXAMINATION
Modifier:   - 26      PROFESSIONAL COMPONENT
-----
                               ==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*16 June 2000 – CPT modifiers added to report; report changed to 80 column format.

Reports Menu ...

## Discharge Data Report by Patient (80)

[HBHCRP5]

Use this option to display all discharge data fields for a particular patient, or for locating specific episode of care information. Data entry accuracy can be verified by comparing the report printout to the original Form 5.

### Example:

```
Select HBHC PATIENT NAME: HBPCPATIENT,SEVEN 5-20-66 00000007 YES ACTIVE DUTY
Enrollment Priority: GROUP 1 Category: IN PROCESS End Date:
01-03-00
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)
```

```
>>> HBPC Patient Discharge Data Report <<<

Run Date: FEB 29, 2000

=====
Patient Name: HBPCPATIENT,SEVEN Last Four: 0007
=====
1. Hospital Number: 499 | 20. Primary Diagnosis @ D/C: 102.2
-----
2. Discharge Date: 02-29-00 | 21. Secondary Diagnoses @ D/C:
-----
3. Eligibility @ Discharge: 01 | 22. Vision @ Discharge: 3
-----
4. Marital Status @ Discharge: 1 | Hearing @ Discharge: 3
-----
5. Living Arrangements @ D/C: 2 | 23. Expressive Communication @ D/C: 4
...

```

Reports Menu ...

## Episode of Care/Length of Stay Report (80)

[HBHCRP12]

This report mimics the Austin generated DMS COIN 157 report which is received quarterly. This report lists only those patients admitted or discharged in the date range specified.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will provide the same results. This report will only print active patients.

<sup>1</sup>The report is sorted by patient and includes: Patient Name, SSN, Admission Date, Discharge Date, and Length of Stay. It does the following:

- Calculates the length of stay on episodes without a Discharge Date,
- Prints "Active" in the Discharge Date column if there is no Discharge Date,
- Displays patients and length of stay totals by day, and
- For complete episodes of care, average length of stay and final totals are included.

### Example:

Beginning Report Date: **T-365** (MAR 02, 1999)  
Ending Report Date: **T** (MAR 01, 2000)  
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

```
>>> HBPC Episode of Care/Length of Stay Report <<<                               Page: 1
Run Date: MAR 01, 2000                               Date Range: MAR 02, 1999 to
                                                         MAR 01, 2000

Patient Name          SSN          Date          Discharge   Length
                    Date          Date          Date        /Stay
=====
HBPCPATIENT,EIGHT    000-00-0008    11-03-99      Active      119
-----
HBPCPATIENT,FIVE     000-00-0005    02-29-00      Active      1
-----
HBPCPATIENT,NINE     000-00-0009    12-03-99      12-03-99    0
-----
HBPCPATIENT,TWO      000-00-0002    01-03-00      02-29-00    57
-----
HBPCPATIENT,TEN      000-00-0010    12-02-99      Active      90
-----

Total Patients: 5      Total Days: 267

Complete Episodes of Care Only:
  Total Patients: 2      Total Days: 57      Average Length of Stay: 28

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*6 July 1997 Changes to report.



Reports Menu ...

## Admissions/Discharges by Date Range Report (132)

[HBHCRP7]

This report prints HBPC Admissions or Discharges for a selected date range. The report is sorted by Admission/Discharge Date and includes: Admission/Discharge Date, Patient Name, SSN, and ICD9 or ICD10 Code and Diagnosis Text (Primary Diagnosis @ Admission/Discharge), with Total. The report requires a device that can print 132 column format.

**Note:** The column header in various ICD Code reports is customized to match the type of ICD code that appears in the report. If the report only covers ICD-9 era dates, the column header is ICD9; if the report covers only ICD-10 era dates, the column header is ICD10; and if the report covers both ICD-9 and ICD-10 era dates, the column header is ICD.

### Example:

Select Admissions or Discharges: (A/D): Admissions  
Beginning Report Date: 3/21/2000 (MAR 21, 2000)  
Ending Report Date: T (MAR 28, 2000)  
DEVICE: HOME// (Enter a device capable of printing 132 columns)

```
>>> HBPC Admissions by Date Range Report <<< Page: 1
Run Date: MAR 28, 2000 Date Range: MAR 21, 2000 to
MAR 28, 2000
=====
Admission Date Patient Name SSN ICD9 Code Diagnosis Text
=====
11-03-99 HBPCPATIENT,EIGHT 000-00-0008 571.49 CHRONIC HEPATITIS NEC
-----
12-02-99 HBPCPATIENT1,ONE 000-00-0011 230.2 CA IN SITU STOMACH
-----
12-03-99 HBPCPATIENT,NINE 000-00-0009 231.0 CA IN SITU LARYNX
-----
01-03-00 HBPCPATIENT,TWO 000-00-0002 147.8 MAL NEO NASOPHARYNX NEC
-----
02-29-00 HBPCPATIENT,FIVE 000-00-0005 157.1 MAL NEO PANCREAS BODY
-----
03-09-00 HBPCPATIENT1,TWO 000-00-0012 157.3 MAL NEO PANCREATIC DUCT
-----
Total Admissions: 6
=====
==== End of Report ====
```

Reports Menu ...

## <sup>1</sup>Rejections from HBPC Program Report (132)

[HBHCRP16]

Use this option to print a list of rejections for a selected date range. The data is sorted by patient name and includes: Patient Name, SSN, Evaluation Date, and Reject/Withdraw Reason, with Total. The report requires a device that can print 132 column format.

### Example:

Beginning Report Date: 3/1/2000 (MAR 01, 2000)  
Ending Report Date: 3/31/2000 (MAR 31, 2000)  
DEVICE: HOME// (Enter a device that is capable of printing 132 columns)

```
Run Date: APR 05, 2000                >>> HBPC Rejections from Program Report <<<                Page: 1
                                         Date Range: MAR 01, 2000 to
                                         MAR 31, 2000
```

Patient Name	SSN	Date	Reject/Withdraw Reason
HBPCPATIENT1,THREE	000-00-0013	03-06-00	Not Located in Service Area (01)

```
=====  
Program Rejections Total: 1  
=====
```

==== End of Report ====

<sup>1</sup> Patch HBH\*1\*6 July 1997 New option

Reports Menu ...

## <sup>1</sup>Visit Data by Date Range Report (80)

[HBHCRP4]

This report is sorted alphabetically by provider. Each provider starts a new page with a beginning page number of 1. The report contains the Visit Date, Patient, Last 4 of the SSN, Diagnosis(es), CPT Codes and Modifiers, with a visit total. A final visit total is included at the end of the report if all providers selected.

Do you wish to include ALL providers on the report? Yes// **N** (No)

Select HBPC Provider: **HBPCPROVIDER,TWO** HPT IRM FIELD OFFICE I  
RM FIELD OFFICE 152 HBPCPROVIDER,TWO BLUE TEAM  
...OK? Yes// **<RET>** (Yes)

Select HBPC Provider: **<RET>**

Beginning Report Date: **5/29** (MAY 29, 2000)

Ending Report Date: **6/2** (JUN 02, 2000)

DEVICE: HOME// (Enter a printer or press the <RET> key to view on screen.)

```
>>> HBPC Visit Data by Date Range Report <<<                               Page: 1
      Provider: HBPCPROVIDER,TWO (152)

Run Date: JUN 02, 2000                               Date Range: MAY 29, 2000 to
                                                    JUN 02, 2000
=====
Visit Date: 06-02-2000  Patient Name: HBPCPATIENT,EIGHT      Last 4: 0008
Diagnosis:  161.3     MAL NEO CARTILAGE LARYNX
CPT Code:   92502     EAR AND THROAT EXAMINATION
  Modifier:   - 26     PROFESSIONAL COMPONENT
  Modifier:   - 77     REPEAT PROCEDURE BY ANOTHER PHYSICIAN
-----
=====
Provider: HBPCPROVIDER,TWO (152)  Visits Total:  1
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*16 June 2000 – CPT modifiers added to report; report changed to 80 column format; selection of multiple providers.

Reports Menu ...

## <sup>1</sup>CPT Code Summary Report (80)

[HBHCRP17]

Use this option to obtain totals for selected procedure(s) (CPT Codes) over a specified date range. You are prompted for a date range, and CPT Code(s) or range of codes for inclusion on the report. The data is sorted by CPT Code with totals for each CPT Code plus a grand total.

### Example:

Beginning Report Date: 3/1/2000 (MAR 01, 2000)

Ending Report Date: 3/31/2000 (MAR 31, 2000)

Will CPT Codes selected be a Range of codes (Y/N)? NO

Select CPT: W0100 GENERAL MEDICAL EXAM, VA FAC

Select CPT: <RET>

DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

```

                >>> HBPC CPT Code Summary Report <<<                               Page: 1
Run Date: APR 08, 2000                               Date Range: MAR 01, 2000 to
                                                        MAR 31, 2000

CPT Code                                           Total
-----
W0100 GENERAL MEDICAL EXAM, VA FAC                2
-----
Total CPT Codes:                2
-----

                ==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*6 July 1997 New option.

Reports Menu ...

## <sup>12</sup>Provider CPT Code Summary Report (80)

[HBHCRP22]

Use this option to obtain a total for selected procedures performed by specific providers. You are prompted to enter a date range, CPT code(s) (can be range of CPTs), and Provider(s) for inclusion on report.

This report is sorted alphabetically by provider. Each provider starts a new page with a beginning page number of 1. A final procedure total is included at the end of the report if all providers selected.

Beginning Report Date: 3/1/2000 (MAR 01, 2000)

Ending Report Date: 3/31/2000 (MAR 31, 2000)

Will CPT Codes selected be a Range of codes (Y/N)? NO

Select CPT: W0100 GENERAL MEDICAL EXAM, VA FAC

Select CPT: <RET>

Select HBPC Provider: ?

Answer with HBHC PROVIDER NUMBER, or PROVIDER NAME

Choose from:

100	HBPCPROVIDER,EIGHT	BLUE TEAM
101	HBPCPROVIDER,FOUR	HINES TEAM 2
102	HBPCPROVIDER,TWO	BLUE TEAM
104	HBPCPROVIDER,FIVE	HINES TEAM 2
150	HBPCPROVIDER,THREE	HINES TEAM 2

...

Select HBPC Provider: 150 HBPCPROVIDER,THREE

...OK? Yes// <RET> (Yes)

Select HBPC Provider: <RET>

DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

```
>>> HBPC Provider: HBPCPROVIDER,THREE CPT Code Summary Report <<< Page: 1
Run Date: APR 08, 2000 Date Range: MAR 01, 2000 to
MAR 31, 2000

CPT Code Total
=====
W0100 GENERAL MEDICAL EXAM, VA FAC 2
-----

Total CPT Codes: 2
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*11 July 1998 New option.

<sup>2</sup> Patch HBH\*1\*16 June 2000 – Allows selection of multiple providers.

Reports Menu ...

## <sup>1</sup>ICD Code/Dx Text by Date Range Report (80)

[HBHCR19A]

Use this option to print a list of all or selected patient diagnoses for visits over a specified date range. You are prompted to enter a date range, and the ICD9 or ICD10 Code(s), or category of codes, for inclusion on the report. The report is sorted by ICD9 or ICD10 Code category, then alphabetically by patient within the category, with totals for each ICD9 or ICD10 Code category, plus a grand total.

**Note:** The column header in various ICD Code reports is customized to match the type of ICD code that appears in the report. If the report only covers ICD-9 era dates, the column header is ICD9; if the report covers only ICD-10 era dates, the column header is ICD10; and if the report covers both ICD-9 and ICD-10 era dates, the column header is ICD.

### Example:

Beginning Report Date: **12/1/99** (DEC 01, 1999)

Ending Report Date: **12/31/99** (DEC 31, 1999)

Do you wish to include ALL ICD Diagnosis Codes on the report? No// **Y** (Yes)

DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

```
>>> HBPC ICD Code/Diagnosis Text by Date Range Report <<< Page: 1
Run Date: MAR 28, 2000                               Date Range: DEC 01, 1999 to
                                                         DEC 31, 1999

Patient Name                SSN                ICD9 Code/Diagnosis Text
=====
HBPCPATIENT1,FOUR          000-00-0014    147.1    MAL NEO POST NASOPHARYNX
Category:  147  Count:  1
-----
HBPCPATIENT,TWO            000-00-0002    230.1    CA IN SITU ESOPHAGUS
Category:  230  Count:  1
-----
HBPCPATIENT1,FOUR          000-00-0014    416.8    CHR PULMON HEART DIS NEC
HBPCPATIENT,FIVE           000-00-0005    416.8    CHR PULMON HEART DIS NEC
HBPCPATIENT1,FIVE          000-00-0015    416.8    CHR PULMON HEART DIS NEC
Category:  416  Count:  3
-----
.....
=====
ICD10 Diagnosis Categories Total: 46
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*8 January 1998 New option.

Reports Menu ...

## <sup>1</sup>Unique Patients by Date Range Summary Report (80)

[HBHCRP20]

Use this report to obtain a total for single and multiple visits by unique patients for a selected date range. You are prompted to enter the date range for inclusion on the report. The report prints separate totals for patients with a single visit only or multiple visits, plus a grand total for unique patients.

### Example:

Beginning Report Date: **12/1/99** (DEC 01, 1999)  
Ending Report Date: **12/31/99** (DEC 31, 1999)  
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

```
>>> HBPC Unique Patients by Date Range Summary Report <<<           Page: 1
Run Date: MAR 28, 2000                               Date Range: DEC 01, 1999 to
                                                         DEC 31, 1999
=====
Total Patients with Single Appointment Only:         20
Total Patients with Multiple Appointments:           7
Total Unique Patients:                               27
                                                         ==== End of Report =====
```

<sup>1</sup> Patch HBH\*1\*8 January 1998 New option.

Reports Menu ...

## <sup>1</sup>Total Visits by Date Range Report (80)

[HBHCRP21]

Use this option to obtain a total number of visits for a selected date range. A visit is omitted from the report if it contains any of the CPT codes shown in the example. You can also select additional CPT codes to omit from the report. The report includes: Patient Name, the last four digits of the SSN, Total Visits per patient, Date (admitted to HBPC program) and Discharge Date (if applicable), with grand totals of patients and visits.

### Example:

Beginning Report Date: 3/1/2000 (MAR 01, 2000)

Ending Report Date: 3/31/2000 (MAR 31, 2000)

Visits containing any of the following CPT Codes are omitted from report:

```
99358  PROLONGED SERV, W/O CONTACT
99359  PROLONGED SERV, W/O CONTACT
99361  PHYSICIAN/TEAM CONFERENCE
99362  PHYSICIAN/TEAM CONFERENCE
99371  PHYSICIAN PHONE CONSULTATION
99372  PHYSICIAN PHONE CONSULTATION
99373  PHYSICIAN PHONE CONSULTATION
99374  HOME HEALTH CARE SUPERVISION
99375  HOME HEALTH CARE SUPERVISION
99376  CARE PLAN OVERSIGHT/OVER 60
```

Enter any other CPT code you wish to omit: <RET>

Select one of the following:

```
A      Alphabetical
V      Number of Visits
```

<sup>2</sup>Sort Preference: V// <RET> Number of Visits

DEVICE: HOME// (enter a printer or press the <RET> key to print to your screen)

---

<sup>1</sup> Patch HBH\*1\*11 July 1998 New option.

<sup>2</sup> Patch HBH\*1\*13 March 1999 New functionality.



Run Date: APR 03, 2000

Date Range: MAR 01, 2000 to  
MAR 31, 2000

Patient Name	Last Four	Visit Total	Date	Discharge Date
--------------	--------------	----------------	------	-------------------

Visits containing any of the following CPT Codes are omitted from report:

- 99358 PROLONGED SERV, W/O CONTACT
- 99359 PROLONGED SERV, W/O CONTACT
- 99361 PHYSICIAN/TEAM CONFERENCE
- 99362 PHYSICIAN/TEAM CONFERENCE
- 99371 PHYSICIAN PHONE CONSULTATION
- 99372 PHYSICIAN PHONE CONSULTATION
- 99373 PHYSICIAN PHONE CONSULTATION
- 99374 HOME HEALTH CARE SUPERVISION
- 99375 HOME HEALTH CARE SUPERVISION
- 99376 CARE PLAN OVERSIGHT/OVER 60

HBPCPATIENT,FIVE	0005	1	MAR 03, 2000	MAR 03, 2000
HBPCPATIENT1,TWO	0012	1	MAR 09, 2000	MAR 09, 2000
HBPCPATIENT,NINE	0009	1	MAR 03, 1999	MAR 03, 2000

...

Total Patients with 1 Visit(s): 24

HBPCPATIENT,TWO	0002	2	MAR 29, 2000	MAR 29, 2000
-----------------	------	---	--------------	--------------

Total Patients with 2 Visit(s): 1

\*\*\*\*\* Total Visits Summary \*\*\*\*\*

Total Patients with 1 Visit(s):	24
Total Patients with 2 Visit(s):	1
Total Patients:	25
Total Visits:	26

==== End of Report ====

# <sup>1</sup> Patient Days of Care by Date Range Report (80)

[HBHCRP23]

Use this option to print HBPC Patient Days of Care by Date Range Report. Report includes: file internal entry number (IEN), Patient Name, Social Security Number (SSN), Date, Discharge Date, & Patient Days. Patient Days is calculated based on the user selectable date range. Summary totals of Patients and Patient Days are included for both Complete Episodes of Care and Active Cases.

Date of Discharge is omitted from the Patient Days total (e.g., Adm Date: 7/1/03, D/C Date: 7/5/03 would total 4 Patient Days, not 5). Report prints in 80 column format

## Example:

Beginning Report Date: 10/01/03 (OCT 01, 2003)  
Ending Report Date: 12/31/03 (DEC 31, 2003)  
DEVICE: HOME// (Enter a device that prints 80 columns)

```
>>> HBPC Patient Days of Care by Date Range Report <<< Page: 1

Run Date: JUL 22, 2004 Date Range: OCT 01, 2003 to DEC 31, 2003

IEN Patient Name SSN Date Discharge Date Patient Days
=====
`1588 HBHpatient,One 000-04-2286 02-05-01 06-04-04 92
-----
`1903 HBHpatient,Two 000-01-0761 04-10-03 03-04-04 92
-----
`1869 HBHpatient,Three 000-08-7970 01-14-03 10-02-03 1
-----
`1274 HBHpatient,Four 000-13-2705 05-28-99 10-07-03 6
-----
`1884 HBHpatient,Five 000-11-6057 02-13-03 92
-----
`1847 HBHpatient,Six 000-06-9738 11-15-02 92
-----
`1909 HBHpatient,Seven 000-06-8732 04-22-03 12-16-03 76
-----
`1957 HBHpatient,Eight 000-26-1343 10-27-03 66
...

=====
>>> Date Range: OCT 01, 2003 to DEC 31, 2003 <<<
=====
Total Active Patients: 169
=====
Complete Episodes of Care Only:
Total Patients: 37 Total Patient Days in Date Range: 1,327
=====
Total Patients: 206 Total Patient Days in Date Range: 15,576
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*21 February 2005 – New option and example added to the Reports Menu

Reports Menu ...

## **Census Reports Menu ...**

[HBHC CENSUS REPORTS MENU]

The Census Reports Menu contains the following options:

- Program Census Report (80) [HBHCRP10]
- <sup>1</sup> Address Included Program Census (132) [HBHCRP25]
- <sup>2</sup> Expanded Program Census Report (80) [HBHCRP24]
- Active Census with ICD Code/Text Report (132) [HBHCRP18]
- Team Census Report (80) [HBHCRP11]
- Case Manager Census Report (132) [HBHCRP6]
- Provider Census Report (132) [HBHCRP9]

---

<sup>1</sup> Patch HBH\*1\*21 February 2005 – New option added to the Census Reports Menu

<sup>2</sup> Patch HBH\*1\*21 February 2005 – New option added to the Census Reports Menu

Reports Menu ...  
Census Reports Menu ...

## Program Census Report (80)

[HBHCRP10]

Use this option to obtain an HBPC census report for a specified date range. The report is sorted by patient name and includes: Patient Name, SSN, and <sup>1</sup>Admission Date, with Total.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

### Example:

Beginning Report Date: 1/1/99 (JAN 01, 1999)  
Ending Report Date: 12/31/99 (DEC 31, 1999)  
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

```
>>> HBPC Program Census Report <<<                               Page: 1
Run Date: MAR 29, 2000                               Date Range: JAN 01, 1999 to
                                                         DEC 31, 1999

Patient Name                SSN                Date
=====
HBPCPATIENT,EIGHT          000-00-0008          NOV 03, 1999
-----
HBPCPATIENT1,SIX           000-00-0016          DEC 02, 1999
-----
...
-----
Program Census Total: 64
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*6 July 1997 Changed Admission Date header in report to Date.

Reports Menu ...  
Census Reports Menu ...

## <sup>1</sup>Address Included Program Census (132)

[HBHCRP25]

This option prints the HBPC Address Included Program Census Report. The user is prompted to enter a date range for inclusion on the report. The report is sorted alphabetically by patient name & includes: Patient Name, Last 4, Admission Date, Address, City, ZIP Code, Phone Number, Case Manager, & Total. Report prints in 132 column format.

### Example:

Beginning Report Date: 1/1/04 (JAN 01, 2004)  
Ending Report Date: 1/31/04 (NOV 09, 2004)  
DEVICE: HOME// (Enter a device that prints 132 columns)

```
>>> HBPC Address Included Program Census Report <<<                               Page: 1
Run Date: JUL 22, 2004                               Date Range: JAN 01, 2004 to JAN 31, 2004

Patient Name    Last Admission      Street Address  City      ZIP      Phone      Case
Four           Date              Manager
=====
HBHPT,ONE       0000   JAN 14, 2004   123 Oak Leaf  Perch    70000   (000)320-0000  HBHPROVIDER1
-----
HBHPT,TWO       0000   JAN 09, 2004   1355 Sherwood Rogers    90000   (000)280-0000  HBHPROVIDER2
-----
HBHPT,THREE     0000   JAN 15, 2004   9584 Mouse Top Lane     90000   (000)980-0000  HBHPROVIDER2
-----
HBHPT,FOUR      0000   JAN 15, 2004   911 Help Court Menu     40000   (000)920-0000  HBHPROVIDER3
-----
HBHPT,FIVE      0000   JAN 08, 2004   938 George Dr  Forman   20000   (000)430-0000  HBHPROVIDER4
-----
HBHPT,SIX       0000   JAN 20, 2004   221 Normal Dr  Lane     20000   (000)340-0000  HBHPROVIDER5
-----
HBHPT,SEVEN     0000   JAN 14, 2004   982 Powder Puff Canes  90000   (000)950-0000  HBHPROVIDER4
=====
Program Census Total: 7
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*21 February 2005 – New option and example added to the Census Reports Menu

Reports Menu ...  
Census Reports Menu ...

## **Expanded Program Census Report (80)**

[HBHCRP24]

Use this option to print the HBPC Expanded Program Census Report. The user is prompted to enter the date range for inclusion on the report. The report is sorted by patient name and includes: Patient Name, Last 4, Admission Date, Case Manager, Most Recent Visit Date, Visit Discipline, & total. Report prints in 80 column format.

### **Example:**

Beginning Report Date: 1/1/04 (FEB 01, 2005)  
Ending Report Date: 1/31/04 (NOV 01, 2006)  
DEVICE: HOME// (Enter a device that prints 80 columns)

```
>>> HBPC Expanded Program Census Report <<<                                     Page: 1

Run Date: JUL 22, 2004                               Date Range: JAN 01, 2004 to JAN 31, 2004

Patient Name      Last   Admission   Case           Most Recent     Visit
                  Four    Date         Manager        Visit Date/Time Discipline
=====
HBHPATIENT,ONE   4358   JAN 14, 0000  HBHPROVIDER,ONE  JUN 08, 2004@14:00  RNP/PA
-----
HBHPATIENT,TWO   9584   JAN 09, 0000  HBHPROVIDER,TWO  JUN 30, 2004@11:00  Other
-----
HBHPATIENT,TWO   5832   JAN 15, 0000  HBHPROVIDER,FOUR  MAY 21, 2004@15:30  RNP/PA
-----
HBHPATIENT,FOUR  4805   JAN 15, 0000  HBHPROVIDER,ONE  JAN 26, 2004@07:30  RNP/PA
-----
HBHPATIENT,FIVE  1220   JAN 08, 0000  HBHPROVIDER,ONE  FEB 05, 2004@10:50  Soc Wrkr
-----
HBHPATIENT,SIX   2549   JAN 20, 0000  HBHPROVIDER,FOUR  JUL 02, 2004@11:30  Other
-----
HBHPATIENT,SEVEN 8685   JAN 14, 0000  HBHPROVIDER,ONE  MAR 16, 2004@9:30   RNP/PA
=====
Program Census Total: 7
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*21 February 2005 – New option and example added to the Census Reports Menu

Reports Menu ...  
Census Reports Menu ...

## <sup>1</sup>Active Census with ICD Code/Text Report (132) [HBHCRP18]

Use this option to print the HBPC active census including diagnoses for a specified date range. The report is sorted by patient name, then by admission date, and includes: Patient Name, SSN,<sup>2</sup> Admission Date, ICD9 or ICD10 Code, and ICD9 or ICD10 Text, with Total. Report requires 132 column print format.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

**Note:** The column header in various ICD Code reports is customized to match the type of ICD code that appears in the report. If the report only covers ICD-9 era dates, the column header is ICD9; if the report covers only ICD-10 era dates, the column header is ICD10; and if the report covers both ICD-9 and ICD-10 era dates, the column header is ICD.

### Example:

Beginning Report Date: **1/1/1999** (JAN 01, 1999)  
Ending Report Date: **12/31/1999** (DEC 31, 1999)  
DEVICE: HOME// (Enter a device that prints 132 columns)

```
>>> HBPC Active Census with ICD Code/Text Report <<<                               Page: 1
Run Date: MAR 29, 2000                               Date Range: JAN 01, 1999 to
                                                    DEC 31, 1999
Patient Name           SSN           Date           ICD9 Code      Diagnosis Text
-----
HBPCPATIENT,EIGHT     000-00-0008    NOV 03, 1999   416.8          CHR PULMON HEART DIS NEC
-----
HBPCPATIENT1,SIX      000-00-0016    DEC 02, 1999   416.8          CHR PULMON HEART DIS NEC
-----
...
-----
Active Census Total: 64
-----
=====
==== End of Report =====
```

<sup>1</sup> Patch HBH\*1\*6 July 1997 New option.

<sup>2</sup> Patch HBH\*1\*6 July 1997 Changed Admission Date header in report to Date.

Reports Menu ...  
Census Reports Menu ...

## Team Census Report (80)

[HBHCRP11]

Use this option to print a census report for each team over a selected date range. The report is sorted by Team and includes: Team Name, Patient Name, SSN, and <sup>1</sup>Admission Date, with Totals for each Team and Final Totals for all Teams.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

### Example:

Beginning Report Date: **1/1/99** (JAN 01, 1999)  
Ending Report Date: **12/31/99** (DEC 31, 1999)  
DEVICE: HOME// (Enter a printer or press the <RET> key to print to your screen)

>>> HBPC Team Census Report <<<		Page: 1
HBPC Team: Blue Team		
Run Date: MAR 29, 2000	Date Range: JAN 01, 1999 to DEC 31, 1999	
Patient Name	SSN	Date
HBPCPATIENT,EIGHT	000-00-0008	NOV 03, 1999
HBPCPATIENT1,SIX	000-00-0016	DEC 02, 1999
...		
Team: Blue Team	Census Total: 14	
...		
All Team Census Total: 64		
==== End of Report ====		

<sup>1</sup> Patch HBH\*1\*6 July 1997 Changed Admission Date header in report to Date.



Reports Menu ...  
Census Reports Menu ...

## <sup>1</sup>Case Manager Census Report (132) [HBHCRP6]

Use this option to print a report of the census for selected or all case managers over a date range. The report is sorted by Case Manager and includes: Case Manager, Patient Name, SSN, Admission Date, Street Address, City, ZIP Code, and Phone, with Totals for each Case Manager and Final Totals if 'All' is selected. Each Case Manager begins a new page starting with page number 1. The report prints in 132 column format.

Note: To obtain an accurate census report, use the admission date for the patient that has been on the program the longest. An arbitrary date of 1/1/85 will give you the same results. This report will only give you active patients.

### Example:

Do you wish to include ALL case managers on the report? Yes// <RET> (Yes)

Beginning Report Date: 11/1/99 (NOV 01, 1999)

Ending Report Date: 11/30/99 (NOV 30, 1999)

DEVICE: HOME// (Enter a printer that supports 132 column printout)

```
>>> HBPC Case Manager Census Report <<<                               Page: 1
      Case Manager: ACKERMAN,PROVIDER (150)

Run Date: MAR 28, 2000                               Date Range: NOV 01, 1999 to
                                                    NOV 30, 1999

Patient Name      SSN      Date      Street Address      City      ZIP Code      Phone
=====
HBPCPATIENT,EIGHT 000-00-0008 11-03-99 187 NOWHERE ST      CHICAGO    60612-3939 666-098-7654
-----
HBPCPATIENT,TWO   000-00-0002 12-03-99 123 SYCAMORE AVE    CHICAGO    60606      666-123-4567
-----
....

Case Manager: HBPCPROVIDER,THREE (150) Case Census Total: 10

....

All Case Census Total: 34
=====

==== End of Report ====
```

<sup>1</sup> Patch HBH\*1\*16 June 2000 – Allows selection of multiple providers; report formatting changes

Reports Menu ...  
Census Reports Menu ...

## <sup>1</sup>Provider Census Report (132)

[HBHCRP9]

Use this option to obtain a census report by provider(s) for a specified date range. The report can be run for All or individual Providers. Only patients with a current admission will be included. The report is sorted by Provider and includes: Provider Name, Provider Number, Patient Name, SSN, Admission Date, Street Address, City, ZIP Code, and Phone, with Totals for each Provider and Final Totals if 'All' is selected. Each provider begins a new page starting with page number 1. The report prints in 132 column format.

Note: The admission date is irrelevant for the date range even though it will appear on this report.

### Example:

Do you wish to include ALL providers on the report? Yes// N (No)

Select HBPC Provider: **HBPCPROVIDER,THREE** NCA IRM FIELD OFFICE  
PHYSICIAN 150 HBPCPROVIDER,THREE  
...OK? Yes// **<RET>** (Yes)

Select HBPC Provider: **<RET>**

Beginning Report Date: **1/1/99** (JAN 01, 1999)  
Ending Report Date: **12/31/99** (DEC 31, 1999)  
DEVICE: HOME// (Enter a device that prints 132 column format)

Patient Name	SSN	Date	Street Address	City	ZIP Code	Phone
HBPCPATIENT,EIGHT	000-00-0008	11-03-99	187 NOWHERE ST	CHICAGO	60612-3939	555-098-7654
HBPCPATIENT,TWO	000-00-0002	12-03-99	123 SYCAMORE AVE	CHICAGO	60606	555-123-4567
....						

Provider: ACKERMAN,PROVIDER (150) Case Census Total: 10

==== End of Report ====

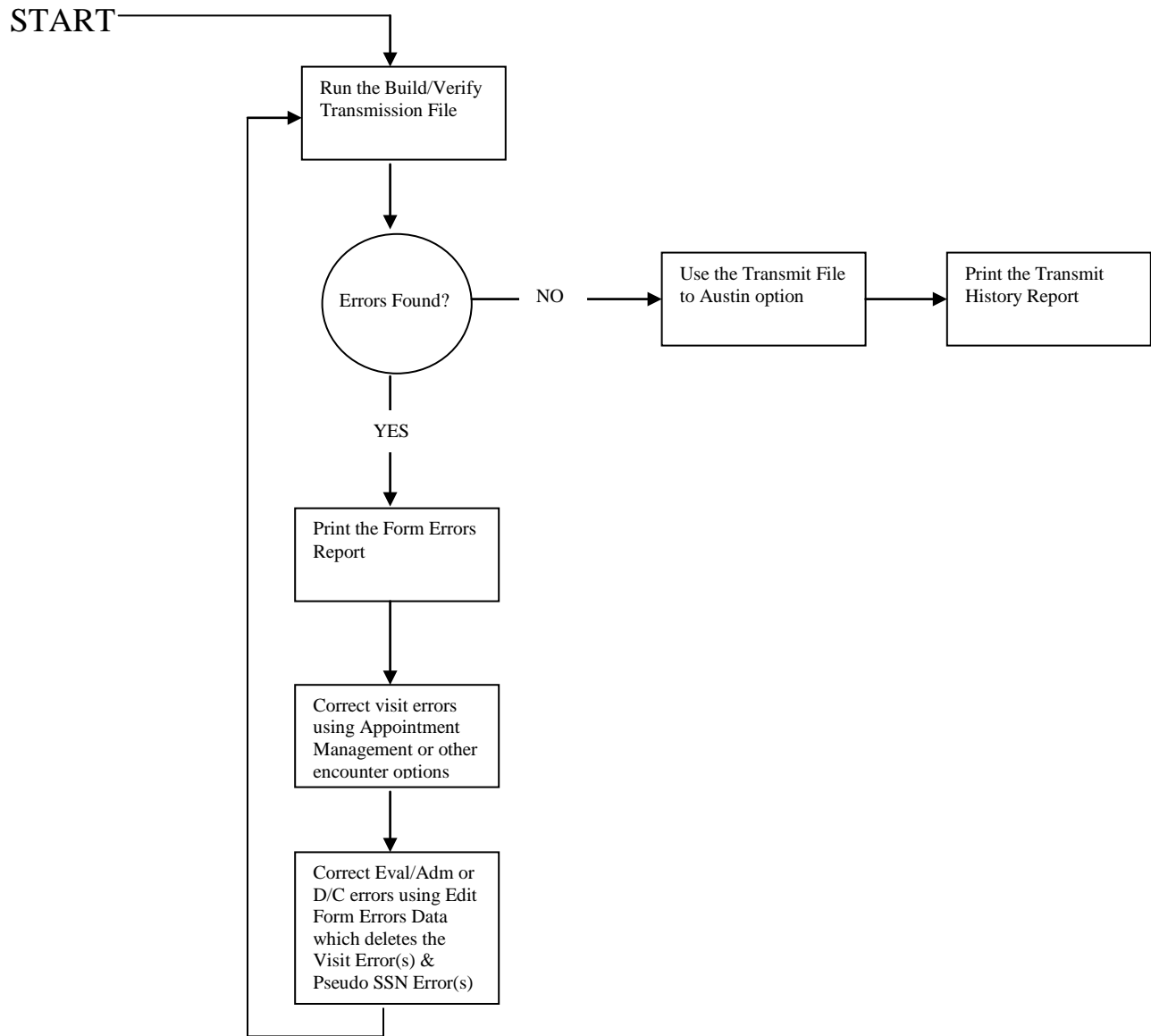
<sup>1</sup> Patch HBH\*1\*16 June 2000 – Allows selection of multiple providers; report formatting changes

## VI. Transmitting Data to Austin

The options in this menu should be used in the order that they appear.

1. Build/Verify Transmission File: Builds the file that will be transmitted and checks the data for completeness.
2. Form Errors Report (80): Prints out any errors found by the Build/Verify Transmission File option.
3. Edit Form Errors Data:
  - Lets you correct admission or discharge errors by prompting for only what is missing and then deletes the Admission and Discharge Errors files.
  - Deletes the Visit Error(s) and the Pseudo SSN Error(s) files.
4. Transmit File to Austin: Transmits the data to Austin.
5. Print Transmit History Report (80): Prints a copy of the transmission.

## Transmission Options Flow



## Build/Verify Transmission File

[HBHCFILE]

Use this option to create the data file for transmission to Austin. All records with a "Needs to be Transmitted" value in the Transmit Status Flag field are processed. This includes all new or corrected Admission and Discharge records. It also scans for all Visit records within a selected Number of Visit Days to Scan.<sup>1</sup>

Each run of this option updates the HBHC Visit file #632 and the HBHC Transmit file #634. If there are invalid records, it also populates the appropriate HBHC Visit Error(s) file #634.2, the HBHC Evaluation/Admission Error(s) file #634.1, the HBHC Discharge Error(s) file #634.3, and/or the HBHC Pseudo SSN Error(s) file #634.5. Errors found through the verification process can be viewed by printing the [Form Errors Report \(80\)](#).

The software considers the following as incomplete:

- Visits without provider, diagnosis code(s), CPT code(s),
- Admission and discharge records with missing data, or
- Records with erroneous data.

The HBHC Transmit file #634 continues to grow each time this option is run until the [Transmit File to Austin](#) option is performed. Once transmitted, the data remains in this file until the next time the Build/Verify Transmission File option is used. This preserves the intact transmit file in case re-transmission to Austin is necessary.

## Messages

- 1 If you receive the following message, the Build/Verify Transmission File or the automated Visit File Update option has run and errors were found. To view the errors that need correcting, run the option Form Errors Report.

```
Records containing errors exist and must be corrected before transmit
file can be created or updated.
```

- 2 <sup>2</sup>If the tasked job runs to completion and there are no errors, the HBH Mail Group will receive the following mail message:

```
[Date] HBHC Build Transmit File is complete with no errors found.
```

```
Number of Visit days to Scan system parameter: nn
```

```
Date range: [Date] thru [Date]
```

<sup>1</sup> Patch HBH\*1\*5 June 1995 Routine no longer excludes visits for the prior 7 days from the Austin transmission.

<sup>2</sup> Patch HBH\*1\*10 March 1998 Added mail messages for tasked job.

Start time: [Time] End time: [Time] Elapsed minutes: nn  
\*\*\*\*\* Reminder: Please run Transmit file to Austin option. \*\*\*\*\*

- 3 If the tasked job runs to completion and there are errors, the HBH Mail Group will receive the following mail message:

Subj: APR 10,2000 HBHC File Update [#52110] 10 Apr 00 15:29 1 line  
From: HBHC FILE UPDATE MAIL GROUP In 'IN' basket. Page 1

-----  
Please run Form Errors Report option for HBHC errors to correct.

**Note: Set the Number of Visit Days to Scan to a large enough number to include the entire transmit batch date range. See the example below where the parameter was changed from 7 to 42 to include the entire month of March from the date it is run (April 10).**

### Example Build with No Errors

This option builds the file for transmission to Austin. Do you wish to continue? No// **Y** (Yes)

Select one of the following:

- |    |           |
|----|-----------|
| 1  | January   |
| 2  | February  |
| 3  | March     |
| 4  | April     |
| 5  | May       |
| 6  | June      |
| 7  | July      |
| 8  | August    |
| 9  | September |
| 10 | October   |
| 11 | November  |
| 12 | December  |

Month for which data is to be transmitted: 3// **<RET>** March

<sup>1</sup>Number of Visit Days to Scan: 7// **42**

<sup>2</sup>Build Transmit File processing has been queued. Task number: 192757

---

<sup>1</sup> Patch HBH\*1\*8 January 1998 Field added to option.

<sup>2</sup> Patch HBH\*1\*10 March 1998 The option was changed to a queued job and includes the display of a task number. The person who queued the job will receive a mail message when the job is complete.

## HBH Mail Message Following a Build without Errors

```
Subj: APR 10,2000 HBHC Build Transmit File [#52111] 10 Apr 00 15:34
9 lines
From: HBHC BUILD TRANSMIT FILE MAIL GROUP In 'IN' basket. Page 1 *New*
-----
APR 10,2000 HBHC Build Transmit File is complete with no errors found.

    Number of Visit Days to Scan system parameter: 42

    Date range: FEB 29,2000 thru MAR 31,2000

    Start time: 15:34:32 End time: 15:34:32 Elapsed minutes: 0

***** Reminder: Please run Transmit File to Austin option. *****
```

## Form Errors Report (80)

[HBHCRP1]

This report is used to determine which patient records contain errors. The errors are found during the data verification process of the [Build/Verify Transmission File](#) option or following a run of the Auto-queue File Update of the HBHC Visit file. It is printed alphabetically by patient last name. A blank space is provided to the left of Patient Name to allow you to check off the patient's name as errors are corrected.

### Correcting Errors

- 1 For visit errors, use the Appointment Management option. Visits entered utilizing Progress Notes are also accessible in Appointment Management under Add/Edit. <sup>1</sup>If other options besides Appointment Management or Progress Notes were used for entry of visit data, there may be instances where the visits do not show in Appointment Management. In this case, whatever package was used for entering the data must be used to correct the data.
- 2 For errors in Evaluation/Admission and Discharge records, use the option [Edit Form Errors Data](#). The Edit Form Errors Data option also deletes the Visit Error(s) and Pseudo SSN Error(s) files.
- 3 After making all the corrections, run the Build/Verify Transmission File option. It should always be run after correcting the data and prior to transmitting to Austin.

---

<sup>1</sup> Patch HBH\*1\*10 March 1998 Ambulatory Care Reporting Project Interface Toolkit functionality added to software.



**Note:** The column header in various ICD Code reports is customized to match the type of ICD code that appears in the report. If the report only covers ICD-9 era dates, the column header is ICD9; if the report covers only ICD-10 era dates, the column header is ICD10; and if the report covers both ICD-9 and ICD-10 era dates, the column header is ICD.

**Example:**

DEVICE: HOME// (Enter a printer name or press the <RET> key to print to your screen)

```

                >>> HBPC Form Errors Report <<<                                Page: 1
Run Date: MAR 29, 2000
Patient
File IEN  Patient Name                Last      Visit Clinic Name  Date                Form
=====
` 37  HBPCPATIENT1,THREE  0013  n/a                MAR 06, 2000      E/Adm
-----
` 98  HBPCPATIENT1,TWO    0012  n/a                MAR 09, 2000      E/Adm
-----
` 98  HBPCPATIENT1,TWO    0012  n/a                MAR 09, 2000      D/C
-----
` 58  HBPCPATIENT,EIGHT  0008  ASSESSMENT        MAR 24, 2000@16:00  Visit
Error:  Provider Missing
ICD9:   * 230.1  CA IN SITU ESOPHAGUS *  Primary Dx
-----
Note:   Please use Appointment Management to Correct Visit Errors.  1Run
        Edit Form Errors Data option when corrections are complete.

                ==== End of Report ====

```

<sup>1</sup> Patch HBH\*1\*10 March 1998 Added message to "Run Edit Form Errors Data option ..." to report when visit errors exist.

Transmission Menu ...

## Edit Form Errors Data

[HBHCUPD]

Use this option to correct errors found during the data verification process of the [Build/Verify Transmission File](#) option. This option also deletes the following error files:

- HBHC Evaluation/Admission Error(s) (#634.1)
  - HBHC Visit Error(s) (#634.2)
  - HBHC Discharge Error(s) (#634.3)
  - HBHC Pseudo SSN Error(s) (#634.5)
1. If the error is on an E/Adm or D/C Form (see example on previous page), then this option should be used to correct the errors. **Do not use** the options Evaluation/Admission Data Entry or Discharge Data Entry to correct the errors. You are prompted for a patient, then the routine prompts for the fields that are missing or invalid in each record. These errors are found when either the Build Verify Transmission File [HBHCFILE] or the Auto-queue File Update [HBHC AUTO-QUEUED FILE UPDATE] option is run and must be corrected before transmission to Austin is allowed.
  2. If the error is on a Visit form, then use [Appointment Management](#) or other appropriate outpatient encounter package to correct the data. After correcting the visit errors, this option must be accessed to clean up the Visit Error(s) file.
  3. If you should get a message like the following, use the option [Pseudo Social Security Number Report \(80\)](#) to find out which patient has a pseudo SSN. Patient visit records with pseudo social security numbers (SSNs) exist. Print the 'Pseudo Social Security Number Report' located on the HBHC Reports Menu to obtain a list of patients with invalid SSNs. HBHC must determine what corrective action is appropriate to eliminate these records from the HBHC Information System.

Transmission Menu ...

## Transmit File to Austin

<sup>1</sup>[HBHCXMT] Locked with HBHC TRANSMIT key

This option creates and transmits the HBPC MailMan messages to Austin using the data in the HBHC Transmit file #634. All errors found via the [Build/Verify Transmission File](#) option must be corrected before transmission to Austin is allowed. This option is locked with the HBHC TRANSMIT security key.

With each run of the Build/Verify Transmission File, data is added to the Transmit file until the Transmit File to Austin option is run. Once transmitted, the file remains unchanged until the next time the Build/Verify Transmission File option is used.

The Application Coordinator and any other user(s) in the HBH Mail Group will receive confirmation messages from Austin upon receipt of the electronic transmission by Austin. (See HBPC Technical Manual for mail group information.) In the event that no confirmation messages are received within 24 hours of a transmission request being queued, the Application Coordinator should contact their local IRM for assistance (e.g., domain could be closed, network traffic/troubles, hardware failure, etc.).

Multiple mail messages may be generated by the software package for each Austin transmission. Each MailMan message contains a maximum of 100 HBPC records to conform to Austin message size specifications. A corresponding confirmation message should be received for every MailMan message received by Austin. For example if 845 records need transmitting, 9 MailMan messages would be generated (8 messages containing 100 records each, plus 1 message containing 45 records) and 9 confirmation messages should be received.

The subject of the Austin confirmation MailMan message is LTE9999 HBH CONFIRMATION.  
Sample message text:

```
Ref: Your HBH message #9999999 with Austin ID #99999999, is assigned
confirmation number 99999999999999. (numbers vary on each message)
```

## Transmission Messages

After selecting the option, one of the following messages will appear:

1. Transmission request has been queued.

This message indicates that all records are correct and complete and a background job to transmit the file to Austin has been initiated by the software package.

---

<sup>1</sup> Patch HBH\*1\*8 January 1998 HBH Transmit key moved from the Transmission Menu to the Transmit File to Austin option.

2. Records containing errors exist and must be corrected before file can be transmitted.

The above message indicates all errors detected by the Build/Verify Transmission File option must be corrected before the user can proceed.

Transmission Menu ...

## <sup>1</sup>Print Transmit History Report (80)

[HBHCR15A]

To keep a record of transmissions, use this option to print the transmission history. You are prompted for a date from within the last 12 transmit batches and also to select the forms for inclusion on the report.

A Transmit History Report for the current transmission batch can be generated automatically from the Transmit File to Austin option if a default printer is defined in the System Parameters file #631.9 (see [System Parameters Edit](#)). If no printer is defined, no report will be generated at transmit time.

### Example

1. APR 10, 2000

Select Transmit Date: 1// <RET>

Select one of the following:

3	Admission
4	Visit
5	Discharge
6	Correction
A	All
S	Summary

Select Forms to Include: Summary// <RET>

DEVICE: HOME// (Enter a printer)

```
>>> HBPC APR 10, 2000 Transmit, Summary Report <<<           Page: 1
Run Date: APR 10, 2000
                               Summary
=====
Admit Eval/Adm Form 3 Total:      22
Reject Eval/Adm Form 3 Total:      2
Visit Form 4 Total:                102
Discharge Form 5 Total:            19
Correction Form 6 Total:            0
-----
All Forms Total:                   145

===== End of Report =====
```

<sup>1</sup> Patch HBH\*1\*6 July 1997 New option.

*(This page included for two-sided copying.)*

## VII. Medical Foster Home Functionality

Medical Foster Home (MFH) is a special add-on that only works at sites that have received MFH sanction status approval from the Director of Home & Community-Based Care in the Office of Geriatrics and Extended Care, VA Central Office (VACO). Sites that do not have this sanction should not utilize the MFH portion of the Home Based Primary Care (HBHC) Information System software.



**NOTE:** Medical Foster Home (MFH) sanction status approval is required prior to utilization of the MFH portion of the Home Based Primary Care (HBHC) Information System software. The MFH functionality described in this chapter is dormant for sites without an approved MFH sanction status. Approval is received from the Director of Home & Community-Based Care, in the Office of Geriatrics and Extended Care, VA Central Office (VACO).

### Background

Medical Foster Home (MFH) combines adult foster care in a privately owned residence located in the community, with Home Based Primary Care (HBPC) or Spinal Cord Injury Home Care (SCI-HC). MFH offers a safe alternative to nursing home placement, merging personal care in a private home with medical & rehabilitation support from specialized VA home care programs. Veterans placed in MFH meet nursing home admission criteria. Payment of MFH charges is the responsibility of the veteran.

### MFH Basics

- HBPC MFH patients will be a subset of HBPC patients
- Each MFH Admission will begin a new episode of care record
- MFH episode of care records are MFH specific
- HBPC/MFH records will be 'combo' record, representing both a HBPC & MFH patient
- Discharge (D/C) Date from 'HBPC only' episode & Admission Date of MFH combo record for same patient, should be same date, since D/C Date is not counted in Patient Days calculation
- HBHC System Parameter, Med Foster Home Sanction Date, will turn on MFH functionality within HBPC Information System software; indicates MFH site
- MFH 'home specific' data will be collected in separate file, HBHC Medical Foster Home (#633.2)
- MFH home specific data for capacity purposes, not software enforcement of data validation
- HBPC Evaluation/Admission Data Entry will prompt for Medical Foster Home Patient (Yes/No), & Medical Foster Home Name (MFH must already exist in MFH file)
- MFH Patient field = Yes will indicate MFH patient for report purposes
- Certain reports will be capable of printing MFH population separately from HBPC, as a subset; subset only indicates MFH Report; HBPC reports will include both HBPC &

MFH patients, with MFH patient designation indicated (e.g. Program Census & Patient Days of Care reports)

## **Using the Medical Foster Home (MFH) Menu**

### **[HBHC MFH MENU]**

Use of these options is discussed in the following pages:

- Blank MFH Worksheet Report (80) [HBHCBLNK]
- Demographic Data Entry for MFH [HBHC MFH DEMOGRAPHIC INPUT]
- Inspection Data Entry for MFH [HBHC MFH INSPECTION INPUT]
- Training Data Entry for MFH [HBHC MFH TRAINING INPUT]
- Edit MFH Form Errors Data [HBHCUPDM]
- MFH Reports ... [HBHC MFH REPORTS MENU]
  - MFH File Data Report (132) [HBHCRP26]
  - Worksheet for MFH (80) [HBHCWORK]
  - Inspection/Training Due Report for MFH (80) [HBHCRP27]
  - Rate Paid Report for MFH (80) [HBHCRP28]
  - License Due for MFH Report (80) [HBHCRP29]
  - Caregiver Age Report (132) [HBHCRP30]
  - Form Errors Report for MFH (80) [HBHCRP31]
  - Delimited Text File Output Menu for MFH ... [HBHC MFH TEXT FILE OUTPUT MENU]
    - Inspection/Training Delimited Text File Output [HBHCTXT2]
    - Rate Paid Delimited Text File Output [HBHCTXT]

## **Blank MFH Worksheet Report (80)**

### **[HBHCBLNK]**

This option prints the HBPC Medical Foster Home (MFH) Blank Worksheet Report. This worksheet will be used for collection of all MFH demographic data fields specific to the home. Report prints in 80 column format.



Address: \_\_\_\_\_

City: \_\_\_\_\_

State Code: \_\_\_\_\_

County Code: \_\_\_\_\_

ZIP Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Opened Date: \_\_\_\_\_

Primary Caregiver Name: \_\_\_\_\_

Caregiver Date of Birth: \_\_\_\_\_

Maximum Patients: 1 2 3 Bedbound Patient Maximum: 0 1 2

License Required: Yes No License Expiration Date: \_\_\_\_\_

Closure Date: \_\_\_\_\_ Voluntary Closure: Yes No

Nurse Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Social Work Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Dietitian Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_

Fire/Safety Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_

==== End of Report ====

## Demographic Data Entry for MFH

### [HBHC MFH DEMOGRAPHIC INPUT]

This option allows data entry of Medical Foster Home (MFH) demographic fields in the HBHC Medical Foster Home file (#633.2). Once entered, the MFH Name field (#.01) is not editable via this option. Inspection & Training data are entered via separate options.

Sample data entry session:

```
Select Medical Foster Home (MFH) Menu Option: Demographic Data Entry for MFH

Select HBHC MEDICAL FOSTER HOME NAME: MFH TEST 7
  Are you adding 'MFH TEST 7' as a new HBHC MEDICAL FOSTER HOME (the 7TH)? No//
Y (Yes)

ADDRESS: Address
CITY: City
STATE CODE: ARKANSAS
COUNTY CODE: 119      PULASKI      119
ZIP CODE: 72205
PHONE NUMBER: (501) 555-1234
OPENED DATE: 1/1/08 (JAN 01, 2008)
PRIMARY CAREGIVER NAME: Caregiver,Primary
CAREGIVER DATE OF BIRTH: 1/10/50 (JAN 10, 1950)
MAXIMUM PATIENTS: 2
BEDBOUND PATIENT MAXIMUM: 1
LICENSE REQUIRED: N No
CLOSURE DATE: <RET>
```

## Inspection Data Entry for MFH

[HBHC MFH INSPECTION INPUT]

This option allows data entry of the Medical Foster Home (MFH) Inspection multiples in the HBHC Medical Foster Home file (#633.2). Inspection data collected includes: Date of Inspection & Name of person performing the inspection for each of the following disciplines: Nurse, Social Work, Dietitian, & Fire/Safety. Person must exist in the New Person file (#200).

Sample data entry session:

```
Select Medical Foster Home (MFH) Menu Option: Inspection Data Entry for MFH

Select HBHC MEDICAL FOSTER HOME NAME: MFH TEST 7
Select NURSE INSPECTION DATE: 1/3/08 JAN 03, 2008
Are you adding 'JAN 03, 2008' as a new NURSE INSPECTION DATE (the 1ST for
this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
NURSE INSPECTION NAME: Inspector, Nurse
Select SOCIAL WORK INSPECTION DATE: 1/2/08 JAN 02, 2008
Are you adding 'JAN 02, 2008' as a new SOCIAL WORK INSPECTION DATE (the 1ST
for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
SOCIAL WORK INSPECTION NAME: Inspector, Social Work
Select DIETITIAN INSPECTION DATE: 1/4/08 JAN 04, 2008
Are you adding 'JAN 04, 2008' as a new DIETITIAN INSPECTION DATE (the 1ST for
this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
DIETITIAN INSPECTION NAME: Inspector, Dietitian
Select FIRE/SAFETY INSPECTION DATE: 1/4/08 JAN 04, 2008
Are you adding 'JAN 04, 2008' as a new FIRE/SAFETY INSPECTION DATE (the 1ST
for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
FIRE/SAFETY INSPECTION NAME: Inspector, Fire
```

## Training Data Entry for MFH

### [HBHC MFH TRAINING INPUT]

This option allows data entry of the Medical Foster Home (MFH) Training multiples in the HBHC Medical Foster Home file (#633.2). Training data collected includes: Date of Training. Training is tracked for each of the following categories: Home Operation, Fire/Safety, Medication Management, Personal Care, Infection Control, End of Life Issues, & Other. The Other category also prompts for Topic.

Sample data entry session:

```
Select Medical Foster Home (MFH) Menu Option: Training Data Entry for MFH

Select HBHC MEDICAL FOSTER HOME NAME: MFH TEST 7
Select HOME OPERATION TRAINING DATE: 1/2/08 JAN 02, 2008
  Are you adding 'JAN 02, 2008' as a new HOME OPERATION TRAINING DATE (the 1ST
  for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
Select FIRE/SAFETY TRAINING DATE: 1/4/08 JAN 04, 2008
  Are you adding 'JAN 04, 2008' as a new FIRE/SAFETY TRAINING DATE (the 1ST for
  this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
Select MEDICATION MANAGEMENT TRN DATE: 1/2/08 JAN 02, 2008
  Are you adding 'JAN 02, 2008' as a new MEDICATION MANAGEMENT TRN DATE (the
  1ST for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
Select PERSONAL CARE TRAINING DATE: 1/2/08 JAN 02, 2008
  Are you adding 'JAN 02, 2008' as a new PERSONAL CARE TRAINING DATE (the 1ST
  for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
Select INFECTION CONTROL TRAIN DATE: 1/2/08 JAN 02, 2008
  Are you adding 'JAN 02, 2008' as a new INFECTION CONTROL TRAIN DATE (the 1ST
  for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
Select END OF LIFE ISSUES TRAIN DATE: 1/2/08 JAN 02, 2008
  Are you adding 'JAN 02, 2008' as a new END OF LIFE ISSUES TRAIN DATE (the 1ST
  for this HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
Select OTHER TRAINING DATE: 1/3/08 JAN 03, 2008
  Are you adding 'JAN 03, 2008' as a new OTHER TRAINING DATE (the 1ST for this
  HBHC MEDICAL FOSTER HOME)? No// Y (Yes)
  TOPIC: Topic 1
```

## Edit MFH Form Errors Data

[HBHCUPDM]

This option allows editing of the HBPC Medical Foster Home (MFH) Form Errors Data. The user is prompted for a MFH name listed on the Form Errors Report for MFH (80) [HBHCRP31], then the software prompts only for the fields that are missing or invalid in each record. These errors are found when the Build/Verify Transmission File [HBHCFILE] option is run and must be corrected before transmission to Austin is allowed. The MFH Form Errors also appear on the HBPC Form Errors Report (80) [HBHCRP1].

Sample data entry session:

```
Select HBHC MEDICAL FOSTER HOME NAME: MFH TEST 25

      === Editing Medical Foster Home (MFH) Demographic data ===

CAREGIVER DATE OF BIRTH: 4/8/60 (APR 08, 1960)
LICENSE REQUIRED: N No
```

## **MFH Reports ...**

[HBHC MFH REPORTS MENU]

The MFH Reports Menu contains the following options:

- MFH File Data Report (132) [HBHCRP26]

- Worksheet for MFH (80) [HBHCWORK]

- Inspection/Training Due Report for MFH (80) [HBHCRP27]

- Rate Paid Report for MFH (80) [HBHCRP28]

- License Due for MFH Report (80) [HBHCRP29]

- Caregiver Age Report (132) [HBHCRP30]

- Form Errors Report for MFH (80) [HBHCRP31]

- Delimited Text File Output Menu for MFH ... [HBHC MFH TEXT FILE OUTPUT MENU]

  - Inspection/Training Delimited Text File Output [HBHCTXT2]

  - Rate Paid Delimited Text File Output [HBHCTXT]

## **MFH File Data Report (132)**

[HBHCRP26]

This option prints the HBHC Medical Foster Home (MFH) file (#633.2) report. The report is sorted alphabetically by Medical Foster Home Name & includes: Medical Foster Home Name, Opened Date, Primary Caregiver Name, Maximum Patients, Bedbound Patient Maximum, Closure Date, & Voluntary Closure. Report prints in 132 column format.

Note: this report prints in 132 column format; format slightly altered to fit page

```

>>> HBPC Medical Foster Home (MFH) File Data Report <<<
Page: 1
Run Date: JAN 09, 2008

```

MFH Name	Opened Date	Primary Caregiver Name	Max Pts	Bed Pts	Closure Date	Voluntary Closure
MFH TEST 1	01-01-00	Hbhcaregiver, One	3	1	04-30-05	Yes
MFH TEST 2	06-01-01	Hbhcaregiver, Two	2	0		
MFH TEST 3	03-31-02	Hbhcaregiver, Three	3	2		
MFH TEST 4	04-14-05	Hbhcaregiver, Four	3	0		
MFH TEST 5	01-01-00	Hbhcaregiver, Five	3	1	04-30-07	Yes
MFH TEST 6	03-10-02	Hbhcaregiver, Six	2	0		
MFH TEST 7	01-02-08	Hbhcaregiver, Seven	2	1		

```

Maximum Patients Total: 18
Bedbound Maximum Total: 5
Medical Foster Home (MFH) Total: 7
=====
==== End of Report ====

```

## Worksheet for MFH (80)

[HBHCWORK]

This option prints the Medical Foster Home (MFH) Data Entry Worksheet. MFH must exist in HBHC Medical Foster Home file (633.2). Any data already on file will be printed on the report. A line of underscores will be printed when no data exists for a specific field. Worksheet prints in 80 column format.

Run Date: AUG 28, 2008

MFH Name: MFH TEST

Address: Address

City: City

State Code: ARKANSAS

County Code: PULASKI (119)

ZIP Code: 72205

Phone Number: (501) 555-1234

Opened Date: JAN 01, 2008

Primary Caregiver Name: Caregiver, Primary

Caregiver Date of Birth: JAN 01, 1950

Maximum Patients: 3 Bedbound Patient Maximum: 0

License Required: Yes License Expiration Date: JUL 31, 2008

Closure Date: AUG 01, 2008 Voluntary Closure: No

Nurse Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Previous Inspection(s): \_\_\_\_\_

Social Work Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Previous Inspection(s): \_\_\_\_\_

Dietitian Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Previous Inspection(s): \_\_\_\_\_

Fire/Safety Inspection:

Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Previous Inspection(s): \_\_\_\_\_

Home Operation Training Date:

Previous Training Date(s): \_\_\_\_\_

Fire/Safety Training Date:

Previous Training Date(s): \_\_\_\_\_

Medication Management Training Date:

Previous Training Date(s): \_\_\_\_\_

Personal Care Training Date:

\_\_\_\_\_



Previous Training Date(s):

Infection Control Training Date: \_\_\_\_\_  
Previous Training Date(s):

End of Life Issues Training Date: \_\_\_\_\_  
Previous Training Date(s):

Other Training Date: \_\_\_\_\_

Topic: \_\_\_\_\_

Previous Training Date(s):

==== End of Report ====

## Inspection/Training Due Report for MFH (80)

[HBHCRP27]

This option prints the HBPC Medical Foster Home (MFH) Inspection or Training report. Inspection & Training data are multiples within the HBHC MEDICAL FOSTER HOME file (#633.2). The data includes inspections/training due within the next 6 months, based on month only. Report includes: inspections/training due & most recent inspection/training date. Report prints in 80 column format.

```
>>> HBPC Medical Foster Home (MFH) Inspection(s) Due Report <<<      Page: 1
Run Date: AUG 10, 2007
=====
No MFH inspections currently due.
                                     ==== End of Report ====
```

Run Date: MAY 07, 2008

=====  
Home Operation Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent Home Operation Training Date

MFH TESTING AGAIN                              OCT 01, 2007

Fire/Safety Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent Fire/Safety Training Date

MFH TESTING AGAIN                              OCT 01, 2007

Medication Management Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent Medication Management Training Date

MFH TESTING AGAIN                              OCT 01, 2007

Personal Care Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent Personal Care Training Date

MFH TESTING AGAIN                              OCT 01, 2007

Infection Control Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent Infection Control Training Date

MFH TESTING AGAIN                              OCT 01, 2007

End of Life Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent End of Life Training Date

MFH TESTING AGAIN                              OCT 01, 2007

Other Training Due in next 6 months:  
Medical Foster Home Name                      Most Recent Other Training Date

MFH TESTING AGAIN                              OCT 01, 2007

==== End of Report ====

## Rate Paid Report for MFH (80)

[HBHCRP28]

This option prints the HBPC Medical Foster Home (MFH) Rate Paid report. Rate Paid data is a multiple in the HBHC PATIENT file (#631). The user selects to sort the data by Patient or MFH, then to include Active ONLY, Individual, or All Patients or MFHs, then whether to include Current ONLY Rate or All Rates Paid. MFH sort also prompts for whether to include Discharged Patients. Report includes: Patient Name, Last Four, Rate Paid, Start Date, & Medical Foster Home Name. Report selection criteria is listed in the report header. Lowest, Highest, & Average Rate Paid are included at the end of the report. Report prints in 80 column format. Note that output can also be to delimited file format appropriate for spreadsheet import.

Samples of Rate Paid selection criteria prompts:

```
Sort by Patient or Medical Foster Home (MFH): (P/M): Patient
Include: Active ONLY, Individual, or All Patient(s): (O/I/A): O Active ONLY
Include: Current Rate, or All Rates Paid: (C/A): Current Rate
Format: Report, or File (Delimited): (R/F): Report Format
DEVICE: <RET>
```

```
Sort by Patient or Medical Foster Home (MFH): (P/M): Medical Foster Home (MFH)
Include: Active ONLY, Individual, or All MFH(s): (O/I/A): All
Include: Discharged Patients: (Y/N): Yes
Include: Current Rate, or All Rates Paid: (C/A): All Rates Paid
Format: Report, or File (Delimited): (R/F): Report Format
DEVICE: <RET>
```

```
Sort by Patient or Medical Foster Home (MFH): (P/M): Patient
Include: Active ONLY, Individual, or All Patient(s): (O/I/A): Individual
Include: Current Rate, or All Rates Paid: (C/A): Current Rate
Select HBHC PATIENT NAME: `2300 HBHCPatient, Six 10-04-06 7-17-51
101227245 YES SC VETERAN FIRM A
Select HBHC PATIENT NAME: <RET>
Format: Report, or File (Delimited): (R/F): Report Format
DEVICE: <RET>
```

>>> HBPC Medical Foster Home (MFH) Rate Paid Report <<< Page: 1

Selected Criteria: All MFH(s) Current Rate Paid Include D/C Pts

Run Date: NOV 09, 2007

Medical Foster Home (MFH) Name	Patient Name	Last Four	Rate Paid	Start Date
MFH TEST 1	HBHCPATIENT,FIVE	7245	1800.00	01-01-07
MFH TEST 2	HBHCPATIENT,SIX	0837	2500.00	08-10-07
MFH TEST 3	HBHCPATIENT,SEVEN	1849	2400.00	11-01-07
MFH TEST 3	HBHCPATIENT,EIGHT	0539	2000.00	02-01-07
MFH TEST 4	HBHCPATINET,NINE	8674	2200.00	03-01-07

=====  
 Lowest Rate: 1800.00 Highest Rate: 2500.00 Average Rate: 2180.00  
 =====

==== End of Report =====

>>> HBPC Medical Foster Home (MFH) Rate Paid Report <<< Page: 1

Selected Criteria: All Patient(s) All Rates Paid

Run Date: NOV 09, 2007

Patient Name	Last Four	Rate Paid	Start Date	Medical Foster Home
HBHCPATIENT,FIVE	7245	1800.00	01-01-07	MFH TEST 1
HBHCPATIENT,SIX	0837	1200.00	06-10-07	MFH TEST 2
HBHCPATIENT,SIX	0837	2500.00	08-10-07	MFH TEST 2
HBHCPATIENT,SEVEN	1849	2400.00	11-01-07	MFH TEST 3
HBHCPATIENT,EIGHT	8674	2200.00	03-01-07	MFH TEST 4
HBHCPATIENT,NINE	0539	2000.00	02-01-07	MFH TEST 3

=====  
 Lowest Rate: 1200.00 Highest Rate: 2500.00 Average Rate: 2016.67  
 =====

==== End of Report =====

## License Due for MFH Report (80)

[HBHCRP29]

This option prints the HBPC Medical Foster Home (MFH) License Due report. The report is sorted alphabetically by MFH Name & contains MFH Name & License Expiration Date. The report includes License Expiration Dates due to expire within 6 months, based on month only. The report prints in 80 column format.

```
>>> HBPC Medical Foster Home (MFH) License Due Report <<<           Page: 1
Run Date: JAN 08, 2008
Medical Foster Home Name           License Expiration Date
=====
MFH TEST 2                         06-01-2008
MFH TEST 4                         03-31-2008
                                     ==== End of Report =====
```

## Caregiver Age Report (132)

[HBHCRP30]

This option prints the HBPC Medical Foster Home (MFH) Caregiver Age Report. The report is sorted alphabetically by MFH Name & includes: Medical Foster Home (MFH) Name, Opened Date, Primary Caregiver Name, Caregiver Date of Birth, & Age. Total number of MFHs & Average Caregiver Age are included at the end of the report. Report prints in 132 column format.

Note: this report prints in 132 column format; format slightly altered to fit page

```
>>> HBPC Medical Foster Home (MFH) Caregiver Age Report <<<           Page: 1
Run Date: MAR 05, 2008

MFH Name           Opened Date           Primary Caregiver Name   Date of Birth           Age
=====
MFH TEXT 7         10-03-07              HBHCCAREGIVER, ONE      02-04-33                75
-----
OLD FOLKS HOME    01-11-08              HBHCCAREGIVER, TWO      01-01-80                28
-----
MFH TEST 25       06-01-04              HBHCCAREGIVER, THREE    04-08-60                47
-----
MFH TEST 48       01-12-08              HBHCCAREGIVER, FOUR     02-20-50                58
-----
MFH TESTING       01-02-08              HBHCCAREGIVER, FIVE     01-01-87                21
-----

=====
Medical Foster Home (MFH) Total:           5
Average Caregiver Age:                     45.8
=====

==== End of Report ====
```

## Form Errors Report for MFH (80)

[HBHCRP31]

This option prints the HBHC Medical Foster Home (MFH) Form Errors Report for MFH option. The report is sorted alphabetically by MFH Name & includes: MFH File (#633.2) Internal Entry Number (IEN), MFH Name, & Opened Date. This option is both freestanding & is called from Form Errors Report [HBHCRP1] option. Report prints in 80 column format.

```
>>> HBPC Medical Foster Home (MFH) Form Errors Report <<<           Page: 1
Run Date: MAR 04, 2008

MFH File IEN      Medical Foster Home Name      Opened Date
-----
`6              MFH TESTING RESUMED
-----
`7              MFH TESTING TOO              03-03-08
-----

===== End of Report =====
```

## Delimited Text File Output Menu for MFH ...

[HBHC MFH TEXT FILE OUTPUT MENU]

The Delimited Text File Output Menu for MFH contains the following options:

Inspection/Training Delimited Text File Output [HBHCTXT2]

Rate Paid Delimited Text File Output [HBHCTXT]



## Inspection/Training Delimited Text File Output

[HBHCTXT2]

This option creates the HBPC Medical Foster Home (MFH) Inspection or Training data delimited text file, suitable for spreadsheet import. Inspection & Training data are multiples in the HBHC MEDICAL FOSTER HOME file (#633.2). Inspection multiples include: Nurse, Social Work, Dietitian, & Fire/Safety Inspections. Training multiples include: Home Operation, Fire/Safety, Medication Management, Personal Care, Infection Control, End of Life, & Other as training categories. Other training category also contains Topic field. File is delimited by "^".

Sample of Inspection delimited file data:

```
Medical Foster Home Name^MFH Closure Date^Inspection Discipline^Inspection
Date^Inspector Name
MFH TEST 1^04-30-2005^Nurse^01-01-2007^INSPECTOR, NURSE
MFH TEST 1^04-30-2005^Social Work^02-01-2006^INSPECTOR, SOCIAL WORK
MFH TEST 1^04-30-2005^Dietitian^05-01-2006^INSPECTOR, DIETITIAN
MFH TEST 1^04-30-2005^Fire-Safety^03-01-2006^INSPECTOR, FIRE
MFH TEST 2^^Nurse^03-10-2006^INSPECTOR, NURSE
MFH TEST 2^^Nurse^11-01-2006^INSPECTOR, NURSE
MFH TEST 2^^Social Work^03-12-2006^INSPECTOR, SOCIAL WORK
MFH TEST 2^^Social Work^11-02-2006^INSPECTOR, SOCIAL WORK
MFH TEST 2^^Dietitian^03-14-2006^INSPECTOR, DIETITIAN
MFH TEST 2^^Dietitian^11-03-2006^INSPECTOR, DIETITIAN
MFH TEST 2^^Fire-Safety^03-30-2006^INSPECTOR, FIRE
MFH TEST 2^^Fire-Safety^11-04-2005^INSPECTOR, FIRE
MFH TEST 3^^Nurse^02-01-2002^INSPECTOR, NURSE
MFH TEST 3^^Nurse^02-01-2006^INSPECTOR, NURSE
MFH TEST 3^^Social Work^02-10-2002^INSPECTOR, SOCIAL WORK
MFH TEST 3^^Dietitian^02-20-2002^INSPECTOR, DIETITIAN
MFH TEST 3^^Dietitian^02-20-2004^INSPECTOR, DIETITIAN
MFH TEST 3^^Fire-Safety^02-28-2002^INSPECTOR, FIRE
MFH TEST 4^^Nurse^05-01-2005^INSPECTOR, NURSE
MFH TEST 4^^Nurse^05-02-2006^INSPECTOR, NURSE
MFH TEST 4^^Nurse^05-10-2007^INSPECTOR, NURSE
MFH TEST 4^^Social Work^05-02-2005^INSPECTOR, SOCIAL WORK
MFH TEST 4^^Social Work^05-03-2006^INSPECTOR, SOCIAL WORK
MFH TEST 4^^Social Work^05-04-2007^INSPECTOR, SOCIAL WORK
MFH TEST 4^^Dietitian^05-03-2005^INSPECTOR, DIETITIAN
MFH TEST 4^^Dietitian^05-04-2006^INSPECTOR, DIETITIAN
MFH TEST 4^^Fire-Safety^05-04-2005^INSPECTOR, FIRE
MFH TEST 4^^Fire-Safety^05-05-2006^INSPECTOR, FIRE
MFH TEST 5^04-30-2007^Nurse^06-01-2006^INSPECTOR, NURSE
MFH TEST 5^04-30-2007^Nurse^06-01-2007^INSPECTOR, NURSE
MFH TEST 5^04-30-2007^Social Work^07-10-2006^INSPECTOR, SOCIAL WORK
MFH TEST 5^04-30-2007^Dietitian^08-14-2006^INSPECTOR, DIETITIAN
MFH TEST 5^04-30-2007^Dietitian^08-14-2005^INSPECTOR, DIETITIAN
MFH TEST 5^04-30-2007^Fire-Safety^09-10-2006^INSPECTOR, FIRE
MFH TEST 6^^Nurse^11-20-2006^INSPECTOR, NURSE
MFH TEST 6^^Social Work^12-02-2006^INSPECTOR, SOCIAL WORK
MFH TEST 6^^Dietitian^01-16-2007^INSPECTOR, DIETITIAN
MFH TEST 6^^Fire-Safety^02-09-2007^INSPECTOR, FIRE
```

Sample of Training delimited file data:

```

Medical Foster Home Name^MFH Closure Date^Training Category^Training Date^Other
Training Topic
MFH TEST 2^^Home Operation^02-02-2006
MFH TEST 2^^Fire-Safety^02-04-2006
MFH TEST 2^^Medication Management^02-20-2006
MFH TEST 2^^Personal Care^03-01-2006
MFH TEST 2^^Infection Control^04-01-2006
MFH TEST 2^^Infection Control^06-10-2007
MFH TEST 2^^End of Life^04-10-2006
MFH TEST 2^^Other^01-15-2006^Topic 1
MFH TEST 2^^Other^07-15-2007^Topic n
MFH TEST 3^^Home Operation^03-01-2002
MFH TEST 3^^Home Operation^09-01-2002
MFH TEST 3^^Fire-Safety^03-02-2002
MFH TEST 3^^Fire-Safety^09-02-2002
MFH TEST 3^^Medication Management^03-03-2002
MFH TEST 3^^Medication Management^09-03-2002
MFH TEST 3^^Medication Management^07-01-2007
MFH TEST 3^^Personal Care^03-04-2002
MFH TEST 3^^Personal Care^09-04-2002
MFH TEST 3^^Infection Control^03-05-2002
MFH TEST 3^^Infection Control^09-05-2002
MFH TEST 3^^End of Life^03-06-2002
MFH TEST 3^^End of Life^09-06-2002
MFH TEST 3^^Other^03-07-2002
MFH TEST 3^^Other^09-07-2002
MFH TEST 4^^Home Operation^05-01-2005
MFH TEST 4^^Home Operation^05-02-2006
MFH TEST 4^^Fire-Safety^05-02-2005
MFH TEST 4^^Medication Management^05-03-2005
MFH TEST 4^^Medication Management^05-08-2007
MFH TEST 4^^Personal Care^05-04-2005
MFH TEST 4^^Personal Care^05-15-2007
MFH TEST 4^^Infection Control^05-06-2005
MFH TEST 4^^End of Life^05-07-2005
MFH TEST 4^^Other^05-08-2005^Topic
MFH TEST 4^^Other^06-01-2007^Topic2
MFH TEST 5^04-30-2007^Infection Control^01-01-2007

```

## Rate Paid Delimited Text File Output

[HBHCTXT]

This option creates the HBPC Medical Foster Home (MFH) Rate Paid delimited text file, suitable for spreadsheet import. Rate Paid data is a multiple in the HBHC PATIENT file (#631). The user selects to sort the data by Patient or MFH, then to include Active ONLY, Individual, or All Patients or MFHs, then whether to include Current ONLY Rate or All Rates Paid. File includes: Patient Name, Last Four, Rate Paid, Start Date, for Patient sort, plus Medical Foster Home Name is included on MFH sort. MFH sort also prompts for whether to include Discharged Patients. File is delimited by "^".

Sample of Rate Paid selection criteria prompts:

```
Sort by Patient or Medical Foster Home (MFH): (P/M): Patient
Include: Active ONLY, Individual, or All Patient(s): (O/I/A): All
Include: Current Rate, or All Rates Paid: (C/A): All Rates Paid
DEVICE: <RET>
```

Sample delimited Rate Paid data based on the above selection criteria:

```
Patient Name^Last Four^Rate Paid^Start Date
CULPAHDFE,WUHTSXY IHYYDT^7245^1800^01-01-2007
DLQDT,AHXY^0837^1200^06-10-2007
DLQDT,AHXY^0837^2500^08-10-2007
FAXPHUT,UXXHUS A^1849^2400^11-01-2007
KDYF,LAGUHI C^8674^2200^03-01-2007
OIXZ,JADGGXUI C^0539^2000^02-01-2007
```

## Sample of Rate Paid selection criteria prompts:

```
Sort by Patient or Medical Foster Home (MFH): (P/M): M Medical Foster Home
(MFH)
Include: Active ONLY, Individual, or All MFH(s): (O/I/A): M All
Include: Current Rate, or All Rates Paid: (C/A): M All Rates Paid
Include: Discharged Patients: (Y/N): Y Yes
DEVICE: <RET>
```

Sample delimited Rate Paid data based on the above selection criteria:

```
Patient Name^Last Four^Rate Paid^Start Date^Medical Foster Home (MFH) Name
CULPAHDFE,WUHTSXY IHYYDT^7245^1800^01-01-2007^MFH TEST 1
DLQDT,AHXY^0837^1200^06-10-2007^MFH TEST 2
DLQDT,AHXY^0837^2500^08-10-2007^MFH TEST 2
FAXPHUT,UXXHUS A^1849^2400^11-01-2007^MFH TEST 3
OIXZ,JADGGXUI C^0539^2000^02-01-2007^MFH TEST 3
KDYF,LAGUHI C^8674^2200^03-01-2007^MFH TEST 4
```

## Queued Options

### Auto-queued Inspection/Training Reminder e-mail

[HBHC MFH AUTO-QUEUED REMINDERS]

This option runs a monthly auto-queued batch job to create separate e-mail reminder messages for HBPC Medical Foster Home (MFH) Inspections &/or Training due within the next 3 months, based on month only. This job should be scheduled for the 1st day of each month, regardless of day of the week for 1st.

The MFH Inspection & Training data used by this option are multiples within the HBHC MEDICAL FOSTER HOME file (#633.2).

Members in mail group HBHC MEDICAL FOSTER HOME receive the reminder mail messages.

Sample Inspection Due e-mails:

```
Subj: AUG 30, 2007 MFH Inspection Due Reminder [#270] 08/30/07@17:38 2 lines
From: <"HBHC MFH INSPECTION REMINDER MAIL GROUP In 'IN' basket. Page 1
-----
Nurse Inspection(s) Due in next 3 months:
Medical Foster Home Name          Most Recent Nurse Inspection Date

    MFH TEST 3                    FEB 01, 2006
    MFH TEST 4                    MAY 02, 2006

Social Work Inspection(s) Due in next 3 months:
Medical Foster Home Name          Most Recent Social Work Inspection Date

    MFH TEST 3                    FEB 10, 2002
    MFH TEST 4                    MAY 03, 2006

Dietitian Inspection(s) Due in next 3 months:
Medical Foster Home Name          Most Recent Dietitian Inspection Date

    MFH TEST 3                    FEB 20, 2004
    MFH TEST 4                    MAY 04, 2006

Fire/Safety Inspection(s) Due in next 3 months:
Medical Foster Home Name          Most Recent Fire/Safety Inspection Date

    MFH TEST 3                    FEB 28, 2002
    MFH TEST 2                    MAR 30, 2006
    MFH TEST 4                    MAY 05, 2006
```

Subj: AUG 30, 2007 MFH Inspection Due Reminder [#270] 08/30/07@17:38 2 lines  
From: <"HBHC MFH INSPECTION REMINDER MAIL GROUP In 'IN' basket. Page 1

-----  
No MFH Inspection currently due.

### Sample Training Due e-mail:

Subj: SEP 05, 2007 MFH Training Due Reminder [#499] 09/05/07@00:05:02 48 lines  
From: <"HBHC MFH TRAINING REMINDER MAIL GROUP In 'IN' basket. Page 1

-----  
Home Operation Training Due in next 3 months:

Medical Foster Home Name	Most Recent Home Operation Training Date
MFH TEST 3	SEP 01, 2002
MFH TEST 2	FEB 02, 2006
MFH TEST 4	MAY 02, 2006

Fire/Safety Training Due in next 3 months:

Medical Foster Home Name	Most Recent Fire/Safety Training Date
MFH TEST 3	SEP 02, 2002
MFH TEST 4	MAY 02, 2005
MFH TEST 2	FEB 04, 2006

Medication Management Training Due in next 3 months:

Medical Foster Home Name	Most Recent Med Mgmt Training Date
MFH TEST 2	FEB 20, 2006

Personal Care Training Due in next 3 months:

Medical Foster Home Name	Most Recent Personal Care Training Date
MFH TEST 3	SEP 04, 2002
MFH TEST 2	MAR 01, 2006

Infection Control Training Due in next 3 months:

Medical Foster Home Name	Most Recent Infect Control Training Date
MFH TEST 3	SEP 05, 2002
MFH TEST 4	MAY 06, 2005

End of Life Training Due in next 3 months:

Medical Foster Home Name	Most Recent End of Life Training Date
MFH TEST 3	SEP 06, 2002
MFH TEST 4	MAY 07, 2005
MFH TEST 2	APR 10, 2006

Other Training Due in next 3 months:

Medical Foster Home Name	Most Recent Other Training Date
MFH TEST 3	SEP 07, 2002

## Auto-queued License Due Reminder e-mail

[HBHC MFH AUTO-Q LICENSE DUE]

This option runs a monthly auto-queued batch job to create an e-mail message for HBPC Medical Foster Home(s) (MFH) with License due within the next 3 months, based on month only. This job should be scheduled for the 1st day of each month, regardless of day of the week for 1st.

Note: This option does NOT need to be scheduled to run for HBPC MFH sites which are in states that do not require licensure.

The MFH License data used by this option resides in the HBHC MEDICAL FOSTER HOME file (#633.2).

Members in mail group HBHC MEDICAL FOSTER HOME receive the reminder mail message.

```
Subj: JAN 08, 2008 MFH License Due Reminder [#933] 01/08/08@17:30 3 lines
From: HBHC MFH LICENSE REMINDER MAIL GROUP In 'IN' basket. Page 1
```

```
-----
Medical Foster Home Name           License Expiration Date
MFH TEST 4                         03-31-2008
```

=====  
Note: The MFH functionality is dormant on the following option for sites without an approved MFH sanction status.

Use of this option is discussed in the following pages:

Under HBPC Information System Menu ... [HBHC INFORMATION SYSTEM MENU]  
Evaluation/Admission Data Entry [HBHCADM]

## Evaluation/Admission Data Entry

[HBHCADM]

This option allows entering/editing of the evaluation/admission data in the HBHC Patient File (#631).

If a site has a sanctioned MFH program, then the user is also prompted as in the sample below. The MFH functionality is dormant on this option for sites without an approved MFH sanction status.

Note: A MFH patient admission always begins a new episode of care. If the patient was a current HBPC patient at the time of admission to MFH, then patient is discharged from the previous HBPC episode of care and a new episode is created for the MFH admission. This is to identify the admission date of when the patient became a MFH patient.

Please refer to the Evaluation/Admission Data Entry chapter for complete instructions for this option. This portion only covers the additional MFH prompts.

```
Select HBPC Information System Menu Little Rock VAMC Option:  Evaluation/
Admission Data Entry
Select HBHC PATIENT NAME:  MFHPATIENT, FOUR           11-2-31     66618604 2     NO
NSC VETERAN
Enrollment Priority:  GROUP 5      Category:  ENROLLED      End Date:

  Are you adding 'MFHPATIENT, FOUR' as a new HBHC PATIENT (the 2527TH)? No// Y
  (Yes)
  HBHC PATIENT DATE:  T   (SEP 24, 2008)
MEDICAL FOSTER HOME PATIENT:  Y   Yes
MEDICAL FOSTER HOME NAME:  MFH TEST
Select RATE PAID START DATE:  T   SEP 24, 2008
  Are you adding 'SEP 24, 2008' as
  a new RATE PAID START DATE (the 1ST for this HBHC PATIENT)? No// Y   (Yes)
  RATE PAID AMOUNT:  2200
DATE:  SEP 24,2008// <Enter>
. . . (Starting with this prompt, this is the same as the Evaluation/Admission
Data Entry form without MFH.)
```



Note: The MFH functionality is dormant on the following options for sites without an approved MFH sanction status.

Use of these options is discussed in the following pages:

Under HBPC Reports Menu ... [HBHC REPORTS MENU]

...

Patient Days of Care by Date Range Report (80) [HBHCRP23]

Census Reports Menu ... [HBHC CENSUS REPORTS MENU]

Program Census Report (80) [HBHCRP10]

## **Patient Days of Care by Date Range Report (80)**

[HBHCRP23]

The option prints HBPC Patient Days of Care by Date Range Report. Report includes: file internal entry number (IEN), Patient Name, Last Four, Date, Discharge Date, & Patient Days. Patient Days is calculated based on the user selectable date range. Summary totals of Patients and Patient Days are included for both Complete Episodes of Care and Active Cases. Date of Discharge is omitted from the Patient Days total (e.g. Adm Date: 7/1/03, D/C Date: 7/5/03 would total 4 Patient Days, not 5). Report prints in 80 column format.

This report requires the beginning date to be the oldest current active Admission on file, or an arbitrary date such as 1/1/85, to obtain the complete active census.

User is prompted to select HBPC or MFH report. HBPC report includes all HBPC patients in the user selected date range, with MFH patients indicated by having their MFH listed. MFH report includes only MFH patients in the user selected date range. Below are samples of both HBPC & MFH reports, with patient specific data omitted.

Note: The MFH functionality is dormant on this report for sites without an approved MFH sanction status.

HBPC report (patient data omitted):

```

>>> HBPC Patient Days of Care by Date Range Report <<<           Page: 1
Run Date: JAN 09, 2008           Date Range: JAN 01, 1985 to
                                  JAN 09, 2008

IEN   Patient Name           Last      Discharge   Patient
      Patient Name           Four      Date        Date        Days       MFH
=====
. . .

>>> HBPC Patient Days of Care by Date Range Report <<<           Page: 329
Run Date: JAN 09, 2008           Date Range: JAN 01, 1985 to
                                  JAN 09, 2008

IEN   Patient Name           Last      Discharge   Patient
      Patient Name           Four      Date        Date        Days       MFH
=====
. . .

>>> Date Range:  JAN 01, 1985 to JAN 09, 2008 <<<

Total Active Patients:           137
=====
Complete Episodes of Care Only:
  Total Patients:    1,828      Total Patient Days in Date Range:    741,663
=====
  Total Patients:    1,965      Total Patient Days in Date Range:    892,358
=====

==== End of Report ====

```

MFH Report (patient data omitted):

```

>>> HBPC MFH Patient Days of Care by Date Range Report <<<       Page: 1
Run Date: JAN 09, 2008           Date Range: JAN 01, 1985 to
                                  JAN 09, 2008

IEN   Patient Name           Last      Discharge   Patient
      Patient Name           Four      Date        Date        Days       MFH
=====
. . .

>>> Date Range:  JAN 01, 1985 to JAN 09, 2008 <<<

Total Active Patients:           3
=====
Complete Episodes of Care Only:
  Total Patients:     2      Total Patient Days in Date Range:     91
=====
  Total Patients:     5      Total Patient Days in Date Range:    1,079
=====

==== End of Report ====

```

## Program Census Report (80)

[HBHCRP10]

This option prints the HBPC Program Census Report. The user is prompted to enter the date range for inclusion on the report. The report is sorted alphabetically by patient name and includes: Patient Name, Last Four, and Admission Date. Report prints in 80 column format.

This report requires the beginning date to be the oldest current active Admission on file, or an arbitrary date such as 1/1/85, to obtain the complete active census.

User is prompted to select HBPC or MFH report. HBPC report includes all HBPC patients in the user selected date range, with MFH patients indicated by having their MFH listed. MFH report includes only MFH patients in the user selected date range. Below are samples of both HBPC & MFH reports, with patient specific data omitted.

Note: The MFH functionality is dormant on this report for sites without an approved MFH sanction status.

### HBPC Report:

```

>>> Program Census Report <<<                                     Page: 1
Run Date: JAN 09, 2008                                           Date Range: JAN 01, 1985 to
                                                                JAN 09, 2008
Patient Name                Last      Date           Medical Foster Name Name
=====
HBHCPatient, One           1234    01-06-08      MFH Test One
. . .
=====
Program Census Total: 137
=====
===== End of Report =====
```

MFH Report:

```
>>> HBPC Medical Foster Home (MFH) Program Census Report <<<      Page: 1
Run Date: JAN 09, 2008                      Date Range: JAN 01, 1985 to
                                           JAN 09, 2008

Patient Name                               Last      Date      Medical Foster Name Name
=====
HBHCPatient, One                          1234     01-06-08   MFH Test One
. . .
=====
Program Census Total: 3
=====

==== End of Report ====
```

Note: The MFH functionality is dormant on the following options for sites without an approved MFH sanction status.

Use of these options is discussed in the following pages:

Under Transmission Menu ... [HBHC TRANSMISSION MENU]

- Build/Verify Transmission File [HBHCFILE]
- Form Errors Report (80) [HBHCRP1]
- Edit Form Errors Data [HBHCUPD]
- Transmit File to Austin [HBHCXMT]
- Print Transmit History Report (80) [HBHCR15A]

Please refer to the Transmitting Data to Austin chapter for complete instructions. This section only covers the additional MFH functionality.

## **Build/Verify Transmission File**

[HBHCFILE]

This option builds the HBPC Transmission Data file (#634) used to transmit to Austin. The records included in this file are verified for completeness and also for validity (e.g. no admission data should be included if the patient was rejected from the HBPC program).

If errors/omissions are found, the records in error are written to another file and must be corrected before transmission is allowed. Once the errors are corrected, this option must be run again to add the corrected records to the transmission file. This process (build file, correct errors, add corrected records via build file) may be repeated as necessary until all records are valid and included in the Transmission Data file.

If a site has a sanctioned MFH program, then the MFH data is also included as part of the build processing. The MFH functionality is dormant on this option for sites without an approved MFH sanction status.

## **Form Errors Report (80)**

[HBHCRP1]

This option prints the HBPC Form Errors Report. The errors were found when the Build/Verify Transmission File [HBHCFILE] option was run. The report is sorted by Form, then by Patient Name and includes: Patient File IEN (internal entry number), Patient Name, Last Four, and corresponding Date. Visits also contain: Clinic Name, Error, Provider, ICD9 or ICD10 Diagnosis, and CPT Code fields. Report prints in 80 column format.

If a site has a sanctioned MFH program, then the MFH data is also included as part of the report. The MFH functionality is dormant on this option for sites without an approved MFH sanction status.

The Form Errors Report for MFH (80) [HBHCRP31] option contains only the MFH errors portion of the Form Errors data.

## **Edit Form Errors Data**

[HBHCUPD]

This option allows editing of the HBPC Form Errors Data. The user is prompted for a patient, then the software prompts for the fields that are missing or invalid in each record. These errors are found when the Build/Verify Transmission File [HBHCFILE] option is run and must be corrected before transmission to Austin is allowed. Visit error corrections must be made using PCE options. Then the Edit Form Errors option must be accessed to clean up the Visit Error file.

If a site has a sanctioned MFH program, then the MFH Errors File is also cleaned up by accessing this option. The MFH functionality is dormant on this option for sites without an approved MFH sanction status.

MFH error corrections must be made using the Edit MFH Form Errors Data [HBHCUPDM] option. The user is prompted for a MFH name, then the software prompts for the fields that are missing or invalid in each record. This option also cleans up the MFH Errors File.

## **Transmit File to Austin**

[HBHCXMT]

This option creates and transmits the HBPC MailMan message using the Transmission Data in HBHC Transmit File (#634) to Austin. All Form Errors found via the Build/Verify Transmission File option must be corrected before transmission to Austin is allowed. A confirmation message will be returned from Austin upon receipt of the HBPC Transmission. This option is locked with the HBHC TRANSMIT security key.

If a site has a sanctioned MFH program, then the MFH data is also included as part of the transmit processing. The MFH functionality is dormant on this option for sites without an approved MFH sanction status.



## Print Transmit History Report (80)

[HBHCR15A]

This option prints the HBPC Transmit History Report. The user is prompted for date from within the last 12 transmit batches & also selects forms for inclusion on the report.

The report includes: form number, patient name, last four, form date, plus Action on form 3 (admission), Provider Number & Provider Name on visits (form 4), & Admission or Discharge on form 6 (corrections).

A Transmit History Report for the current transmission batch can be generated automatically from the Transmit File to Austin option [HBHCXMT] if a default printer is defined in System Parameters file (#631.9). If no printer is defined, no report will be generated at transmit time.

If a site has a sanctioned MFH program, then the MFH data is also included as part of the report. The MFH functionality is dormant on this option for sites without an approved MFH sanction status.

```
>>> HBPC FEB 14, 2008 Transmit, Summary Report <<<                               Page: 1
Run Date: MAR 03, 2008

                               Summary
=====
Admit Eval/Adm Form 3 Total:                4
Reject Eval/Adm Form 3 Total:               0
Visit Form 4 Total:                         68
Discharge Form 5 Total:                     1
Correction Form 6 Total:                    0
Medical Foster Home Form 7 Total:           16
                                           -----
All Forms Total:                             89
Number of Visits Total:                      67

                               =====
                               End of Report
                               =====
```



## VIII. Glossary

Application Coordinator	Person responsible for the implementation, training, and troubleshooting of the software package, also acts as liaison between the HBPC Program personnel and IRM.
Branching	Jumping from one spot to another when entering data. Branching determines which questions will be asked based on current values.
Case Manager	HBPC provider who is assigned responsibility for coordinating specific patient care.
D/C	Discharge.
Default	The most probable answer to the field prompt. The value that appears between the field prompt and two slash marks (/). With the cursor resting next to the field prompt, you can either accept the default answer or enter your own answer. To accept the default, simply press the enter (or return) key. To change the default answer, type in your response.
Device Prompt	A prompt at which you identify where you want to send your report output.
Double Quotes	The " symbol. Enclose patient name with double quotes to inform VA FileMan you wish to create an additional record with the same name as an existing record in the file. (e.g., "lastname,firstname"). This method is used to create additional episode of care records for a patient in the HBHC Patient file.
Enter	Accept the entry or default response to a prompt. Symbolized by <ENTER> or <RET> in this manual.
Episode of Care	An admission to the HBPC Program begins an episode of care. The episode ends when the patient is discharged from the Program. A complete episode of care must include an admission and a discharge or a reject.
Field	In the computing environment, a field is similar to the blank space on a form. Field refers to one element of information (e.g., patient name).
Field Prompt	An online instruction that identifies the type of information you need to enter.
File	A collection of related records treated as a unit.

Form 3	Evaluation/Admission data entry form.
Form 4	Visit Log data entry form.
Form 5	Discharge data entry form.
Form 6	Correction data entry form.
Free Text	A data type that can contain any printable characters.
HBHC	Hospital Based Home Care.
HBHC Provider file	File number 631.4, contains unique HBPC information pertaining to HBPC providers.
HBPC	Home Based Primary Care.
Help	Assistance information which is available online. Enter 1 or 2 question marks at any field prompt to obtain help explaining what answer(s) the field prompt will accept. Enter 3 question marks at any “Select ... Option” prompt to obtain a description of the option.
IRM	Information Resources Management.
Jump	Command that allows you to go from a particular field within a data entry option to another field within that same option.
Key	Special control that allows you to unlock and use options governing sensitive activities and information.
Mail Group	A name assigned to a group of computer users. When you send a message to the group, each member of the mail group receives the message.
Menu	A list of options from which you can select an activity.
Option	A computing activity that you can select from a menu.
Package	The set of programs, files, documentation, online help, and installation procedures that constitute a given software application.
Populate	To fill in a file with data.
Prompt	A question or message from the computer requiring your response.

Queued	A task that is sent for processing in the background.
Record	A collection of data items that refer to a specific entity (e.g., patient name, social security number, date of birth, all referring to the same patient).
Required Field	A mandatory field, one that must not remain blank.
Return	On the computer keyboard, the key located where the carriage return is on a typewriter. Symbolized by <RET> in this manual .
Security Key	Special control that allows you to unlock and use options governing sensitive activities and information.
Software	The set of programs that comprise the HBPC computer application.
Team	An interdisciplinary group of staff who care for a specific group of HBPC patients. Some HBPCs are composed of only one team; some have two teams, others three or more.









# X. Index

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