DATA SPECIFICATIONS FOR HOME CARE 1.00 SUBMISSION FILES (VERSION 1.00)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
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HOME CARE SUBMISSION FILE STRUCTURE

A valid submission file consists of fixed length ** text (ASCII) records. All records in the file must consist of 1097 data bytes followed by a % [percent sign] to indicate end of data and then a carriage return (ASCII 013) and then a line feed (ASCII 010) for a total of 1100 bytes**.

Each submission file consists of a Header Record as the first record, one or more Data Records, and a Trailer Record as the last record.

Header Record

The header record has HDDR in the first four bytes (characters) and is 42 characters long the remaining FILLER is all spaces. The MS-Word Document "HOME CARE File Layout.doc" contains the "HEADER RECORD LAYOUT" which presents a detailed layout for the header record. The header record contains basic identifying information for the agency submitting the HOME CARE 1.00 Submission file.

Data Records

Data records have either an A (Upper Case A), or D (Upper Case D) or, M (Upper Case M) in the first byte (character). A Record Type 'A' indicates a request to add a record, 'M' to modify a record and 'D' to delete a record. The MS-Word Document "HOME CARE File Layout.doc" contains the "DATA LAYOUTS" which presents detailed layouts for each type of Data Record. EACH DATA RECORD contains information EITHER for a single HOME CARE Client Telephone Screening OR single Client Facesheet information OR a single HOME CARE Client assessment OR a single HOME CARE Client Reassessment OR a single Medication OR a single Client Status OR a single Client's Care Setting Status OR a single Client's Memo of Understanding Status OR a single Client's Waiver Status.

There are 2 different types of facesheet's – one type presents information from a facesheet during initial assessment, while another presents facesheet information during a reassessment.

In order to reduce the size of the assessment/reassessment record there exists a separate record for the Medication Data (Medication Name, frequency, prescribed by, and compliance). There are 2 different types of Medication – one type presents medication information for a client at assessment while another presents the medication information of a client during reassessment.

For this we have used a key field called Record Mapping Indicator (value 'A' or 'R') that maps the facesheet and the Medication to the corresponding assessment or reassessment.

Record types are discussed in detail in a section below. The data records are of fixed length of 1100 characters **.

** **The submission file can be changed to variable length if a waiver agent uses a MDCH program called TR9000 to create the DEG Header and Trailer records. This TR9000 program strips the fillers at end of data records**.

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The data records will have different layouts based on record type. E.g. we have the client's information such as name, address, gender, martial status, birth date, race, phone, and SSN Verified flag in the Screen and the Facesheet Record but it is not present in the Assessment, Reassessment, or Medication Record. Note that the Clients information will be on the screen record for the initial load of this Clients information. Changes to this Client's personal information can be done through the facesheet.

Trailer Record

The trailer record has TRLR in the first four bytes and is 48 characters long the remaining FILLER is all spaces. The MS-Word Document "HOME CARE File Layout.doc" contains the "TRAILER RECORD LAYOUT" which presents a detailed layout for the trailer record. The trailer record indicates the end of the submission file, and this record includes a count of the total records in the file including the Header and Trailer Records.

HOME CARE File Layout.doc: The Microsoft Word Document used to generate the detailed data specifications for the Header, Data and Trailer records for Version 1.00.

MS Word Document HOME CARE File Layout.doc Contents

HEADER RECORD LAYOUT contains the detailed layout for the Header records.

DATA LAYOUTS

SCREEN RECORD LAYOUT contains the detailed layout for Screen Data records.

FACESHEET RECORD LAYOUT contains the detailed layout for Facesheet Data records and is used for both assessment facesheets and for reassessment facesheets.

ASSESSMENT/ REASSESSMENT RECORD LAYOUT contains detailed layout for the Assessment/Reassessment Data records

MEDICATION RECORD LAYOUT contains the detailed layout for Medication Data records for both Assessments and Reassessments.

CLIENTS STATUS RECORD LAYOUT contains the detailed layout for Client Status Data records.

CARE SETTING STATUS RECORD LAYOUT contains the detailed layout for Clients Care Setting Status Data records.

MEMO OF UNDERSTANDING (MOU) STATUS RECORD LAYOUT contains the detailed layout for Memo of Understanding Status Data records.

WAIVER STATUS RECORD LAYOUT contains the detailed layout for Waiver Status Data records.

TRAILER RECORD LAYOUT contains the data layout for Trailer records.

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DATA RECORD TYPES

There are 9 different data record types and these record types are defined and described in Tables on the following 2 pages. For the first 5 record types (i.e. Screen, Facesheet, Assessment, Reassessment, Medication) the Items come from the MI CHOICE Forms.

IMPORTANT NOTE: There are items in the **MI-CHOICE CARE MANAGEMENT ASSESSMENT/REASSESSMENT Forms, which** are not recorded in the database. These items are not included in the record layout.

Table 1 ("Record Type Determination for the HOME CARE 1.00") gives a code, name, and brief description for each of the 9 record types. Each record type has a different pattern of fields in their record layouts except Assessment and Reassessment records they share the same record layout.

TABLE 1
RECORD TYPE DETERMINATION FOR THE HOME CARE 1.00

The HOME CARE 1.00 Record Types are as follows:

CODE	NAME	DESCRIPTION
S	Screen	Basic Telephone Screening
F	Facesheet	Client's Information recorded at the time of Client's Assessment/Reassessment.
A	Assessment	Client's Assessment
R	Reassessment	Client's Periodic Reassessment
M	Medication	Client's Medication Information during Assessment/Reassessment
C	Client Status	Client's Status Information
B	Care Setting Status	Client's Care Setting Status Information
D	MOU Status	Client's Memo of Understanding Status Information
W	Waiver Status	Client's Waiver Status Information

FIELD BY FIELD SPECIFICATIONS

Detailed field-by-field specifications are provided for HOME CARE data records (including screening, facesheet, assessments/reassessments, Medication and all other status records) in the MS-Word Document "**HOME CARE File Layout.doc**". File Transfer Control Record Layout for header/trailer records is also included in the same document.

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In these data specifications, there is a separate entry for each field in the HOME CARE data record layout. Additional entries are used to allow information to be provided about groups of fields. These additional entries all have a "Type" of "GRP LABEL" (group label). Now consider the different types of information given for each entry.

INDEX. The "Index" column gives a unique number to identify each field uniquely.

FIELD. The "Item Field" column gives the field names. All the items in the **Screening, Facesheet, Assessment, Reassessment,** and **Medication records** are from the Form Locations (e.g., "SC_A1, SC means the Screening form, section A item 1").

These forms are
- MI CHOICE TELEPHONE SCREEN
- MI CHOICE CARE PARTICIPANT INFORMATION
- MI CHOICE CARE MANAGEMENT ASSESSMENT
- MI CHOICE CARE MANAGEMENT REASSESSMENT

Form Location Coding Conventions:
All MI Choice Telephone Screening Form Items are preceded with "SC_".
For eg: For the Item Screen Source, location on the Form is 4. Hence it is coded as "SC_4"

All MI Choice Participant Information (Facesheet) Items are preceded with "FS_"
For eg: For the Item Spouse Date of Birth, location on the Form is A6. Hence it is coded as "FS_A6"

All MI Choice Assessment/Reassessment Items are preceded with "AR_". For eg: For the Item Date Case Opened/Reopened, location on the Form is A7. Hence it is coded as "AR_A7"

Note to avoid confusion between dates of Assessment and Reassessment (Item A2 in the Assessment/Reassessment Form), Date of Assessment is coded as AR_A2_DA and Date of Reassessment is coded as AR_A2_DR.

ITEM DESCRIPTION. The "Item Description" column gives a verbal description (e.g., "Screening Date") for the Fields.

LEN. The "Len" column gives the length of the field in characters (bytes).

COLUMNS TO AND FROM. Gives the starting location in the record where the value must be placed.

SPECIFICATIONS. The "Specifications" column gives a variety of information concerning the data requirements for the field. If a specification item in this column is tagged with an asterisk (*), then failure to comply with that specification will result in a FATAL ERROR and the HOME CARE record will be REJECTED by the State. If a specification is not tagged with an asterisk (*), then failure to comply will result in a non-fatal error and the record will be accepted by the State. In some cases non-fatal errors will produce a warning record in the error file.

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RANGE.** The "*Range if Active" section lists the permissible values for an active field. The asterisk in the label indicates that range errors are FATAL. If the active field does not have a value listed in the range, ***then a FATAL error will occur and the HOME CARE record will be REJECTED. The following conventions are used in the range list. A value of a single space is indicated by "space"; a value of two spaces, by "space (2)"; a value of three spaces, by "space (3)"; etc. Spaces are used to indicate that there is no value for that field, that field was blank when the HOME CARE form was submitted.

PICTURE. The "Picture" section provides basic format information for the field. A picture of "X" indicates a single alpha-numeric character, while "XX" or "X(2)" indicates two alpha-numeric characters. A picture of "MMDDYYYY" is used for date fields indicating month, day, and then year (including century) format.

TYPE. The "Type" section gives the type of data for each field. Types are CODE, COUNT, TEXT, DATE, CHECKLIST and GRP LABEL. For active fields, a blank (space) is entered if the item is skipped because of a skip pattern on the HOME CARE form. For example, when REC_TYPE=A or R Items AR_C7 thru AR_C10 Index 64-81 are ACTIVE fields. But the value of these items depends on LIVES WITH CLIENT (AR_C6) Index 62 field value. I.e. IF AR_C6 Index 62 = 2 then Items AR_C7 Index 64 thru AR_C10 Index 81 will be skipped.

FORMAT INFO. The "Format Info" section indicates additional specifications for the required formatting of a value for an active field. Examples are requirements that text entries be upper case and left justified, and that (count) entries be right justified and leading zero filled. If a specification listed in Format Info is preceded by an asterisk (*), then failure to comply with that specification is ***a FATAL error that will result in record REJECTION***. For example, the format info for some numeric (count) entries includes the specification

"*Right justified and leading zero filled number or blank".

If the value for an active field does not comply with such an asterisk tagged specification, then a ***FATAL error will occur***. If a Format Info specification is not tagged with an asterisk (*), then failure to comply will result in a non-fatal error and the record will still be accepted by the State. In some cases non-fatal errors will produce a warning record in the error file.

CONSISTENCY. Some fields or pairs of fields or groups of fields must have consistent values. Other fields may have a value that is dependent on the value of another field. For example, an end date must be greater than it's corresponding begin date. The "Consistency" section indicates such consistency specifications for the fields. If a consistency specification is preceded by an asterisk (*) then failure to comply with that specification is ***a FATAL error that will result in record REJECTION***. For example, the consistency requirements for field AR_C7a includes the specification:

"*1. Value must be blank in the HOME CARE record, if AR_C6=2 (Index 62)."

Similarly, there are fields for which the specification says "*1.Required Field. Cannot be blank." This implies that those fields are required fields. If any of those fields are blank, then it will result in a FATAL ERROR that will result in record REJECTION.

If the value for the field does not comply with such an asterisk-tagged specification, then **a FATAL error will occur**. If a consistency specification is not tagged with an asterisk (*), then failure to comply will result in a non-fatal error and the record will be accepted by the State. Some but not all non-fatal errors will produce a warning record in the error file.

There are required consistencies among the various dates within the HOME CARE record. The requirements for date consistency have been listed for the relevant date fields under "CONSISTENCY".

There are also required consistencies between HOME CARE records for an individual client, and the ordering of the record types in the file. What record types must come first before other record types. These consistencies are detailed in "Required Sequencing/Timing of HOME CARE 1.00 Records", a later section of this document.

FATAL AND NONFATAL ERRORS IN HOME CARE DATA SUBMITTED TO THE STATE

When HOME CARE 1.00 data files are submitted to the State, the submission file and each component record is validated against standard data specifications by the standard State HOME CARE system. A detailed error file is sent back to the submitting agent indicating all errors found in the HOME CARE data submitted. Most HOME CARE data errors involve bad values for a particular data field, and the majority of these errors are **fatal**. That is the data record involving the error is rejected and must be corrected and resubmitted to the State.

If no fatal errors are detected, then any non-fatal errors will be reported to the agents by the standard State HOME CARE system and the HOME CARE record will be accepted into the State HOME CARE database.

There are two different types of fatal errors. Some fatal errors involve file integrity and lead to rejection of an entire HOME CARE submission file--these are **fatal file errors**. Other fatal errors involve range or consistency errors for specific fields within an HOME CARE record and such errors lead to rejection of the single record with errors--these are **fatal record errors**.

FATAL FILE ERRORS

Fatal file errors involve problems with the basic integrity of the submission file (detailed description of a submission file appears later in HOME CARE File Layout.doc). A submission file consists of a header record with appropriate identifiers, followed by HOME CARE data records, and ending with a trailer record. Header, data, and trailer records are described in more detail later in this document, and detailed field-by-field specifications are presented in HOME CARE File Layout.doc. The following errors are considered fatal file errors and will lead to rejection of an entire submission file:

1. Any of the fields in the Header record are missing or contains invalid values.
2. Any record (Header, Data, or Trailer) is of variable length [**].
3. The Header or Trailer record is missing or out of order.

[**] **The submission file can be changed to variable length if the waiver agent uses a MDCH program called TR9000 to create the DEG Header and Trailer records. The TR9000 program strips the filler at end of the records.**

4. There are no HOME CARE data records.
5. The HOME CARE data records are out of order. For Eg: The Header record must be the first record and the Trailer record must be the last record. The HOME CARE data records must be after the Header Record but before the Trailer Record.
6. The record count given in the Trailer record does not match the total number of records in the submission file including Header and Trailer records.
7. The Header data does not match with the Trailer data. I.e. Items from index 2-12 in Header must match with items from index 2-12 in the Trailer record.

When a fatal file error occurs, the agents must correct the error to produce an acceptable submission file, and then resubmit the file.

FATAL RECORD ERRORS
An individual HOME CARE data record will be rejected if there is a fatal range, format, or consistency error for any field in the record [***].

Detailed information is specified in the HOME CARE RECORD REJECTION CRITERIA. An individual HOME CARE record will also be rejected if there is insufficient information to identify the resident or if a duplicate record (matching key fields) already exists in the State's database.

Such fatal errors occur if:
1. there is insufficient key information to identify the client, or
2. a duplicate record (same critical key fields) already exists in the State's database.

When a fatal record error occurs, the agency must correct the appropriate fields in the record. The record can then be resubmitted with the next HOME CARE file transmitted to the State.

Note that there will be no Fatal Error if the data that contains alphabetic characters is not in upper case.

HOME CARE RECORD REJECTION CRITERIA
FOR ADDITIONS AND MODIFICATIONS OF NON-KEY FIELDS

The following criteria are for Additions, or Modifications to **non-key** fields**.** Criteria for Deletions, or Modifications to **key** fields will be covered later. An HOME CARE record will be rejected if any of the conditions below occur. Rejected records must be corrected and resubmitted.

1. Any standard telephone screen record [REC_TYPE S] is rejected if

   - Client Social Security Number (SC_SOCIAL_SECURITY_NUMBER Index 5) is missing.
   - Agent Code (SC_AGENT_CODE Index 6) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.

[***] **Although the formal policy is that all the LTC records should be submitted 15 days after the reporting month, the program will accept new records anytime. This will not result in a fatal error.**

- Client Last Name (SC_1 Index 7), Client First Name (SC_1 Index 8) is missing.
- Screening Date (SC_SCREENING_DATE Index 21) is invalid, or missing.
- SSN Verification (SC_8 Index 25) is missing or out of range.
- In the state Home Care Warehouse. Before a new screening record can be added any prior case must be closed, for that submitting agent. A Client Status record must exist where the Case Status (Index 8) has a closed code for any prior cases. The valid closed codes are 'C', 'N', or 'S'.
- The screening record can't be deleted if any other record type exists with that screening date, this includes Facesheet, Assessment, Reassessment, Client Status, Care Setting Status, MOU Status, and Waiver Status.

2. Any standard facesheet record [REC_TYPE F] is rejected if
   - Client Social Security Number (FS_SOCIAL_SECURITY_NUMBER Index 6) is missing.
   - Agent Code (FS_AGENT_CODE Index 7) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
   - Screening Date (FS_SCREENING_DATE index 24) is missing, invalid or exceeds the Facesheet Date (FS_FACESHEET_DATE Index 27).
   - Facesheet Date (FS_FACESHEET_DATE Index 27) is missing, or invalid.
   - Client Last Name (FS_A1 Index 8), or Client First Name (FS_A1 Index 9) is missing.
   - SSN Verification (FS_A11 Index 40) is missing or out of range.
   - There is no corresponding screen record for that client with the same Screening Date as the Facesheet record.

3. Any standard assessment record (AR_A4=0,1,2,3,4,5,6) [REC_TYPE A] is rejected if

   - Client Social Security Number (AR_SOCIAL_SECURITY_NUMBER Index 5) is missing or invalid.
   - Agent Code (AR_AGENT_CODE Index 6) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
   - Screening Date (AR_A1 Index 8) is missing or invalid or exceeds the Date of Assessment (AR_A2_DA Index 9).
   - Date of Assessment (AR_A2_DA Index 9) is missing or invalid. No partial dates are allowed.
   - Assessment Reason (AR_A4 Index 11) is out of range. Valid values are 0,1,2,3,4,5,6,space.
   - No corresponding Screen record exists for that particular participant with the same Screening Date.
   - If corresponding Medication records exist with the same assessment date.

4. Any standard reassessment record (A4=0,1,2,3,4,5) [REC_TYPE R] is rejected if

   - Client Social Security Number (AR_SOCIAL_SECURITY_NUMBER Index 5) is missing.
   - Agent Code (AR_AGENT_CODE Index 6) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
   - Screen Date (AR_A1 Index 8) is missing or invalid or exceeds or equals the Date of Reassessment (AR_A2_DR Index 9).

- Date of Reassessment (AR_A2_DR Index 9) is missing or invalid.
- Reassessment Reason (AR_A4 Index 11) is out of range. Valid values are 0,1,2,3,4,5, space. (6 is not a valid value).
- No corresponding Screen or Assessment record exists for that particular participant.
- If corresponding Medication records exist with the same assessment date.

5. Any standard medication record [REC_TYPE M] is rejected if

- Client Social Security Number (AR_SOCIAL_SECURITY_NUMBER Index 6) is missing or invalid.
- Agent Code (AR_AGENT_CODE Index 7) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
- No corresponding Assessment/Reassessment record exists for that particular participant with the same Medication record's assessment date.
- Sequence Number (SEQ_NUM Index 9) of the Medication for an Assessment/Reassessment date is missing or invalid or is a duplicate. This is a required field.
- Medication Name/Strength (AR_R9_NS Index 10) is missing. This is a required field.

6. Any standard Clients Status record [REC_TYPE C] is rejected if

- Agent Code (AGENT_CODE Index 5) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
- Client Social Security Number (SOCIAL_SECURITY_NUMBER Index 6) is missing or invalid.
- Screening Date (SCREENING_DATE Index 7) is missing or invalid or exceeds the Date case status started (FROM_DATE Index 9).
- Case Status (CASE_STATUS Index 8) is missing or invalid. Refer STATUS CODE TABLE.doc for valid codes.
- Date case status started (FROM_DATE Index 9) is missing or invalid or exceeds the current date.
- Date case status started (FROM_DATE Index 9) exceeds the end date (TO_DATE Index 10).
- No corresponding Screening record exists with the screening date of the Client Status record.

7. Any standard Clients Care Setting Status record [REC_TYPE B] is rejected if

- Agent Code (AGENT_CODE Index 5) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
- Client Social Security Number (SOCIAL_SECURITY_NUMBER Index 6) is missing or invalid.
- Screening Date (SCREENING_DATE Index 7) is missing or invalid or exceeds the Date care setting status started (FROM_DATE Index 9).
- Type of Care Setting (CARE_SETTING Index 8) is missing or invalid. Refer to STATUS CODE TABLE.doc for valid codes.

- Date care setting started (FROM_DATE Index 9) is missing or invalid or exceeds the current date.
- Date care setting started (FROM_DATE Index 9) exceeds the Care Setting end date (TO_DATE Index 10).
- No corresponding Screening record exists with the screening date of the Care Setting Status record.

8. Any standard Clients Memo of Understanding Status record [REC_TYPE D] is rejected if

   - Agent Code (AGENT_CODE Index 5) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
   - Client Social Security Number (SOCIAL_SECURITY_NUMBER Index 6) is missing or invalid.
   - Screening Date (SCREENING_DATE Index 7) is missing or invalid or exceeds the Start Date of MOU status (FROM_DATE Index 9).
   - MOU Status Code (MOU STATUS CODE Index 8) is missing or invalid. Refer STATUS CODE TABLE.doc for valid codes.
   - Start Date of MOU Status (FROM_DATE Index 9) is missing or invalid or exceeds the current date.
   - Start Date of MOU Status (FROM_DATE Index 9) exceeds the End date of MOU status (TO_DATE Index 10).
   - No corresponding Screening record exists with the screening date of the Memo of Understanding Status record.

9. Any standard waiver status record [REC_TYPE W] is rejected if

   - Agent Code (AGENT_CODE Index 5) is invalid or missing. For validity, Agent Codes are checked against the Agent Table.
   - Client Social Security Number (SOCIAL_SECURITY_NUMBER Index 6) is missing or invalid.
   - Screening Date (SCREENING_DATE Index 7) is missing or invalid or exceeds the Start date of Clients Eligibility status (FROM_DATE Index 9) or exceeds the current date.
   - Client Type (CLIENT_TYPE Index 8) is missing or invalid. Refer STATUS CODE TABLE.doc for valid codes.
   - Client's waiver eligibility status (WAIVER_ELIGIBILITY Index 9) is missing or invalid. Refer STATUS CODE TABLE.doc for valid codes.
   - Start date of Client's Eligibility status (FROM_DATE Index 10) exceeds the End Date of Clients waiver eligibility status (TO_DATE Index 11) or exceeds the current date.
   - No corresponding Screening record exists with the screening date of the Waver Status.

10. A newly submitted record [RECORD_ID A] that is found to be a duplicate of an existing record is rejected.

    For SCREEN – REC_TYPE S
    Duplicate records have: (1) identical SSN (SC_SOCIAL_SECURITY_NUMBER Index 5), (2) identical Screening Date (SC_SCREENING_DATE Index 21), (3) identical Agent code (SC_AGENT_CODE Index 6).

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For FACESHEET – REC_TYPE F
Duplicate records have: (1) identical SSN (FS_SOCIAL_SECURITY_NUMBER Index 6), (2) identical Screening Date (FS_SCREENING_DATE Index 24), (3) identical Agent (FS_AGENT_CODE Index 7), (4) identical Facesheet Date (FS_FACESHEET_DATE Index 27).

For ASSESSMENT – REC_TYPE A
Duplicate records have: (1) identical SSN (AR_SOCIAL_SECURITY_NUMBER Index 5), (2) identical Screening Date (AR_A1 Index 8), (3) identical Agent code (AR_AGENT_CODE Index 6), (4) identical Date of Assessment (AR_A2_DA Index 9).

For REASSESSMENT – REC_TYPE R
Duplicate records have: (1) identical SSN (AR_SOCIAL_SECURITY_NUMBER Index 5) (2) identical Screening Date (AR_A1 Index 8), (3) identical Agent (AR_AGENT_CODE Index 8), (4) identical Date of Assessment (AR_A2_DR Index 9).

For MEDICATION – REC_TYPE M
Duplicate records have: (1) identical SSN (AR_SOCIAL_SECURITY_NUMBER Index 6), (2) identical Agent code (AR_AGENT_CODE Index 7), (3) identical Date of Assessment (AR_A2_DR Index 8), (4) Identical Medication Sequence Number (SEQ_NUM Index 9).

For CLIENT STATUS – REC_TYPE C
Duplicate records have: (1) identical SSN (SOCIAL_SECURITY_NUMBER Index 6), (2) identical Screening Date (SCREENING_DATE Index 7), (3) identical Agent code (AGENT_CODE Index 5), (4) identical Date case Status started (FROM_DATE Index 9), (5) identical case status (CASE_STATUS Index 8).

For CARE SETTING STATUS – REC_TYPE B
Duplicate records have: (1) identical SSN (SOCIAL_SECURITY_NUMBER Index 6), (3) identical Screening Date (SCREENING_DATE Index 7), (3) identical Agent (AGENT_CODE Index 5), (4) identical Date care setting started (FROM_DATE Index 9), (5) identical type of care setting (CARE_SETTING Index 8).

For MOU STATUS – REC_TYPE D
Duplicate records have: (1) identical SSN (SOCIAL_SECURITY_NUMBER Index 6), (2) identical Screening Date (SCREENING_DATE Index 7), (3) identical Agent (AGENT_CODE Index 5), (4) identical Start Date of MOU Status started (FROM_DATE Index 9), (5) identical MOU Status code (MOU_STATUS_CODE Index 8).

For WAIVER STATUS – REC_TYPE W
Duplicate records have: (1) identical SSN (SOCIAL_SECURITY_NUMBER Index 6), (2) identical Screening Date (SCREENING_DATE Index 7), (3) identical Agent (AGENT_CODE Index 5), (4) identical Start date of clients eligibility Status (FROM_DATE Index 10), (5) identical client type (CLIENT_TYPE Index 8), (6) identical Waiver Eligibility (WAIVER_ELIGIBILITY Index 9).

In short, the **critical keys** to determine the uniqueness

For Screen :

SSN + SCREENING_DATE + AGENT_CODE

For Facesheet:
SSN + SCREENING_DATE + AGENT_CODE + FACESHEET_DATE

For Assessment:
SSN + SCREENING_DATE + AGENT_CODE + ASSESS_DATE

For Reassessment:
SSN + SCREENING_DATE + AGENT_CODE + REASSESS_DATE

For Medication related to assessment:
SSN + AGENT_CODE + ASSESS_DATE + SEQ_NUM

For Medication related to Reassessment:
SSN + AGENT_CODE + REASSESS_DATE + SEQ_NUM

For Client Status:
SSN + SCREENING_DATE + AGENT_CODE + CASE_STATUS + FROM_DATE

For Care Setting Status:
SSN + SCREENING_DATE + AGENT_CODE + CARE_SETTING + FROM_DATE

For MOU Status:
SSN + SCREENING_DATE + AGENT_CODE + MOU_STATUS_CODE + FROM_DATE

For Waiver Status:
SSN + SCREENING_DATE + AGENT_CODE + CLIENT_TYPE + WAIVER_ELIGIBILITY + FROM_DATE

11. Any standard assessment record [REC_TYPE A] is rejected if that particular CLIENT does not have a corresponding screen record.

12. Any standard reassessment record [REC_TYPE R] is rejected if that particular client does not have a corresponding screen record.

13. Any record will be rejected if REC_ID, REC_TYPE, or REC_INDICATOR is missing or invalid.

MODIFYING NON-KEY FIELDS OF AN ASSESSMENT OR REASSESSMENT

A modification request does <u>not</u> overlay the original assessment/reassessment record but a new assessment/reassessment record is added. This new assessment/reassessment record has the same assessment/reassessment date as the original. The stored on dates will be different. In other words, a client can have several assessment records with the same assessment date as the original assessment, depending on the number of modifications processed for that particular assessment. The same is true for reassessments. To do an

inquiry to locate the most current assessment/reassessment record, the inquiry would have to find the record with the most current stored on date.

When requesting a delete of an assessment/reassessment (index 9) that has modifications, multiple records with the same assessment/reassessment date, all records that have that same assessment/reassessment date will be deleted.

HOME CARE RECORD CORRECTION.

Suppose a record that is previously submitted to the State contains some erroneous data, then that record has to be corrected and resubmitted to the State.

RECORD ID (REC_ID Index 1) field is the first item in each data record submitted, which indicates whether a record is to be Added or Modified or Deleted.

Permissible values for the HOME CARE RECORD_ID field are:

a) A (Upper Case A) for a new data record being submitted to the State database
b) M (Upper Case M) for a request to modify a record that was previously accepted into the State database.
c) D (Upper Case D) for a request to delete a record that was previously accepted into the State database.

The KEY fields to identify the records in the State Database are
For REC_TYPE=S

SC_SOCIAL_SECURITY_NUMBER
SC_SCREENING_DATE
SC_AGENT_CODE

For REC_TYPE=F

FS_SOCIAL_SECURITY_NUMBER
FS_SCREENING_DATE
FS_FACESHEET_DATE
FS_AGENT_CODE
REC_INDICATOR (Assessment / Reassessment Record Mapping Indicator)

For REC_TYPE=A

AR_SOCIAL_SECURITY_NUMBER
AR_AGENT_CODE
AR_A1 (Screening Date)
AR_A2 (AR_A2_DA Date of Assessment)

For REC_TYPE=R

AR_SOCIAL_SECURITY_NUMBER
AR_AGENT_CODE
AR_A1 (Screening Date)
AR_A2 (AR_A2_DR Date of Reassessment)

For REC_TYPE=M

AR_SOCIAL_SECURITY_NUMBER
AR_AGENT_CODE
AR_A2 (AR_A2_DR Date of Reassessment)
SEQ_NUM (Medication Sequence Number)
REC_INDICATOR (Assessment/Reassessment Record Mapping Indicator)

For REC_TYPE=C
SOCIAL_SECURITY_NUMBER
AGENT_CODE
SCREENING_DATE
CASE_STATUS
FROM_DATE

For REC_TYPE=B
SOCIAL_SECURITY_NUMBER
AGENT_CODE
SCREENING_DATE
CARE_SETTING_STATUS
FROM_DATE

For REC_TYPE=D
SOCIAL_SECURITY_NUMBER
AGENT_CODE
SCREENING_DATE
MOU_STATUS
FROM_DATE

For REC_TYPE=W
SOCIAL_SECURITY_NUMBER
AGENT_CODE
SCREENING_DATE
CLIENT_TYPE
WAIVER_ELIGIBILITY
FROM_DATE

For erroneous data records that were previously submitted to the State, the corrections could be of 2 types to modify **KEY** field's data and/or modify **NON-KEY** fields data.

IF modifications are for the **NON-KEY** Field's data, then that **entire record** has to be resubmitted to the State with RECORD_ID=M. The modified record "replaces" the erroneous record information in the State Database. Except for assessment/reassessment modifications where a new record is created.

IF modifications are for the **KEY** Fields data then two transaction need to be submitted to the state, the same erroneous record has to be submitted again by the Agency with RECORD_ID=D (Delete). This submission record needs to **only** contain the **KEY FIELD values based on the REC_TYPES**. This provides sufficient information for the erroneous record information to be located and deleted in the State Database. If you request a delete on an assessment/reassessment that has multiple records with the same assessment/reassessment date then all records with that assessment/reassessment date

will be deleted. Then the second record has to be submitted with RECORD_ID=A (Add) and must have all of the information for that record type so that it is added to the State Database with all the correct information.

When REC_TYPE=S (Screening) and RECORD_ID=D,
The KEY fields
a) SC_SOCIAL_SECURITY_NUMBER
b) SC_SCREENING_DATE
c) SC_AGENT_CODE must be submitted.
All other Screen information can be skipped.

When REC_TYPE=F (Facesheet) and RECORD_ID=D,
The KEY fields
a) SC_SOCIAL_SECURITY_NUMBER
b) SC_SCREENING_DATE
c) SC_FACESHEET_DATE
d) SC_AGENT_CODE must be submitted.
All other Facesheet information can be skipped.

When REC_TYPE=A or R (Assessment or Reassessment) and RECORD_ID=D,
The KEY fields are
a) AR_SOCIAL_SECURITY_NUMBER
b) AR_AGENT_CODE
c) AR_A1 (Screening Date)
d) AR_A2 (Date of Assessment /Reassessment) must be submitted.
All other Assessment / Reassessment information can be skipped.

When REC_TYPE=M (Medications), RECORD_MAPPING_INDICATOR=A and RECORD_ID=D,
The KEY fields are
a) AR_SOCIAL_SECURITY_NUMBER
b) AR_AGENT_CODE
c) AR_A2 (Date of Assessment) must be submitted.
d) SEQ_NUM (Sequence Number of Medication)
All other Assessment information can be skipped.

When REC_TYPE=M (Medications), RECORD_MAPPING_INDICATOR=R and RECORD_ID=D,
The KEY fields are
a) AR_SOCIAL_SECURITY_NUMBER
b) AR_AGENT_CODE
c) AR_A2 (Date of Reassessment) must be submitted.
d) SEQ_NUM (Sequence Number of Medication)
All other Reassessment information can be skipped.

When REC_TYPE= C (Client Status) and RECORD_ID=D,
The KEY fields are
a) SOCIAL_SECURITY_NUMBER
b) AGENT_CODE
c) SCREENING_DATE
d) CASE_STATUS
e) FROM_DATE must be submitted.

All other Client status information can be skipped.

When REC_TYPE= B (Care Setting Status) and RECORD_ID=D,
The KEY fields are
a) SOCIAL_SECURITY_NUMBER
b) AGENT_CODE
c) SCREENING_DATE
d) CARE_SETTING
e) FROM_DATE must be submitted.
All other Care Setting status information must be skipped.

When REC_TYPE= D (MOU Status) and RECORD_ID=D,
The KEY fields
a) Record Creation Date)
b) SOCIAL_SECURITY_NUMBER
c) AGENT_CODE
d) SCREENING_DATE
e) MOU_STATUS
f) FROM_DATE must be submitted.
All other MOU status information must be skipped.

When REC_TYPE= W (Wavier Status) and RECORD_ID=D,
The KEY fields
a) SOCIAL_SECURITY_NUMBER
b) AGENT_CODE
c) SCREENING_DATE
d) CLIENT_TYPE
e) WAIVER_ELIGIBILITY
f) FROM_DATE must be submitted.
All other Waiver status information can be skipped.

REQUIRED CONSISTENCY FOR DATES IN THE HOME CARE 1.00 RECORD

There are 3, 6, 4, 4, 2, 4, 4, 4, 4 dates that can be contained in HOME CARE Screen, Facesheet, Assessment, Reassessment, Medication, Client Status, Care Setting Status, MOU Status, Waiver Status records respectively. There are requirements for the sequencing of these dates. Each of these topics is considered below. When any of these dates in a HOME CARE record is submitted, then that date should be less than or equal to the current date. The State HOME CARE system will validate all dates in the HOME CARE record and if any date is later than the validation date, then ***a FATAL error will occur and the record will be rejected.***

SEQUENCING OF DATES IN THE HOME CARE 1.00 RECORD

Table 2A, 2B, 2C, 2D, 2E, 2F, 2G, 2H, and 2I presents the required date sequencing relationships for dates within an HOME CARE record. For each of the HOME CARE dates, this table details which other dates (that are present in the record) must be "prior to" or must be "prior to or same as". If any of the relationships depicted in Table 2 is violated, then a fatal error will occur and the record will be rejected. For example, if SC_2 (Client Date of

Birth) is later than SC_SCREENING_DATE (Screening Date), then the requirement that SC_2 be prior to SC_SCREENING_DATE is violated. Such a date sequencing error indicates serious problems and the record will be rejected.

SEQUENCING OF THE DATES PRESENT IN HOME CARE RECORD, based on REC_TYPES

TABLE 2A

REC_TYPE S

ITEM INDEX	Item/Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			ROW DATE IS PRIOR TO	ROW DATE IS PRIOR TO OR SAME AS
21	SC_SCREENING_ DATE	Client Screening Date		Current Date
10	SC_2	Client Birth Date	SC_SCREENING_DAT E	

TABLE 2B

REC_TYPE F

ITEM INDEX	Item/Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR TO	PRIOR TO OR SAME AS
24	FS_SCREENING_ DATE	Client Screening Date		FS_FACESHEET_DATE
11	FS_A2	Client Birth Date	FS_SCREENING_DAT E	
32	FS_A6	Spouse Birthdate	FS_SCREENING_DAT E	
49	FS_A21	Referral Date		FS_FACESHEET_DATE

TABLE 2C

REC_TYPE A

ITEM INDEX	Item/Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
8	AR_A1	Screening Date		AR_A2_DA Assessment Date
9	AR_A2_DA	Date of Assessment		CURRENT DATE
12	AR_A7	Date Case Opened/Reopened		AR_A2_DA Assessment Date

TABLE 2D

REC_TYPE R

ITEM INDEX	Item /Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
8	AR_A1	Screen Date		AR_A2_DR Date of Reassessment
9	AR_A2_DR	Date of Reassessment		CURRENT DATE
12	AR_A7	Date Case Opened/Reopened		AR_A2_DR Date of Reassessment

TABLE 2E

REC_TYPE M

ITEM INDEX	Item/ Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
8	AR_A2_DA or AR_A2_DR	Date of Assessment/Reassess ment		CURRENT DATE

TABLE 2F

REC_TYPE C

ITEM INDEX	Item /Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
7	SCREENING_DATE	Screen Date		FROM_DATE Date case status started, CURRENT DATE
9	FROM_DATE	Date case status started		CURRENT DATE, TO_DATE WHEN NOT NULL

TABLE 2G

REC_TYPE B

ITEM INDEX	Item /Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
7	SCREENING_DATE	Screen Date		FROM_DATE Date care setting status starts, CURRENT DATE
9	FROM_DATE	Date care setting status starts		CURRENT DATE, TO_DATE WHEN NOT NULL

TABLE 2H

REC_TYPE D

ITEM INDEX	Item /Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
7	SCREENING_DATE	Screen Date		FROM_DATE Start date of MOU Status, CURRENT DATE
9	FROM_DATE	Start date of MOU Status		CURRENT DATE, TO_DATE WHEN NOT NULL

TABLE 2I

REC_TYPE W

ITEM INDEX	Item /Form Location	DESCRIPTION	SEQUENCING OF DATE FIELD IN ROW WITH OTHER DATES PRESENT IN THE HOME CARE RECORD	
			PRIOR_TO	PRIOR TO OR SAME AS
7	SCREENING_DATE	Screen Date		FROM_DATE Start date of clients eligibility status, CURRENT DATE
10	FROM_DATE	Start date of clients eligibility status		REC_CREATION_DATE, TO_DATE WHEN NOT NULL

*** **Note:**

a) In most of the Facesheet records, the Facesheet Date and the Date of Assessment is the same.

EXPECTED SEQUENCING AND TIMING OF HOME CARE 1.00 Records

RECORD SEQUENCING

The sequence of records ***FOR A CLIENT*** should conform to certain expectations. For example a Reassessment Record would not be expected to follow a Telephone Screen Record an Assessment should. If there are exceptions to the following specifications then the Agent may have skipped a record or submitted an inappropriate record.

Initial Record.

The initial record should be: TYPE S

REASON:
The Telephone Screening record is the first data collection point for a client. Screens gather some basic client information as well as screening questions. Without a screen, no facesheet or assessment data can be submitted.

Facesheet Record.
The next record after the Initial Screening record should be: TYPE F with RECORD MAPPING INDICATOR A

REASON:
Facesheet (Participant Information): Collects more demographic and referral information as well as insurance and financial information. It is the second stage in data collection, but is usually completed in conjunction with the Assessment. A Screening record must exist before a Facesheet record can be added. A Facesheet record is not required to add an Assessment or Reassessment. Subsequent Facesheet records should have Record Mapping Indicator R, mapping it to a Reassessment.

Assessment Record
Record following the Facesheet
The next record after the Facesheet Record should be: TYPE A.

REASON:
Basically, The TYPE A record consists of Assessment Information.

Assessment: Asks extensive questions about the client's psychological, social, medical, physical functioning and environmental status, and details services in place.

Medication Record
Record following the Assessment
The next record after the Assessment Record should be Medication: TYPE M. with RECORD_MAPPING_INDICATOR 'A'

REASON:
Basically, This record consists of Clients Medication Information at the time of Assessment.

Facesheet Record
Record following the Medication (for Assessment) Record: TYPE F with RECORD MAPPING INDICATOR R

REASON:
Facesheet (Participant Information): Before Reassessment the facesheet Information is reviewed.

Reassessment Record
Record following the Facesheet (for Reassessment) Record: TYPE R

REASON:
Reassessments are completed every 90 days for active clients and every 180 days for maintenance clients (only after assessment has been completed).

Medication Record
Record following the Reassessment:
The next record after the Reassessment Record should be Medication: TYPE M. with RECORD_MAPPING_INDICATOR 'R'

REASON:
This consists of Clients Medication Information at the time of Reassessment.

SEQUENCING OF STATUS RECORDS - (CLIENT, CARE SETTING, MOU and WAIVER STATUS)
There is no particular record sequencing between the various STATUS RECORDS.

However, for any STATUS record to be added in the State Database, the corresponding Client's:

- Screen [REC_TYPE S] must already exist or be before the status record in the same submission file.
- Assessment [REC_TYPE A] Record (Not Reassessment [REC_TYPE R]) must already exist in the database.

EXCEPTIONS IN RECORD SEQUENCING
There are cases where the Client's record with an agency was CLOSED due to a reason JUST AFTER the

a. Telephone screening.
   In such cases there will not be any Facesheet, Assessment, Medication-Assessment, Reassessment or Medication – Reassessment record for that Client. There will only be a Telephone Screening Record.

b. Assessment.
   In such cases there will not be any Reassessment or Medication – Reassessment record for that Client.

For most clients you can expect them to have all 9 records i.e. Telephone Screen Record [REC_TYPE S], all four of the status records [REC_TYPE C, B, D, and W], Facesheet Record [REC_TYPE F], Assessment Record [REC_TYPE A], Medication Record [REC_TYPE M, Indicator A], Reassessment Record [REC_TYPE R], and Medication Record [REC_TYPE M, Indicator R].

Note that
1. Facesheet Record cannot exist without a corresponding Screen Record.

2. Assessment Record cannot exist without a corresponding Screen Record.
3. Assessment Medication record cannot exist without a corresponding Assessment Record.
4. Reassessment record cannot not exist without a corresponding Assessment record and screen record. This is not true it has been allowed in the past and will continue to be allowed per the Long Term Care Group.
5. Reassessment Medication record cannot exist without a corresponding Reassessment Record.
6. Any of the Status records cannot exist without the corresponding Screen, and Assessment Records.

APPENDIX A – DATA ELECTRONIC GATEWAY (DEG) INFORMATION

The HC (Home Care) submission file is transferred to the Warehouse using DEG (Data Electronic Gateway) and has the file name of:

For Testing:
/homedch/dev/rawdata/mdshc/4933

For Production:
/homedch/prod/rawdata/mdshc/4933

Update Log:

Update Date	Person who did the Update	Update Description
6/29/2003	Andree Almer	Change the Locking specifications on page 12-13
7/7/2003	Andree Almer	Removed old locking specifications on page 7 because the locking definitions do not need to be in two areas.
7/28/2003	Andree Almer	Remove Social Security Edits because they are changing too fast to keep up in the programs.
12-23-2003	Julie Donall	Page 1,2,3 - HOME CARE_WITH_STATUS.doc does not exist, it is replaced with HOME CARE File Layout.doc, where the actual layouts can be found.
12/23/2003	Julie Donall	Page 6, 23 - Facesheet is not required.
12/23/2003	Julie Donall	Page 23 – Sequencing the Status Records, removed the requirement for Locked Facesheet. Screening and Assessment records must exist before adding any of the status records.
04/08/2004	Julie Donall	There will be no locking (restricting the number of days deleting or modifying is allowed) of any record type. All references to locking have been removed.
04/08/2004	Julie Donall	The creation date will no longer be part of the key items used to find a unique record, for all record types. All references to creation date as part of the key have been removed.