HOSPICE ABSTRACTION REPORTING TOOL (HART) USER GUIDE

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INTRODUCTION
The Hospice Abstraction Reporting Tool (HART) was developed by the Centers for Medicare & Medicaid Services (CMS). HART is a free Java-based Windows application available for download and use which provides an option for Hospice providers to collect and maintain facility, patient and Hospice Item Set (HIS) Record information for subsequent submission to the appropriate national data repository. HART displays electronic HIS Record forms similar to the paper version of the item set forms. Once the abstraction is completed, facilities are able to export their data from the application and submit it to the appropriate national data repository.

This User Guide will cover all of the user functionality found in HART as well as the Help and Security features. The iQIES Help Desk is available for technical support and assistance if needed, and may be contacted by phone at 800-339-9313 or by email to iqies@cms.hhs.gov.

INSTALLATION
INSTALLERS
To install HART the User must be logged into the PC as a Workstation Administrator. Users of the application MUST have read/write access to the location where the database is installed.

HARDWARE/SOFTWARE SPECIFICATIONS
The Minimum and Recommended System Requirements may be found on the QIES Technical Support Office home page: https://www.qtso.com/index.php

SECURITY
Making information security one of your organization’s core values ensures the prevention of unauthorized viewing of Personally Identifiable Information (PII) or Protected Health Information (PHI). It is important that providers work with their Information Technology (IT) team or other resources to build a security-minded organizational culture which enforces strong authentication and access controls as well as limits physical access to devices (e.g., laptops, handhelds, desktops, servers, thumb drives, CDs, backups) containing PII or PHI data.

CMS recommends that providers encrypt the hard drive of any electronic device which has access to data containing PII or PHI, such as exported HIS records. Once HIS records have been exported from the HART application the data will no longer be encrypted. It is also recommended that those electronic devices, which contain PII or PHI, be physically secured and locked (password protected) when not in use.

WINDOWS SETTINGS
In order to ensure the reliable operation of the HART software application use of a supported Microsoft Windows operating system is imperative. The Font Size property must be set to “Small Fonts”. This property can be found under the Settings tab of desktop properties: Start\Control Panel\Appearance and Personalization\Display.\.

SYSTEM CONFIGURATION/INSTALLATION TYPE
STANDALONE
The Standalone installation is self-contained on one workstation.

NETWORK CLIENT
The Network Client/Server installation uses a server to support one or more individual workstations, all accessing one database by multiple computers and users.
- Servers hold the central database and must utilize the Server installation file first.
- Network Clients are placed on the users individual workstations which then access the
database on the Server. The Network Client is installed after the Server installation has been successfully completed.  

Please refer to the HART Installation Guide for assistance installing and setting up the HART application. The iQIES Help Desk is available for technical support and assistance if needed, and may be contacted by phone at 800-339-9313 or by email to iqies@cms.hhs.gov.

VERSION VERIFICATION

Information about the version of HART currently installed may be found by selecting ‘About Quality Management System’ from the ‘Help’ drop-down on the Menu Bar.

![About Quality Management System]

The System Configuration/Installation Type, Feature Label and Feature Version as well as the Help Desk contact information are displayed.

When the HART application is accessed and the computer running HART has an internet connection, the application will compare the version currently installed with the version available on the QIES Technical Support Office (QTSO) website.

If a new version of HART is available, a message will display directing the user to the QTSO website to download the latest version.

GENERAL OVERVIEW

HART software provides the following functionality:

- Facility Setup/Maintenance
- User Setup/Maintenance
- Patient Setup/Maintenance
- HIS Record Maintenance
ACCESS
Once HART has been installed, access the program using one of the following methods:
- Start Menu – Select the HART icon from the Start Menu
- Desktop – Double click the HART icon found on the desktop
- Directory – Navigate to the directory where HART is installed, double click the HART.exe

ACCESSIBILITY
Selecting the ‘Enable Accessibility Features’ checkbox at the bottom of the login screen will turn on accessibility features for users requiring assistive technology (e.g. screen readers). The box will remain checked or unchecked until changed by the user.

SCREEN LAYOUT

TITLE BAR
Displays the name of the software application: HART.

MENU BAR
Located just below the Title, the Menu Bar consists of drop-down lists which contain command selections dependent on user role and the screen that is currently active.

Pressing the Alt key on the keyboard will place the cursor in the menu bar. Using the arrow keys on the keyboard, users can navigate through the selections on the menu bar. For example: On the HIS record Search screen, if the cursor is on the File menu item, pressing the right directional arrow will move the cursor to the next menu item. Pressing the up and/or down directional arrows will provide navigation through the drop-down menu list.

TOOL BAR
Located just below the Menu Bar, the Tool Bar contains screen specific buttons and icons to assist the user. Hover or “mouse over” the icons to display a description of the available functionality.

SCREEN TABS
Located just below the Tool Bar, Screen Tabs will display the open screens (e.g. Facility, Patient, User, and HIS record). An asterisk (*) will display on the tab to the left of the tab title if there are screen changes which need to be saved.

SCREEN AND COLUMN SIZE CONTROL
The various screens available are divided into distinct functional sections. Search and Summary sections may be collapsed by a single click of the arrow located next to the section title. Clicking on the arrow a second time will expand the section.

Columns and sections may be resized if needed by hovering over the line which separates the sections or column headers. The cursor will create an arrow. Click and drag the “left-right arrow” icon to the desired width.
FIELD TYPES

TEXT
Text fields allow data to be entered manually. Data entered must adhere to the rules of the Hospice Data Specifications (length, use of special characters etc.). The following is an example of a text field.

DATE
Date fields are formatted for the entry of a valid date (MM-DD-YYYY) where MM = 01-12, DD = 01-31, and YYYY = the four digit year. Some date fields allow other data to be entered, such as a (-) for ‘not assessed/no information’, these fields will be defined by the Hospice Data Specifications.

The following is an example of a date field.

Please Note: When the ‘Enable Accessibility Features’ checkbox is checked on the HART Login Screen the calendar icon will NOT be displayed. When the ‘Enable Accessibility Features’ checkbox is unchecked on the HART Login Screen there will be a calendar icon next to each date field that the user may utilize instead of manually entering in a date.

CHECKBOX
Checkboxes allow the selection of “yes” answers simply by clicking the box next to the appropriate value. Double clicking the check box will mark the response as ‘not assessed’. Clicking the check box a third time will uncheck the box for a selection of “no”.

The following is an example of a checkbox.

DROP-DOWN LIST
Drop-down lists contain allowable answers to a specific field.

To answer a drop-down question, tab to the field and use the arrow keys on the keyboard to navigate through the answer options. Once the appropriate answer is displayed, use the Tab key to move to the next question.

A mouse may also be used to select an answer in a drop-down list. Click the arrow on the right side of the field to expand the list. Click the desired answer. Click the mouse on the next question. The ‘Delete’ key on the keyboard can be used to clear the field.
The following is an example of a drop-down list.

![Gender (A0800)*](image)

**EDITS**

Data integrity edits are applied as information is entered into HART. These edits are unique messages put in place to assist users with the accurate completion of data entry. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the HIS record is saved and validated.

The following types of edits may occur in HART:

**ERRORS**

This type of edit lets the user know information is missing or invalid. It must be entered or corrected before the information will be saved.

**WARNINGS**

This type of edit indicates there is information entered that should be verified as accurate, or serve as a reminder of how some fields should be populated.

**INFORMATIONAL**

This type of edit gives the user general information about the HIS record.

**DATA ENTRY TIPS**

- For optimization of the skip patterns and/or edits, it is recommended that HIS record data be entered in the order the questions appear on the screen.
- Enter data in each field and use the ‘Tab’ key on the keyboard to navigate from field to field. This allows skip patterns and edits to be appropriately applied and helps ensure all fields are addressed.
- Some fields require use of additional keys. For example, checkbox fields use the ‘Tab’ and ‘Shift + Tab’ keys to scroll through the available responses. Once the desired response is highlighted, pressing the spacebar will make the selection. Press the ‘Tab’ key to move to the next field and ‘Shift + Tab’ to go to the previous selection. The mouse may also be used to move to a field and make a selection.

**ORDER OF DATA ENTRY**

- Create a facility
- Create a user
- Create a patient
- Create a HIS record
- Export the HIS record

**LOGIN**

**Please Note:** The Default User account (hart) cannot be used to create patients or HIS records. For detailed instructions regarding the initial login please consult the HART Installation Guide.

Complete the following steps to login to HART:

1. Launch the HART application from the start menu, desktop or directory where installed.
2. The HART splash screen containing the CMS logo displays momentarily.
The ‘Welcome to HART’ screen will display while the program is loading. This may take a few minutes and requires no response from the user.

The ‘Login’ screen displays.

1. Enter the assigned User ID.
2. Enter the Password. When logging in for the first time enter your assigned User ID in both the ‘User ID’ and ‘Password’ fields; these are case sensitive.
3. Click ‘Login’.
When logging in for the first time, the ‘Change Password’ screen displays as follows:

- The new password and the confirm new password must match.
- The new password must be at least 8 characters long.
- The new password must be no more than 20 characters long.
- The new password must not contain any space.
- The new password must not contain the User ID, First Name, Last Name, or Email.
- The new password must not begin with a number.
- The new password can only contain a maximum of 3 repetitive characters.
- The new password must contain at least one for each of the following type of characters:
  - Upper-case Character: A-Z
  - Lower-case Character: a-z
  - Number: 0-9
  - Special Character: &~!@#$%^*()_+={}[]\:"<>?,./
- The new password must not match any of the user's most recent 6 passwords.
- The new password will be set to expire in 60 days.

4. Enter a new password in the ‘New Password’ and ‘Confirm New Password’ fields. The password is case sensitive and must match in both fields.

5. Select ‘Continue’ to complete the login process.

Please Note: Selecting ‘Cancel’ will display the following message: “You must change your password before accessing the system. If you do not change your password, you will be logged off the system.” Clicking ‘Cancel’ on this pop-up will take the User back to the previous ‘Change Password’ pop-up. Clicking ‘OK’ takes the User to the login screen where they must re-enter the assigned User ID in both the ‘User ID’ and ‘Password’ fields.
The ‘Security Questions’ screen displays the following questions:

- What city were you born in?
- What year did you graduate from high school?
- What is your favorite sport?
- What was the make of your first car?
- What was the color of your first car?
- What is your mother's maiden name?
- What was the name of your first pet?
- What size shoe do you wear?
- What is your favorite season of the year?
- What is your favorite movie?

To enable the OK button, a minimum of 6 answers are required.

What city were you born in? [ ]
What year did you graduate from high school? [ ]
What is your favorite sport? [ ]
What was the make of your first car? [ ]
What was the color of your first car? [ ]
What is your mother's maiden name? [ ]
What was the name of your first pet? [ ]
What size shoe do you wear? [ ]
What is your favorite season of the year? [ ]
What is your favorite movie? [ ]

6. Complete the answers to a minimum of six (6) questions.
7. Tab to the bottom of the list to enable the ‘OK’ button.
8. Click ‘OK’ to continue to the ‘Home’ screen.

The following ‘Welcome to HART’ message will be displayed prior to the ‘Home’ screen only when ‘Enable Accessibility Features’ has been selected upon login.
HOME SCREEN

The options displayed on the ‘Home’ screen are dependent upon User Type. A System Administrator will have full access while a Data Entry User will have limited access. Please see the User Setup and Maintenance section for additional information regarding User Types.

Below is an example of the System Administrator’s ‘Home’ screen.

HOME SCREEN DEFAULT

By default, the ‘Home’ screen will be displayed upon each login. The screen may be closed by selecting the white “X” on the tab titled ‘Home’. This will close the ‘Home’ screen for the remainder of the user’s session.

To reactivate the ‘Home’ screen once it has been closed, select ‘Help’ from the Menu Bar at the upper right followed by ‘Home Screen’ OR use the short-cut, Ctrl+Alt+W.

If the user does not wish to see the ‘Home’ screen upon each login the default setting may be turned off by placing a checkmark into the box at the lower left corner of the screen next to the following statement: “Do not display this home screen after logging into the application”.

FACILITY SETUP AND MAINTENANCE

The Default User must create at least one facility before being permitted to add any further data to the HART application. Please consult the HART Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

The ‘Facility Information’ screen allows users, dependent upon their User Type, to setup and modify facilities. The term “facility” refers to a Hospice provider.

The ‘Facility Information’ screen displays in two sections:

- Facility Summary (on the left)
- Facility Detail (on the right). All facility data entry is done in this section.

ADD A FACILITY

Complete the following steps to create a new facility:

1. Select ‘Facility’ from the Administration drop-down on the Menu Bar or ‘Go To Facility’ from the ‘Home’ screen.
The ‘Facility Information’ screen displays.

2. Enter the appropriate facility information into the Facility Detail section. Required fields display on the screen in bold type with an asterisk.

3. After facility information has been entered, click the ‘Save’ icon. Saved facility information will display in the Facility Summary section on the left side of the screen.

4. To add additional facilities, click the ‘New’ icon, enter data and click the ‘Save’ icon.

**MODIFY A FACILITY**

Complete the following steps to modify an existing facility:

1. Locate and highlight the facility in the Facility Summary section.

2. Make the appropriate changes in the Facility Detail section on the right side of the screen.

3. Click the ‘Save’ icon.

The following message will display on the ‘HIS Record Search’ screen when opening an existing HIS record after facility information has been modified: “The facility information has changed, would you like to update the HIS record to reflect these changes?”
The user will be shown the field name, values currently in the HIS record (Before Value) as well as the value after selecting ‘Yes’ on the Facility Data Updated pop-up window (After Value). Selecting ‘No’ will open the existing record without updating the facility information.

Please Note: This message will continue to be displayed each time a HIS record is opened after modifying the facility data until ‘Yes’ is selected.

DELETE A FACILITY

Complete the following steps to delete a facility:

1. Locate and highlight the facility in the Facility Summary section.
2. Click the ‘Delete’ icon.

- Only a System Administrator can delete a facility.
- Deletions cannot be made if Users, Patients, or HIS records are currently associated to a facility.

USER SETUP AND MAINTENANCE

The Default User must create at least one System Administrator User before being permitted to add any further data to the HART application. It is highly recommended to set up more than one System Administrator User. In the event the primary System Administrator User’s account becomes locked, the second System Administrator will have the ability to unlock the primary account.

Please consult the HART Installation Guide for detailed instructions regarding the initial login and setup by the Default User.

USER TYPES

To enhance the security of data there are four User Types available within the HART application, each having a unique level of access. The following User Types are available:

- Default User (only to be used during initial setup)
- System Administrator
- Data Entry
- View Only

Please Note: The Default User ID (HART) may only be used to add facilities and users. After successfully creating at least one Facility and one System Administrator, the Default User must log out of the application. The newly created User must login to display the full HART menu.

The table below provides a summary of the functions available to each User Type. An “X” denotes that a function will be available to that particular User Type unless otherwise specified. Note: You will not see the Default User in this summary as it may only be used to add/maintain facility and user information.

<table>
<thead>
<tr>
<th>Features/Functionality</th>
<th>System Administrator</th>
<th>Data Entry</th>
<th>View Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIS records</td>
<td>Add/Edit/Delete</td>
<td>Add/Edit</td>
<td>-</td>
</tr>
<tr>
<td>Create Inactivation Requests</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Create Modification Requests</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Export Files</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Import Files</td>
<td>X</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Maintain Facility Information</td>
<td>Add/Edit</td>
<td>Edit</td>
<td>-</td>
</tr>
<tr>
<td>Maintain Patient Information</td>
<td>Add/Edit/Hide/Delete</td>
<td>Add/Edit</td>
<td>-</td>
</tr>
<tr>
<td>Maintain User Information</td>
<td>Add/Edit/Delete</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Perform Data Entry for HIS form</td>
<td>X</td>
<td>X</td>
<td>-</td>
</tr>
<tr>
<td>Print HIS records (Report)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>View HIS record Data Entry Report</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>View HIS records Entered by Any User</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>View Event Tracking Report</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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ADD A USER
The ‘User Information’ screen allows users, dependent upon their User Type, to modify and setup new user accounts. The term ‘user’ refers to the individuals who will be viewing or entering data into the HART application.

The ‘User Information’ screen displays in two sections:
- User Summary (on the left)
- User Detail (on the right): All user data entry is done in this section.

Complete the following steps to add a new user:
1. Select ‘User’ from the Administration drop-down on the Menu Bar or ‘Go to User’ from the ‘Home’ screen.
2. The ‘User Information’ screen displays.
3. Enter the appropriate user information into the User Detail section. Required fields display on the screen in bold type with an asterisk.
4. After entering all required user information, click the ‘Save’ icon. Saved user information will display in the User Summary section on the left side of the screen.
5. To add additional users, click the ‘New’ icon, enter data and click the ‘Save’ icon.

TERMINATION DATE
A Termination Date should only be entered if an active user is no longer valid (i.e., no longer works for the facility). If a Termination Date is entered for a user with pending HIS records, a Termination Date message box will display advising pending HIS records should be reassigned to an active user.
If there is only one System Administrator and that person terminates his/her position, a new System Administrator must be set up prior to entering the Termination Date for the existing System Administrator.

**MODIFY A USER**
Complete the following steps to modify an existing user:
1. Locate and highlight the user in the User Summary section.
2. Make the appropriate changes in the User Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

**DELETE A USER**
Complete the following steps to delete a user:
1. Locate and highlight the user in the User Summary section.
2. Click the ‘Delete’ icon.
   a. Deletions cannot be made if the user has created or modified facility, patient, or HIS record data.

**CHANGE PASSWORD**
User passwords may be changed at any time. Complete the following steps to change a password:
1. Login to HART.
2. Select ‘Change Password’ from the Security drop-down on the Menu Bar.
3. The ‘Change Password’ screen displays along with the following rules:
   - The new password and the confirm new password must match.
   - The new password must be at least 8 characters long.
   - The new password must be no more than 20 characters long.
   - The new password must not contain any space.
   - The new password must not contain the User ID, First Name, Last Name, or Email.
   - The new password must not begin with a number.
   - The new password can only contain a maximum of 3 repetitive characters.
   - The new password must contain at least one for each of the following type of characters:
     — Upper-case Character: A-Z
     — Lower-case Character: a-z
     — Number: 0-9
     — Special Character: ~!@#$%^*()_+-={}[]\:";'<>,.?/
The new password must not match any of the user's most recent 6 passwords.
The new password will be set to expire in 60 days.

The new password and the confirm new password must match.
The new password must be at least 8 characters long.
The new password must be no more than 20 characters long.
The new password must not contain any space.
The new password must not contain the User ID, First Name, Last Name, or Email.
The new password must not begin with a number.
The new password can only contain a maximum of 3 repetitive characters.
The new password must contain at least one for each of the following type of characters:
  Upper-case Character: A-Z
  Lower-case Character: a-z
  Number: 0-9
  Special Character: &$%'^*()_+-={|}[]<>>,./
The new password must not match any of the user's most recent 6 passwords.
The new password will be set to expire in 60 days.

4. Enter the current password in the ‘Password’ box.
5. Enter a new password in the ‘New Password’ and ‘Confirm New Password’ box.
6. Select ‘Change Password’. Selecting ‘Cancel’ will close the ‘Change Password’ screen and will not change the existing password.

FORGOT PASSWORD
Complete the following steps if you have forgotten your password:

1. Enter the User ID and select the ‘Forgot Password’ button.

2. The ‘Security Questions’ pop-up window displays with three (3) of the security questions which were answered during the initial setup of the given User ID.
3. Enter responses to the questions provided.

4. Select ‘OK’ to continue to the ‘Change Password’ screen. Selecting ‘Cancel’ will close the security questions and return to the login screen.

**LOCKED USER ACCOUNT**

HART will allow three (3) login attempts prior to locking a user account and removing the ability to login. The following message will be displayed when a user account becomes locked: “Your account has been locked. Contact your System Administrator or click Forgot Password Alt+F to unlock your account.”

As stated in the error message there are two options when a user account has become locked. Click ‘OK’ to return to the ‘Login’ screen. Follow the instructions for [Forgot Password](#) to unlock the account.

The user may also contact a System Administrator who can reset the account using the following steps:

1. Select ‘User’ from the Administration drop-down on the Menu Bar.

2. Locate and highlight the locked user account in the User Summary section. Locked user accounts will display in bold type.

3. Check the ‘Reset Password/Unlock The Account’ checkbox in the User Detail section on the right side of the screen.

4. Click the ‘Save’ ![Save icon](#) icon.

5. The user account is now unlocked. The password has been reset to match the User ID. Please note the password is case sensitive and must match in both the ‘User ID’ and ‘Password’ fields.

**Please Note:** In the event the primary System Administrator account becomes locked, a second System Administrator OR the Default User (User ID = hart) may log in and reset the account by following the steps defined above.
If the System Administrator account cannot be unlocked using the [Forgot Password] instructions or the [Locked User Account] instructions please contact the QIES Help Desk for further assistance. The Help Desk will reset the Default User account (User ID=hart) which may then be used to unlock the account or setup a new System Administrator.

**PATIENT SETUP AND MAINTENANCE**

The ‘Patient Information’ screen allows users to add, edit, delete and search for patients. The ‘Patient Information’ screen displays in 4 sections:

- Search Criteria (top of the screen)
- Patient Summary (on the left)
- Patient Detail (on the right): All patient data entry is done in this section.
- Actions (on lower right)

**ADD A PATIENT**

Complete the following steps to add a new patient:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.

The ‘Patient Information’ screen displays.

2. Enter the appropriate patient information into the Patient Detail section. Required fields display on the screen in bold type with an asterisk.

3. After entering the required patient information, click the ‘Save’ icon. Saved patient information will display in the Patient Summary section.
4. To add additional patients click the ‘New’ icon, or utilize the ‘Add Patient’ button located in the Actions section on the right side of the screen. Enter data and click the ‘Save’ icon.

**HIDE A PATIENT RECORD**

The ‘Hide Patient Record’ field located in the Patient Detail section allows users to hide records that no longer need to be accessed. For example, when a patient is no longer in the facility and all associated HIS records have been exported, the user can hide the patient record. To hide a patient’s records, select the “Yes, hide record” option within the Patient Detail section.

![Hide Patient Record](image)

**PATIENT SEARCH**

The ‘Search Criteria’ section is located at the top of the ‘Patient Information’ screen. To retrieve all existing patient records, leave the Search Criteria blank and click the ‘Search’ button.

Complete the following steps to retrieve one or more records based on Search Criteria:

1. Select criteria from the ‘Field Name’ and ‘Condition’ lists.
2. Enter a ‘Field Value’.
3. Select the box next to ‘Show Hidden’ to include records marked ‘Yes, hide record’ in the Patient Details section.
4. Click the ‘Search’ button.
5. Click the ‘Clear’ button to remove search criteria and begin a new patient search.

**Please Note:** A System Administrator will see duplicate patients listed in the Patient Summary section if a patient has been at multiple facilities and the System Administrator has access to all of those facilities within the HART application.

**MODIFY A PATIENT**

Complete the following steps to modify an existing patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Make the appropriate changes in the Patient Detail section on the right side of the screen.
3. Click the ‘Save’ icon.

The following message will display on the ‘HIS Record Search’ screen when opening an existing HIS record after patient information has been modified: “The patient information has changed, would you like to update the HIS record to reflect these changes?”
The user will be shown the field name, values currently in the HIS record (Before Value) as well as the value after selecting ‘Yes’ on the Patient Data Updated pop-up window (After Value). Selecting ‘No’ will open the existing record without updating patient information.

**Please Note:** This message will continue to be displayed each time a HIS record is opened after modifying the patient data until ‘Yes’ is selected.

### DELETE A PATIENT

Complete the following steps to delete a patient:

1. Locate and highlight the patient in the Patient Summary section.
2. Click the ‘Delete’ icon or the ‘Delete Patient’ button in the Actions section of the ‘Patient Information’ screen.

**Note:** Deletions cannot be made if one or more HIS records have been created for the patient.

### MOVE A PATIENT

In the event a patient is moved from one Hospice facility to another within the same corporation, it is necessary to reassign the patient to the appropriate facility. Before reassigning a patient to a new facility ALL existing HIS records must be in an ‘Exported’ or ‘Outdated’ status.

### VERIFY HIS RECORD STATUS

Complete the following steps to verify the status of a patient’s HIS records:

1. Perform a HIS record search by following the [HIS record Search](#) procedure. It is recommended that the ‘show hidden’ checkbox be applied to ensure all existing records are shown.
2. If all HIS records found have an ‘Exported’ or ‘Outdated’ status, proceed to [Assign a New Facility ID](#) below.
3. If ‘Non-Exported’ HIS records are found, enter any remaining applicable data to complete the HIS record. Required fields will appear in bold type in the ‘Navigator’ section of the ‘HIS Record’ screen. You may also choose to delete a HIS record if it has been entered in error.
4. Click the ‘Save and Validate’ icon.
5. If the HIS record is complete you will have achieved a status of ‘Outdated’ or ‘Export Ready’. Close the HIS record.
6. For ‘Export Ready’ HIS records follow the [Export](#) procedure to set the status appropriately.

### ASSIGN A NEW FACILITY ID

Complete the following steps to assign a patient to a new facility:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.
   The ‘Patient Information’ screen displays.
2. Perform a [Patient Search](#) for the patient you wish to move.
3. Locate and highlight the patient to be reassigned in the Patient Summary section.
4. Verify the patient information in the Patient Detail section on the right.
5. Select the new facility from the ‘Assigned Facility/Provider Submission ID (FAC_ID)’ drop-down.
6. Click the ‘Save’ icon.

The ‘Confirm Change Facility’ screen displays the following message: “Are you sure you want to change the facility for Patient (patient name)? The following HIS records for this patient will remain in the original facility where they were created:”

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>HIS Record Type</th>
<th>Status</th>
<th>Assessor</th>
<th>HIS Record Date</th>
<th>Export Date</th>
</tr>
</thead>
</table>

7. Click ‘Finish’ to complete the patient move process and assign the new facility information.
8. Click ‘Cancel’ to return to the ‘Patient Information’ screen.

When a patient has been successfully moved the following confirmation message will be displayed: “(Patient Name) has been moved successfully.” Saved patient information will display in the Patient Summary section of the Patient Screen.

If HIS records remain for a patient which are not ‘Exported’ or ‘Outdated’, the following error message will be displayed: “All HIS Records associated with this Patient must be in either an OUTDATED or EXPORTED status. Please review these records and set the status to a status mentioned previously.”
**HIS Record Navigation and Maintenance**

**Screen Tabs**
Tabs for active screens (i.e., Home, Patient, HIS Record Search, and HIS Record) will display below the Toolbar at the top of the screen. The ‘HIS Record’ tab will display the HIS record type, patient name and HIS record date.

When the ‘HIS Record’ screen is open no other screens may be accessed. If an attempt to view a subsequent screen tab such as ‘HIS Record Search’ while the ‘HIS Record’ screen is active, the user will receive an error message stating that this function is not allowed. Click ‘OK’ to close the error message and return to the ‘HIS Record’ screen.

**HIS Record Screen Tabs**
When a HIS record is opened four additional tabs will be displayed:
- HIS Record
- Patient Details
- Facility Details
- HIS Record Determination

**HIS Record**
The ‘HIS Record’ tab displays the patient HIS record; this is where all HIS record data entry will be completed.

**Patient Details**
The ‘Patient Details’ tab displays patient demographic data in a view only, non-editable format.

**Facility Details**
The ‘Facility Details’ tab displays facility information in a view only, non-editable format.
HIS RECORD DETERMINATION

The ‘HIS Record Determination’ tab displays data previously entered on the ‘Add HIS record’ wizard in a view only, non-editable, format.

NAVIGATOR

The HIS record ‘Navigator’ is located in the top left corner of the ‘HIS Record’ screen and will display all HIS record items in a collapsible tree format. Unanswered questions will appear in **bold** type.

As questions are answered, they are removed from the tree. To change the display of the tree to continue showing answered questions utilize the ‘Show/Hide’ icon in the Toolbar at the top of the screen.

**TIP:** Clicking on an item in the tree will move the cursor to the selected field within the HIS record.

![HIS Record Navigator](image)

EDITs

Data integrity edits are applied as information is entered into HART. These edits are unique messages put in place to assist users with the accurate completion of data entry. Some edits will present a pop-up message and must be addressed when displayed in order to proceed. Other edits may not appear until the HIS record is saved and validated.

The HIS record ‘Edits’ section is located in the bottom left corner of the ‘HIS record’ screen. This section displays applicable errors or warnings found within a HIS record after selecting the ‘Save and Validate’ icon.
The following types of edits may occur in HART:

**ERRORS (!)**
This type of edit informs the user that information is missing or invalid. Data must be entered or corrected before the HIS record may be completed.

**WARNINGS (#)**
This type of edit indicates there is data entered that should be verified as accurate, or serves as a reminder regarding how certain fields should be completed.

**INFORMATIONAL (?)**
This type of edit gives the user general information about the HIS record data entered.

**TIP:** Clicking on an edit message will move the cursor to the appropriate field within the HIS record so it may be verified or corrected. A HIS Record Error Report may be printed which will display all edits shown on the ‘Edits’ section of the ‘HIS Record’ screen.

**ADD AN HIS RECORD**
Complete the following steps to create an HIS record:

1. Select ‘Patient’ from the Administration drop-down on the Menu Bar.
2. Complete a **Patient Search** or add a new patient.
3. In the Patient Summary section, double click on the patient you wish to add an HIS record for, OR highlight the patient row by clicking on the patient and click the ‘Add HIS record’ button at the bottom of the Patient Detail Section.

The ‘Add HIS Record’ wizard displays.
4. Enter information into the fields as appropriate. Required fields display on the screen in bold type with an asterisk.

5. Click ‘Finish’ to display the ‘HIS Record’ screen and continue entering HIS record data OR click ‘Cancel’ to return to the ‘Patient Information’ screen.

Please Note: After clicking ‘Finish’ errors and/or warning messages, if applicable, will display in a pop-up window before opening the ‘HIS Record’ screen. Below is an example of the ‘HIS Record’ screen:
6. Enter data as appropriate on the ‘HIS Record’ screen. Required fields will appear in bold type in the ‘Navigator’ section at the upper left. Clicking on an item in the ‘Navigator’ will move the cursor to the selected field within the HIS record.

**Please Note:** For optimization of the skip patterns and/or edits, it is recommended that data be entered in the order the questions appear on the screen.

7. To save progress as data is entered, click the ‘Save’ icon or utilize the short-cut, Ctrl+S.

8. When data entry is complete click the ‘Save and Validate’ icon to validate the HIS record for errors or warnings.

**DUPLICATE HIS RECORDS**

In the event that the information entered on the ‘Add HIS record’ wizard duplicates an existing record within the HIS record database, the ‘Next’ button will enable on the ‘Add HIS record’ wizard, instead of the ‘Finish’ button. The following screen will display with a list of duplicate HIS records.

![HIS Record(s) exists for entered admission date](image)

Complete the following steps to proceed in the event of a duplicate HIS record:

1. Click to highlight the HIS record.
2. Click the ‘Finish’ button to review and continue data entry of the existing HIS record or select ‘Cancel’ to return to the ‘Patient’ screen.

If the HIS record found to be a duplicate is already in an exported status, the following message will display after selecting the record from the list provided: “Duplicate HIS record found has a status of “EXPORTED” and cannot be opened from this window. Please use the HIS record search screen.” The user will need to navigate to the HIS Record Search screen to modify or remove the HIS record before proceeding.
HIS RECORD SEARCH

Complete the following steps to search for an HIS record:

1. Select ‘Search’ from the HIS Record drop-down on the Menu Bar.

The ‘HIS Record Search’ screen displays.

2. To retrieve all existing HIS records leave the Search Criteria blank and click the ‘Search’ button.

3. To retrieve one or more HIS records based on Search Criteria:
   a) Select criteria from the Field Name and Condition lists.
   b) Enter a corresponding Field Value.
   c) Click the ‘Search’ button.
   d) Click the ‘Clear’ button to remove search criteria.

Please Note: Selecting the box next to ‘Show Hidden’ will include records for patients marked ‘Yes, Hide Record’ on the ‘Patient Information’ screen.

VIEW ONLY

Occasionally it may be necessary to view previously entered information where there is not a need to modify or edit the data. To view HIS record data without editing or resetting the HIS record status (e.g. Exported HIS record) users may utilize the ‘View Only’ checkbox.

Complete the following steps to open a HIS record in ‘View Only’ mode:

1. Complete a HIS Record Search to locate the desired HIS record.

2. Click to place a checkmark into the ‘View Only’ checkbox at the bottom of the screen.

3. Highlight the desired HIS record and select the ‘View HIS Record’ button at the bottom of the ‘HIS record Search’ screen, or double click to open the HIS record for viewing.
4. The ‘HIS record’ screen opens in ‘View Only’ mode.

**Please Note:** HIS records may not be modified in ‘View Only’ mode. To make changes to this HIS record OR subsequent HIS records the ‘View Only’ checkbox must be unchecked.

**MODIFY AN HIS RECORD**

When modifying an HIS record, the user must first determine the HIS record status. The HIS record status may be viewed on the ‘HIS Record Search’ screen as shown in the example below or on the Tool Bar once a HIS record has been opened. The following HIS record statuses may occur within HART:

- NEW
- IN_USE
- DATA_ENTRY
- EXPORT_READY
- EXPORTED
- OUTDATED (HIS record greater than 36 months old)

**NEW, IN_USE, DATA_ENTRY, EXPORTREADY, OR OUTDATED**

Complete the following steps to modify an existing HIS record with a status of NEW, IN_USE, DATA_ENTRY, EXPORTREADY or OUTDATED:

1. Complete an [HIS Record Search](#) to locate the desired HIS record.

2. Highlight the HIS record and select the ‘Edit HIS Record’ button at the bottom of the ‘HIS Record Search’ screen or double click to open the HIS record for modification.

3. The ‘HIS Record’ screen will display.

**TIP:** Unanswered questions will appear in **bold** type in the Navigator section at the upper left corner of the ‘HIS Record’ screen. Clicking on an item in the Navigator tree will move the cursor to the selected field within the HIS record.

4. Modify the HIS record as appropriate.

5. Select the ‘Save and Validate’ icon on the toolbar to display any applicable warnings or errors found within a HIS record.

**EXPORTED**

Only a user with System Administrator access may modify a HIS record that has been exported. Complete the following steps to modify an existing HIS record with a status of EXPORTED:

1. Complete an [HIS Record Search](#) to locate the desired HIS record.

2. Highlight the HIS record and select the ‘Edit HIS record’ button at the bottom of the ‘HIS Record Search’ screen or double click to open the HIS record for modification.
The ‘Exported HIS record’ pop-up window displays with the following options:

- **Create a correction record** – HIS record opens and displays all previously selected answers. All fields may be modified with the exception of the responses given on the ‘Add HIS record’ wizard. [HIS record Reference Date (A0210), Admission Date (A0220), Reason for HIS record (A0250) and Discharge Date (A0270)]

- **Create an inactivation record** – Inactivation HIS record opens. All fields are a view only, non-editable, format. Once saved the HIS record type will be changed to XX-Inactivation.

- **Reset Status and Edit** – HIS record opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add HIS record’ wizard. [HIS record Reference Date (A0210), Admission Date (A0220), Reason for HIS record (A0250), and Discharge Date (A0270)] The HIS record status will be changed to IN_USE.

- **Open this HIS record in read only mode** - HIS record opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘HIS record Search’ screen. All other HIS records will be view only until this box is unchecked.

**Please Note:** Users who do not have System Administrator access will be shown an ‘Exported HIS Record’ pop-up with only one option to “Open this HIS record in read only mode.” Selecting ‘OK’ will open the HIS record for viewing only, selecting ‘Cancel’ will return the user to the ‘HIS record Search’ screen.

3. Select one of the four options provided on the ‘Exported HIS Record’ pop-up window.
4. Select ‘OK’ to continue.
5. Modify the HIS record if applicable.
6. Click the ‘Save and Validate’ icon on the toolbar.

**COPY AN INACTIVATED HIS RECORD**

Occasionally it may be necessary to inactivate a record which subsequently needs to be modified for re-submission to the national data repository. Hospice policy instructs the provider to submit an inactivation record when the first name, last name, SSN, gender and/or birthdate is to be corrected. A new record with the correct information is then submitted.

After updating the patient information (see Modify a Patient) a copy of the inactivated record can be made to avoid the need to re-enter all of the HIS record data.

Complete the following steps to copy an inactivated HIS record with a status of EXPORTED:

1. Complete an HIS Record Search to locate the inactivated HIS record. Note that the HIS record type will be shown as XX-Inactivation on the ‘HIS Record Search’ screen.
2. Highlight the HIS record and select the ‘Edit HIS record’ button at the bottom of the ‘HIS Record Search’ screen or double click to open the HIS record.

The ‘Exported HIS Record’ pop-up window displays with the following options:

- **Create a copy** – HIS record opens and displays all previously selected answers in an editable format. All fields may be modified with the exception of the responses given on the ‘Add HIS Record’ wizard. ([IF A0250=1 the Target Date shall = A0220. IF A0250=09 the Target Date shall = A0270]) Only one copy per inactivated HIS record is allowed.

- **Reset Status** – Inactivation HIS record opens and displays all applicable fields in a view only, non-editable format. The HIS record status will be changed to IN_USE.

- **Open this HIS record in read-only mode** – Inactivation HIS record opens and displays all previously selected answers in a view only format. This selection checks the ‘View Only’ checkbox at the bottom of the ‘HIS record Search’ screen. All other HIS records will be view only until this box is unchecked.

3. Select one of the three options provided on the ‘Exported HIS record’ pop-up window.

4. Select ‘OK’ to continue.

**Please Note:** The following message will display prior to opening the HIS record if patient information has been modified: “The patient information has changed, would you like to update the HIS record to reflect these changes?”

- Select ‘Yes’ to update the HIS record with the ‘After Value’.
- Select ‘No’ to open the HIS record without updating patient information.

3. Select one of the three options provided on the ‘Exported HIS record’ pop-up window.

4. Select ‘OK’ to continue.

**Please Note:** The following message will display prior to opening the HIS record if patient information has been modified: “The patient information has changed, would you like to update the HIS record to reflect these changes?”

- Select ‘Yes’ to update the HIS record with the ‘After Value’.
- Select ‘No’ to open the HIS record without updating patient information.

The ‘HIS Record’ screen opens.

5. Modify the HIS record data if applicable.

6. Click the ‘Save and Validate’ icon on the toolbar.

7. Close the HIS record.

**DELETE AN HIS RECORD**

Only a user with System Administrator access may delete a HIS record. HIS records with a status of EXPORTED cannot be deleted; the status of these records must be reset to complete the deletion.

Complete the following steps to delete a HIS record:
1. Complete a [HIS Record Search](#) to locate the desired HIS record.

2. Click once to highlight the HIS record.

3. Click the ‘Delete HIS record’ button at the bottom of the ‘HIS Record Search’ screen to delete the selected HIS record.

The ‘Confirm HIS Record Delete’ pop-up window displays the following message: “Are you sure you want to delete HIS record [patient last name, first name, target date]?” [(IF A0250=1 the Target Date shall = A0220. IF A0250=09 the Target Date shall = A0270)]

![Confirm HIS Record Delete pop-up window](image)

4. Select ‘OK’ to delete the HIS record. Select ‘Cancel’ to close the pop-up window. The HIS record will not be deleted.

If an HIS record with a current status of EXPORTED needs to be deleted, the user should first verify that the HIS record has not been submitted to the national data repository.

Complete the following steps to delete a HIS record that has been previously exported:

1. Complete an [HIS Record Search](#) to locate the desired HIS record.

2. Highlight the HIS record and select the ‘Edit HIS Record’ button at the bottom of the ‘HIS Record Search’ screen or double click to open the HIS record.

3. The ‘Exported HIS Record’ pop-up window displays with the following options:
   - Create a correction record
   - Create an inactivation record
   - Reset Status and Edit
   - Open this HIS record in read only mode

![Exported HIS Record pop-up window](image)

4. Select the ‘Reset Status and Edit’ radio button.

5. Select ‘OK’.

The ‘HIS Record’ screen will open setting the status to IN_USE.

6. Close the HIS record.

7. Follow the instructions to [Delete an HIS Record](#) to complete the removal of the HIS record.

**EXPORT AN HIS RECORD**

The ‘Export HIS Records’ screen allows the user to export records for subsequent submission to the appropriate national data repository.
Complete the following steps to export an HIS record:

1. Select ‘Export’ from the Import/Export drop-down on the Menu Bar.

The ‘Export HIS Records’ screen displays:

2. The export process will depend upon which Export Type is chosen. Select one of the following Export Types from the drop-down at the upper left corner of the ‘Export HIS Records’ screen:
   - New Export (HIS records marked as “Export Ready”)
   - Previous Export (HIS records marked as “Export Ready” or “Exported”) The process for each Export Type has been defined below.

**NEW EXPORT**

(HIS records marked as “Export Ready”)

Complete the following steps when selecting New Export:

1. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.
2. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.
3. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.
4. Select the HIS records to be included in the export file by placing a checkmark into the boxes next to the desired HIS records. A minimum of one selection is required.
   - The ‘Select All’ button will select all HIS records displayed in the list to be included in the export file.
• The ‘Clear Selection’ button will unselect all HIS records previously selected.

5. If desired, select the ‘Print HIS Records List’ button to print a list of all HIS records selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.

6. If desired, select the ‘Error Check’ button to validate all HIS records selected for export. Warnings and/or Error results will display in a new screen.
   • Select the ‘Save to File’ button to save the error report.
   • Select the ‘Close’ icon in the upper right corner to close the error report.

7. Select the ‘Export’ button to complete the export process.

8. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of HIS records which have been exported as well as the location of the exported files displays within this pop-up window.

PREVIOUS EXPORT
(HIS records marked as “Export Ready or “Exported”)
Complete the following steps when selecting Previous Export:

1. Begin by highlighting a previously exported file from the list in the Previous Exports section located in the center of the ‘Export HIS Records’ screen.

A list of HIS records included in the previous export will be displayed in the section titled Previously Exported HIS records located at the bottom of the ‘Export HIS records’ screen. HIS records must be in an “Export Ready” or “Exported” status to display in this list.

2. Select the HIS records to be included in the export file by placing a checkmark into the boxes next to the desired HIS record records. A minimum of one selection is required.
   • The ‘Select All’ button will select all HIS records displayed in the list to be included in the export file.
   • The ‘Clear Selection’ button will unselect all HIS records previously selected.

3. Click the ‘Browse’ button to select the Export Path. This is the location where the exported files will be saved.

4. Enter a unique file name into the field labeled Export Name. The Export Name will serve as a reference to the user when submitting the file to the appropriate national data repository. An example of what a user may choose to enter here would be the date the export file is created.
**Please Note:** By default the original Export Path and Export Name will be displayed. It is recommended to use the same Export Path for each export file; however the Export Name should be unique for each export file created. Failure to create a new Export Name may result in the following pop-up window: “The file you are attempting to export already exists, overwrite file?”

- Selecting ‘Yes’ will replace the original export file saved.
- Selecting ‘No’ will return the user to the ‘Export HIS Records’ screen so they may select a new Export Name.

5. Enter the Export Description. This is an optional field which may be used to document additional details regarding the export file.

6. If desired, select the ‘Print HIS Records List’ button to print a list of all HIS records selected to be included in the export file. Please note: This report does not have a preview option and will be sent directly to the printer of the user’s choice.

7. If desired, select the ‘Error Check’ button to validate all HIS records selected for export. Warnings and/or Error results will display in a new screen.
   - Select the ‘Save to File’ button to save the error report.
   - Select the ‘Close’ icon in the upper right corner to close the error report.

8. Select the ‘Export’ button to complete the export process.

9. The ‘Export Complete’ pop-up window displays notifying the user that the export process is complete. The number of HIS records which have been exported as well as the location of the exported files displays within this pop-up window.

**IMPORT**

The ‘Import HIS Records’ screen allows users to determine how data is imported into HART.

Complete the following steps to import a HIS record:

1. Select ‘Import’ from the Import/Export drop-down on the toolbar.

The ‘Import HIS Records’ screen displays:
2. Click the ‘Browse’ button to navigate to the location of the files to be imported.  
**Please Note:** There may be an increased wait time when importing a large number of HIS records due to database encryption.

3. Set the desired preferences. You may select preferences individually or click the ‘Select All Options’ button to check or uncheck all checkboxes.

**PREFERENCES**

**PATIENT DATA OPTIONS CHECKBOX**

Selecting this checkbox turns off the warning message displayed when a new patient is imported. “Do not give warnings when new patient data is added during import.”

**MISCELLANEOUS DATA OPTIONS CHECKBOXES**

- “Do not display warnings in error check results.” Selecting this checkbox removes warning messages from the error check results report that displays after importing data. Only fatal errors are included in the report.
- “Assign Exported status to HIS records without errors (instead of Export Ready).” Selecting this checkbox sets the status of imported HIS records to ‘Exported’ if the HIS record does not contain errors.
- “Associate HIS records with a blank facility ID field to the selected facility below.” Selecting this checkbox links import records which are missing a facility ID to the selected facility.

4. Select the ‘Error Check File’ button to validate all HIS records to be imported. Error results will display in a new screen.
   a. Select the ‘Save to File’ button to save the error report (.txt).
   b. Click the ‘Close’ icon in the top right corner to close the report.

5. Click the ‘Import’ button to import the selected HIS record records into HART.
If the import file chosen contains HIS record records for patients who have not previously been entered into HART a ‘New Patient’ message will be displayed: “A new patient is being added to (Facility – FAC ID). Continue with the import of (patient name)?”

a. Click ‘Yes’ to continue.
b. Click ‘No’ or ‘Cancel’ to stop the import process.

**Please Note:** This message will NOT be shown if the Patient Data Options checkbox has been selected.

The ‘Import Complete’ message displays along with a Status Report for all HIS records included in the import.

6. Click the ‘OK’ button on the ‘Import Complete’ pop-up window to view the Status Report.

7. Click the ‘Save to File’ button on the bottom of the Status Report to save a copy.
8. Click ‘Close’ in the top right corner to close the Status Report. If none of the selected files are successfully imported, the ‘Import Failed’ message displays along with a Status Report stating that “No HIS Records appear to have passed import.”

Please Note: The import Status Report is ONLY available at the time the import process is being completed. It is important to save and review this report for any HIS record warnings or errors. It is especially critical to review this report if the HIS records being imported are to be subsequently submitted to the national data repository.

REPORTS

HART reports allow users to preview and print HIS record information as well as detail and summary information for both facilities and patients.

The following reports are available within the HART application:
- Print HIS Record Report
- HIS Record Error Report
- Event Tracking
- HIS Record Data Entry – By Status

PRINT HIS RECORD REPORT

The ‘Print HIS Record Report’ provides a listing of all data which has been entered into the HIS record. Complete the following steps to obtain the ‘Print HIS Record Report’:

1. Begin generating the report using one of the three available methods:
   - Click the ‘Print HIS Record Report’ icon on the Toolbar.
   - Utilize the short-cut Ctrl+A.
   - Select ‘Print HIS Record Report’ from the File drop-down on the Menu Bar.

   The ‘HIS Record Report’ criteria selection window is displayed.

2. Complete the required fields. Required fields display on the screen in bold type with an asterisk. This criteria selection window may be used to designate the number of signature lines shown on the printed report. The default number of signature lines will be 12.

3. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘HIS Record Report’ criteria selection window; the ‘Print HIS Record Report’ will not be generated.

4. To print the report, click the ‘Print’ icon on the Report Viewer screen.
Below is an example of the Print HIS Record Report.

HART - Hospice Abstraction Reporting Tool - HIS Record Report

| Facility ID: | 123456789 |
| Facility Name: | Facility |
| Facility State: | IA |
| Patient Name: | Last Name, First Name |
| HIS Record Date: | 02/06/2018 |
| Date: | 02/06/2018 |
| Requested by: | SysAdmin |
| Last Entry Date: | 02/06/2018 |
| Data Entry Time: | 00:00:98 |
| Data Entry User: | SysAdmin |

**Header Records**

| HIS Record Type: | HA-HART Admission |
| Admission Date: | 01/01/2018 |
| Patient Name: | Last Name, FirstName |
| SSN: | 999-11-1111 |
| Correction Number: | 00 |

**ASSESSMENT DETERMINATION**

| A0220 Admission Date | 01/01/2018 |
| A0250 Reason for Record | 01. Admission |

**Section A Administrative Information**

| A0050 Type of Record | 1. Add new Record |
| A0100A NRI | |
| A0100B CCN | 999111 |
| A0205 Site of Service at Admission | 01. Hospice in patient’s home/residence |
| A0245 Date Initial Nursing Assessment Initiated | 01/01/2018 |
| A0550 Patient ZIP Code | 50111 |
| A1400 Payor Information | A. Medicare (Traditional fee-for-service) |
| A1802 Admitted From | 01. Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care) |

**Section F Preferences**

| F2000A Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR) | 0. No |
| F2100A Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR | 0. No |
| F2200A Was the patient/responsible party asked about preference regarding hospitalization | 0. No |
| F3000A Was the patient and/or caregiver asked about spiritual/existential concerns | 0. No |

**Section I Active Diagnoses**

| I0010 Principal Diagnosis | 01. Cancer |

5. To save the report, click the ‘Save’ icon on the Report Viewer screen.
6. To export the report, click the arrow next to the ‘Save’ icon.
The following export type values display:

- Export as PDF
- Export as RTF
- Export as Jasper Reports
- Export as HTML
- Export as Single Sheet XLS
- Export as Multi Sheet XLS
- Export as CSV
- Export as XML
- Export as XML with Images

7. Select an export type.
8. Select the location in which you wish to save the report.

**HIS RECORD ERROR REPORT**

The HIS Record Error Report provides a printable listing of all edits received for a HIS record and may be generated in one of the following ways:

- Click the ‘Print Error Report’ button located at the bottom of the ‘Edits’ section.
- Click the ‘Print HIS Record Error Report’ icon on the Toolbar.
- Utilize the short-cut Ctrl+P.

Each option above will display the HIS Record Error Report Viewer.

1. To print the report, click the ‘Print’ icon on the Report Viewer screen. Below is an example of the HIS Record Error Report.
2. To save the report, click the ‘Save’ icon on the Report Viewer screen.

3. To export the report, click the arrow next to the ‘Save’ icon.
The following export type values display:

- Export as PDF
- Export as RTF
- Export as Jasper Reports
- Export as HTML
- Export as Single Sheet XLS
- Export as Multi Sheet XLS
- Export as CSV
- Export as XML
- Export as XML with Images

4. Select an export type.
5. Select the location in which you wish to save the report.

**EVENT TRACKING**

The Event Tracking report is available ONLY to users with System Administrator access. This report may be used to track activity such as additions, deletions and/or modifications which are made to data within the Facility, User, Patient or HIS Record screens.

Complete the following steps to run the Event Tracking report:

1. Select ‘Event Tracking’ from the Reports drop-down on the Menu Bar.
The ‘Event Tracking’ criteria selection window displays.

```
Event* [Dropdown]
Event Date
From* [Field]
To* [Field]
```

2. Complete the required fields. Required fields display on the screen in bold type with an asterisk.
3. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘Event Tracking’ criteria selection window.
4. To print the report, click the ‘Print’ icon on the Report Viewer screen. Below are samples of each Event Tracking Report.

```
HART - Hospice Abstraction Reporting Tool
Facility Event Tracking
01/01/2018 thru 02/06/2018
Requested by: SysAdmin
Event Facility

<table>
<thead>
<tr>
<th>Event Type</th>
<th>User ID</th>
<th>Event Date</th>
<th>Facility Name</th>
<th>Facility City</th>
<th>State</th>
<th>Assigned ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td>hart</td>
<td>02/05/2018 3:57 PM</td>
<td>Facility</td>
<td>City</td>
<td>IA</td>
<td>123456789</td>
</tr>
</tbody>
</table>

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```
## HART - Hospice Abstraction Reporting Tool
### User Event Tracking
01/01/2018 thru 02/06/2018
Requested by: SysAdmin
Event: User

<table>
<thead>
<tr>
<th>Event Type</th>
<th>User ID</th>
<th>Event Date</th>
<th>Login ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td>SYSTEM</td>
<td>02/05/2018 3:56 PM</td>
<td>SYSTEM</td>
</tr>
<tr>
<td>Add</td>
<td>SYSTEM</td>
<td>02/05/2018 3:56 PM</td>
<td>hart</td>
</tr>
<tr>
<td>Modify</td>
<td>hart</td>
<td>02/05/2018 3:57 PM</td>
<td>hart</td>
</tr>
<tr>
<td>Add</td>
<td>hart</td>
<td>02/05/2018 3:57 PM</td>
<td>SysAdmin</td>
</tr>
<tr>
<td>Modify</td>
<td>SysAdmin</td>
<td>02/06/2018 4:08 PM</td>
<td>SysAdmin</td>
</tr>
<tr>
<td>Modify</td>
<td>SysAdmin</td>
<td>02/06/2018 8:56 AM</td>
<td>SysAdmin</td>
</tr>
<tr>
<td>Modify</td>
<td>SysAdmin</td>
<td>02/06/2018 8:57 AM</td>
<td>SysAdmin</td>
</tr>
</tbody>
</table>
## Patient Event Tracking

01/01/2018 thru 02/06/2018  
Requested by: SysAdmin  
Event Patient

<table>
<thead>
<tr>
<th>Event Type</th>
<th>User ID</th>
<th>Event Date</th>
<th>Last Name</th>
<th>First Name</th>
<th>SSN</th>
<th>Birth Date</th>
<th>Hide Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add</td>
<td>SysAdmin</td>
<td>02/06/2018 7:54 AM</td>
<td>Last Name</td>
<td>First Name</td>
<td>999-11-111</td>
<td>01/01/1901</td>
<td>0</td>
</tr>
<tr>
<td>Add</td>
<td>SysAdmin</td>
<td>02/06/2018 7:56 AM</td>
<td>Last</td>
<td>First</td>
<td>999-22-2222</td>
<td>10/10/1910</td>
<td>0</td>
</tr>
</tbody>
</table>
5. To save the report, click the ‘Save’ icon on the Report Viewer screen.

6. To export the report, click the arrow next to the ‘Save’ icon.

The following export type values display:

- Export as PDF
- Export as RTF
- Export as Jasper Reports
- Export as HTML
- Export as Single Sheet XLS
- Export as Multi Sheet XLS
- Export as CSV
- Export as XML
- Export as XML with Images
7. Select an export type.
8. Select the location in which you wish to save the report.

**HIS Record Data Entry – By Status**

The HIS Record Data Entry – By Status report provides a listing of all HIS records for the chosen status. The following statuses are available in HART:

- New
- In Use
- Data Entry
- Export Ready
- Exported
- Outdated

Complete the following steps to run the HIS Record Data Entry – By Status report:

1. Select ‘HIS record Data Entry – By Status’ from the Reports drop-down on the Menu Bar.

The ‘HIS Record Data Entry – By Status’ criteria selection window displays:
2. Complete the required fields. Required fields display on the screen in bold type with an asterisk. To select two or more statuses, hold the Ctrl OR the Shift button on your keyboard while you select or scroll through the list.

3. Select the ‘OK’ button to generate the report. Selecting ‘Cancel’ will close the ‘HIS Record Data Entry – By Status’ criteria selection window.

   The Report Viewer screen opens, displaying the generated report.

4. To print the report, click the ‘Print’ icon on the Report Viewer screen. Below are two examples of the HIS Record Data Entry – By Status Report.

---

**HART - Hospice Abstraction Reporting Tool**

**HIS Record Status Tracking**

**Facility - 123456789 (IA)**

01/01/2018 thru 02/09/2018

*Status: DATA_ENTRY*

Requested by: SysAdmin

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>SSN</th>
<th>Gender</th>
<th>Birth Date</th>
<th>HIS Record Type</th>
<th>Status</th>
<th>Target Date</th>
<th>User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last, First</td>
<td>996-22-2222</td>
<td>Male</td>
<td>10/10/1910</td>
<td>HA-HART Admission</td>
<td>DATA_ENTRY</td>
<td>02/01/2018</td>
<td>SysAdmin</td>
</tr>
<tr>
<td>Last Name, First Name</td>
<td>996-11-1111</td>
<td>Male</td>
<td>09/01/1901</td>
<td>HD-HART Discharge</td>
<td>DATA_ENTRY</td>
<td>02/05/2018</td>
<td>SysAdmin</td>
</tr>
</tbody>
</table>

---

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5. To save the report, click the ‘Save’ icon on the Report Viewer screen.

6. To export the report, click the arrow next to the ‘Save’ icon.

The following export type values display:

- Export as PDF
- Export as RTF
- Export as Jasper Reports
- Export as HTML
- Export as Single Sheet XLS
- Export as Multi Sheet XLS
- Export as CSV
- Export as XML
- Export as XML with Images
7. Select an export type.
8. Select the location in which you wish to save the report.

**CLOSE THE APPLICATION**

To close the HART application select ‘Exit’ from the File drop-down on the Menu Bar. HART may also be closed by selecting the close icon in the upper right corner of the screen.

**LOGOUT**

To log out and return to the HART ‘Login’ screen, select ‘Logout’ from the Security drop-down on the Menu Bar.

**SESSION TIME OUT**

To enhance the security of data stored within the HART application the system will issue a timeout warning if there has been no activity by the user for ten (10) minutes. The following decision message will be displayed: “Do you wish to cancel the session time out?”
To continue with the session click ‘OK’. If the user does not cancel the session time out prior to 15 minutes of inactivity HART will close the active screens and return the user to the ‘Login’ screen. Any data entered and not saved will be lost.

**DATA BACKUP**

When closing an active session of HART the user will receive the following decision message along with a listing of the current backup location: “Would you like to backup the database?”

![Backup Prompt](image)

- Select ‘Yes’ to backup the database and close HART.
- Select ‘No’ to decline the database backup and close the HART application.

**Please Note:** It is strongly recommended that users backup the database each time new data is entered. If a backup has not occurred in the last seven (7) days, HART will automatically backup the database when the application is closed.

When a database backup is attempted and fails, the following message will be displayed: “The database backup procedure has failed. Please contact your System Administrator.” Users should contact the QIES Help Desk for additional assistance.

**CHANGING THE BACKUP FILE LOCATION**

The default location for the database backup is located in a database/backup folder where the application is installed. Only a System Administrator may change the location where the backup will be stored.

Complete the following steps to change the location where the backup will be stored:

1. Select ‘Change Backup File Location’ from the File drop-down on the Menu Bar.

![Menu Bar](image)

The ‘Change Backup File Location’ pop-up window displays with the current backup location highlighted.

2. Select the desired backup location.

3. Select ‘OK’ to set the location and close the ‘Change Backup File Location’ pop-up window.

4. Selecting ‘Cancel’ will close the pop-up window without changing the location of the backup files.

**DATA RESTORE**

A database restore requires the assistance of the QIES Help Desk. In the event of data loss, a System Administrator may perform a data restore using a prior database backup.
When attempting to restore a database using a backup which is older than that of the installed version of HART, the following error message will be displayed: “The version of the backup you selected is older than the current version of HART. Please select a backup of the same version.” Select ‘OK’ to return to the ‘Login’ screen and restore using the appropriate backup file.

**HELP**

The HIS Guidance Manual provides users with item-specific definitions, instructions and tips for completing HIS records. Complete the following steps to access help documentation via the Menu Bar:


The HART ‘Get Help’ screen displays which includes a direct link to the CMS webpage where the HIS Guidance manual will be found.

Please utilize the HIS Guidance Manual for assistance completing the Hospice Item Set (HIS). Chapter two has been organized to correspond with each section of the HIS.


**IQIES HELP DESK**

For additional technical support and assistance please contact the iQIES Help Desk.

Hours: Monday - Friday 7:00 a.m. – 7:00 p.m. (CT)

Phone: 800-339-9313

Email: iqies@cms.hhs.gov, Website: [https://qtso.cms.gov/](https://qtso.cms.gov/)