



## STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870  
MONTGOMERY, ALABAMA 36104

June 15, 2011

Dear Administrator:

Enclosed for completion is the *July* Quarterly Patient Origin Survey. July's survey should include discharges from **April, May, and June**. The deadline for this survey is **August 31<sup>st</sup>, 2011**.

This packet is offered electronically, which allows for immediate delivery, and eliminates lost or misdirected packets. If you or your designated representative would like to begin receiving this packet electronically, complete the appropriate section on the enclosed form. **Please consider filing the patient origin survey data electronically.** Electronic data saves time, paper and storage space and ensures much greater accuracy than manually (paper) submitted data.

Detailed specifications for electronic filing, the preferred method, are also enclosed. The enclosed Survey Transmittal Form **must be** submitted with paper or media-submitted surveys. If the data is sent via E-mail, the same requested information must be provided in the E-mail.

As always, please verify the data prior to submitting it. The correct codes for properly identifying all fields are enclosed with this packet. Also, please indicate which version of the DRG codes your facility is utilizing.

Media submissions or the completed report should be sent to one of the following addresses:

**MAILING ADDRESS** (U. S. Postal Service)  
PO BOX 303025  
MONTGOMERY AL 36130-3025

**STREET ADDRESS** (Commercial Carrier)  
100 NORTH UNION STREET STE 870  
MONTGOMERY AL 36104

E-mail submittals should be made to [data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov).

**Please be aware that we are continuing to contact facilities about past due reports for prior data sets. If you are unsure whether your facility has submitted all prior data sets, please contact me.**

SHPDA has been asked to investigate the possibility of adding an additional service code to cover Long Term Acute Care Patients. It has also been requested that we add an additional payer source code for Medicare HMO patients. Based on conversations with several hospital care providers, I am considering instituting these changes beginning with the 2012 data. Please provide your input and let me know if these two additional codes would be a problem for you to implement into your system.

Through our joint efforts, improvements in the quality and content of data can be accomplished. If you have any questions or concerns, do not hesitate to contact me at (334) 242-4109 or [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov).

Sincerely,

Bradford L. Williams  
Data/Planning Director

BLW/dml  
Enclosures: Form HPOS  
Instructions & transmittal  
Designee form

**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE  
JULY 2011 QUARTERLY PATIENT ORIGIN SURVEY  
MUST INCLUDE DISCHARGE DATA FOR APRIL, MAY AND JUNE**

<b>FIELD NAME</b> <i>(electronic &amp; paper submissions)</i>	<b>INSTRUCTIONS</b> <i>(electronic &amp; paper submissions)</i>	<b>FIELD LENGTH</b> <i>(for electronic submissions only)</i>  <u>All fields should be numeric</u>  <b>Field Length Requirements</b>
<b>Hospital ID #</b>	SHPDA Hospital ID number	
<b>Patient Number</b>	Patient identification number. <u>This number may be a blind number assigned in sequential order.</u> Patient ID numbers <b>cannot</b> be duplicated.	<b>6</b>
<b>Age</b>	The numeric value of the patient's age, consisting of three (3) digits. For example, if the patient is 78, the entry would be 078. If the patient is 103, the entry would be 103. <b><u>INCLUDE ALL NEWBORNS &amp; PEDIATRICS, USING 000 FOR ALL INFANTS UNDER 1 YEAR OF AGE.</u></b>	<b>3</b>
<b>Sex</b>	Use the following values:  <b>MALE:           1                   FEMALE:   2</b>	<b>1</b>
<b>Race or National Origin</b>	Use the following values: <b>WHITE/CAUCASIAN----- 1</b> <b>BLACK/AFRICAN AMERICAN/NEGRO----- 2</b> <b>HISPANIC/SPANISH/LATINO----- 3</b> <b>ASIAN----- 4</b> <b>AMERICAN INDIAN/ALASKAN NATIVE----- 5</b> <b>PACIFIC ISLANDER----- 6</b> <b>INDIA----- 7</b> <b>MIDDLE EASTERN----- 8</b> <b>OTHER----- 9</b>	<b>1</b>
<b>Zip Code</b>	Patient's residence zip code. <b><u>5 digits only</u></b> , report unknown zip codes as "99999".	<b>5</b>

<b>FIELD NAME</b> <i>(electronic &amp; paper submissions)</i>	<b>INSTRUCTIONS</b> <i>(electronic &amp; paper submissions)</i>	<b>FIELD LENGTH</b> <i>(for electronic submissions only)</i>  <u>All fields should be numeric</u>  <b>Field Length Requirements</b>
<b>Length of Stay (LOS)</b>	<p>The number of days calculated from the date of admission until the date of <u>discharge</u> or <u>death</u>. <b>Discharges for this quarter</b> include any patients admitted in previous months and discharged during the months of <b>APRIL, MAY AND JUNE</b>. <i>DO NOT</i> include any patients admitted during this period but not discharged by June 30<sup>th</sup>. Patients must be in the hospital a minimum of 24 hours to be included in the Patient Origin Survey. <b>Examples:</b> A patient admitted on March 31st and discharged on April 4<sup>th</sup> would have a LOS of 004. A patient admitted on April 3<sup>rd</sup> and discharged on April 13<sup>th</sup> would have a LOS of 010. A patient admitted on June 28<sup>th</sup> and not discharged by June 30<sup>th</sup> would not be included.</p>	<b>3</b>
<b>Date of Discharge</b>	<p>For every discharge, Please include the date of discharge for that patient. This should be submitted in a <b>MM/DD/YYYY</b> format.</p>	<b>10</b>
<b>Service Code</b>	<p>Record only the <b>PRIMARY</b> service when more than one clinical service is provided during the hospital stay:</p> <p><b>MEDICINE:</b>           <b>01</b></p> <p><b>SURGERY:</b>           <b>02</b></p> <p><b>PEDIATRICS:</b>       <b>03</b> (use only if your facility has an organized pediatric unit and only for patients <u>17 and under</u>). If your facility does not have an organized pediatric unit, report services under one of the remaining codes. For patients 18 and older, report under one of the remaining codes even if treatment occurred in an organized pediatric unit.</p> <p><b>GYNECOLOGY</b>       <b>04</b> (<u>NO MALES</u>), (medicine or surgery)</p>	<b>2</b>

<b>FIELD NAME</b> <i>(electronic &amp; paper submissions)</i>	<b>INSTRUCTIONS</b> <i>(electronic &amp; paper submissions)</i>	<b>FIELD LENGTH</b> <i>(for electronic submissions only)</i>  <u>All fields should be numeric</u>  <b>Field Length Requirements</b>
<b>Service code continued</b>	<p><b>OBSTETRICS</b>      <b>05</b> (<u>NO MALES</u>)</p> <p><b>ORTHOPEDICS</b>      <b>06</b> (use only if your facility has an organized orthopedic unit.)  Facilities without an organized orthopedic unit should report these patients under the appropriate service.</p> <p><b>PSYCHIATRIC</b>      <b>07</b> (include alcoholism and substance abuse treatments)</p> <p><b>REHABILITATION</b>      <b>08</b></p> <p><b>OTHER</b>      <b>09</b></p>	
<b>DRG/CMG</b>	Patient's <b>DRG</b> (Diagnosis Related Group) or <b>CMG</b> (Case Mix Group) code. <b>As a reminder, please indicate which version of DRG codes your facility is using.</b>	<b>4</b> (add leading 0's as necessary)
<b>Payer Source</b>	Use the following values: <ul style="list-style-type: none"> <li><b>SELF PAY/PRIVATE PAY</b>----- 1</li> <li><b>WORKMAN'S COMPENSATION</b>----- 2</li> <li><b>MEDICARE</b>----- 3</li> <li><b>MEDICAID</b>----- 4</li> <li><b>TRI-CARE</b>----- 5</li> <li><b>BLUE CROSS/BLUE SHIELD</b>----- 6</li> <li><b>NO CHARGE/CHARITY</b>----- 7</li> <li><b>HMO</b>----- 8</li> <li><b>ALL KIDS</b>----- 9</li> <li><b>OTHER INSURANCE</b>----- 10</li> <li><b>HOSPICE</b>----- 11</li> <li><b>OTHER</b>----- 12</li> </ul>	<b>2</b>

Note: Electronic submissions are requested; however, computer printouts or spreadsheets, ***in the same format***, are acceptable. SHPDA has a template available in Excel format. This template may be obtained by visiting the SHPDA website at [www.shpda.alabama.gov](http://www.shpda.alabama.gov), or contacting Bradford L. Williams at (334) 242-4109 or [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov)

**FOR ELECTRONIC SUBMISSIONS ONLY:**

CD-ROMs and DVDs must carry an external label containing a data set name, the total number of records, and the type of software the data originated from (i.e., LOTUS, DBASE, EXCEL, ACCESS). E-Mail transmissions should include information regarding the total number of discharges, hospital name, and ID #, format of data, contact name, and telephone number. The data must be readable by an IBM compatible personal computer, using a DOS operating system. The data must contain only the fields indicated and **must** be in the order and format specified. Please transfer the data in ASCII, Microsoft Excel, or Microsoft Access 97 – 2007 only. If there are any special instructions concerning the data, they should be included with the submission. If data cannot be provided in one of these formats, it **cannot** be submitted electronically for processing. . Please send E-mailed submissions to [data.submit@shpda.alabama.gov](mailto:data.submit@shpda.alabama.gov).

**If there are any questions concerning submission of data, please contact** Bradford L. Williams at (334) 242-4109 or [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov) for clarification *PRIOR* to compiling the data.

# JULY 2011 QUARTERLY HOSPITAL PATIENT ORIGIN SURVEY

**(Include newborns and pediatrics less than 1 year of age)**

NOTE: Electronic submission of this information is preferred (see cover letter). If electronic submission is not possible, please make as many copies of this form as necessary in order to provide enough entries to cover all discharges for the months of **APRIL, MAY AND JUNE**. Please make any corrections to the name of this facility by crossing out the incorrect name, and writing the corrected name to the side.

Patient #	Age	Sex	Race	Zip Code	Length of Stay	Date of Discharge	Type of Service	DRG/CMG	Payer

**Version of DRG Codes** \_\_\_\_\_

**Number of Discharge Entries Reported on this Page** \_\_\_\_\_

# JULY 2011 QUARTERLY HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please attach this sheet as a cover to the JULY Quarterly Hospital Patient Origin Survey for paper submissions. This survey is due by August 31<sup>st</sup>, 2011.

Hospital Name \_\_\_\_\_

Hospital ID # \_\_\_\_\_

Total Number of Survey Sheets Enclosed \_\_\_\_\_

Total Number of Discharges Reported \_\_\_\_\_

Person submitting survey report: \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Telephone Number \_\_\_\_\_

Version of **DRG**  
Codes: \_\_\_\_\_

***Please only use this closeout record if the data is submitted on paper. Retain a copy for your records. Do not use this form if data is transmitted electronically.***