STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

September 17, 2012

Dear Administrator:

Enclosed for completion is the ***Fourth Quarter*** Patient Origin Survey. The fourth quarter's survey should include discharges from **July, August, and September, 2012**. The deadline for this survey is **November 30, 2012.**

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 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

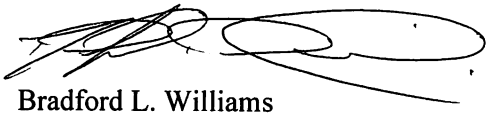
STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104

E-mail submittals should be made to **data.submit@shpda.alabama.gov**.

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.

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.

Sincerely,



Bradford L. Williams
Data/Planning Director

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

PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE FOURTH QUARTER FY 2012 PATIENT ORIGIN SURVEY

MUST INCLUDE DISCHARGE DATA FOR July, August, and September, 2012

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

FIELD NAME *(electronic & paper submissions)*	***INSTRUCTIONS (electronic & paper submissions)***	***FIELD LENGTH*** ***(for electronic submissions only)*** <u>All fields should be numeric</u> **Field Length Requirements**
Length of Stay (LOS)	The number of days calculated from the date of admission until the date of <u>discharge</u> or <u>death</u>. **Discharges for this quarter** include any patients admitted in previous months and discharged during the months of **JULY, AUGUST, AND SEPTEMBER**. *DO NOT* include any patients admitted during this period but not discharged by September 30th. Patients must be in the hospital a minimum of 24 hours to be included in the Patient Origin Survey. ***Examples:*** A patient admitted on June 30th and discharged on July 4th would have a LOS of 004. A patient admitted on August 3rd and discharged on August 13th would have a LOS of 010. A patient admitted on September 28th and not discharged by September 30th would not be included.	**3**
Date of Discharge	For every discharge, Please include the date of discharge for that patient. This should be submitted in a **MM/DD/YYYY** format.	**10**
Service Code	Record only the ***PRIMARY*** service when more than one clinical service is provided during the hospital stay. If the correct service code for a particular DRG is uncertain, please use the service code for *other* (09). ***MEDICINE:*** **01** ***SURGERY:*** **02** ***PEDIATRICS:*** **03** (use only if your facility has an organized pediatric unit and only for patients 17 <u>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. ***GYNECOLOGY*** **04** <u>*(NO MALES)*</u>, (medicine or	**2**

FIELD NAME *(electronic & paper submissions)*	***INSTRUCTIONS (electronic & paper submissions)***	***FIELD LENGTH (for electronic submissions only)*** <u>All fields should be numeric</u> **Field Length Requirements**
Service code continued	surgery) ***OBSTETRICS*** **05** *(<u>NO MALES</u>)* ***ORTHOPEDICS*** **06** (use only if your facility has an organized orthopedic unit.) Facilities without an organized orthopedic unit should report these patients under the appropriate service. ***PSYCHIATRIC*** **07** (include alcoholism and substance abuse treatments) ***REHABILITATION*** **08** ***OTHER*** **09**	**2**
DRG/CMG	Patient's ***DRG*** (Diagnosis Related Group) or ***CMG*** (Case Mix Group) code. **As a reminder, please indicate which version of DRG codes your facility is using.**	**4** (add leading 0's as necessary)
Payer Source	Use the following values: ***SELF PAY/PRIVATE PAY*** **1** ***WORKMAN'S COMPENSATION*** **2** ***MEDICARE*** **3** ***MEDICAID*** **4** ***TRI-CARE*** **5** ***BLUE CROSS/BLUE SHIELD*** **6** ***NO CHARGE/CHARITY*** **7** ***HMO*** **8** ***ALL KIDS*** **9** ***OTHER INSURANCE*** **10** ***HOSPICE*** **11** ***OTHER*** **12**	**2**

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, or contacting Bradford L. Williams at (334) 242-4109 or 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.

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

FOURTH QUARTER FY 2012 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 **JULY, AUGUST, AND SEPTEMBER.** 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 _____

FOURTH QUARTER FY 2012
HOSPITAL PATIENT ORIGIN SURVEY CLOSEOUT RECORD

Please attach this sheet as a cover to the FOURTH QUARTER FY 2012 Hospital Patient Origin Survey for paper submissions. This survey is due by November 30th, 2012.

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.

PATIENT ORIGIN SURVEY DESIGNEE FORM

☐ I prefer to receive the Patient Origin Survey packets electronically, and understand a hard copy will not be received through the mail. The e-mail address for receipt of the electronic copies is:

_____ *(please print clearly)*
E-MAIL ADDRESS

☐ I prefer to continue receiving a hard copy of the Patient Origin Survey packets through the mail.

☐ I designate the individual indicated below to receive all Patient Origin Survey packets on my behalf until further notification:

_____ _____
NAME OF INDIVIDUAL TITLE

_____
MAILING ADDRESS

_____ _____ _____
CITY STATE ZIP

_____(___)_____
TELEPHONE NUMBER

☐ The Patient Origin Survey packets should continue to be mailed to my attention.

_____ _____
SIGNATURE OF ADMINISTRATOR PRINTED NAME

_____
DATE