INSTRUCTIONS FOR COMPLETING THE 2012 ANNUAL REPORT FOR HOME HEALTH AGENCIES

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
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INSTRUCTIONS FOR COMPLETION OF THE 2012 ANNUAL REPORT FOR HOME HEALTH AGENCIES

Form DM-1

These instructions for the 2012 Annual Report for Home Health Agencies are intended to assist in the completion and submission of accurate data reported. To ensure data integrity, and determine utilization rates of services provided by home health agencies, information reported must be consistent from all facilities throughout the state. These instructions are intended to assist in the collection of data, minimizing the number of errors experienced in previous years. Selected verification procedures for reported information are also outlined, and are indicated by (**). Should these instructions not address a particular concern, please request additional assistance by contacting the State Health Planning and Development Agency (SHPDA), Bradford L. Williams, Data/Planning Director, at (334) 242-4109 or bradford.williams@shpda.alabama.gov.

Page 1

The identification number as indicated on the mailing label is assigned by SHPDA.

Verify the name of the facility identified on the mailing label is the name of the facility as indicated on the license issued by the Alabama Department of Public Health (ADPH). Make any necessary changes to the label.

Mailing Address: Provide the complete mailing address to be used by SHPDA for the mailing of annual reports, data, and requests for additional information. This address may be different from the mailing/physical address of the facility.

Physical Address: Provide the complete physical address of this facility as indicated on the ADPH license.

County of Location: Provide the county of physical location of the facility.

Facility Telephone: Provide the general telephone number of the facility, including the area code.

Facility Fax: Provide the general fax telephone number of the facility, including the area code.

The signatures and requested identifying information must be provided by two separate individuals. The primary preparer of the annual report will be contacted first for additional/corrected information. If the primary preparer is not available at the time of attempted contact, the administration official will be contacted to provide additional/corrected information, and to answer any questions.

Page 2

Section I – Agency Operations:

Provide the days of the week that services are regularly available to patients from this agency, and the days for which this agency is only on call.

Section II - Ownership:

Check the type of ownership that is applicable to this agency. If the type of ownership is not listed on the report, please check 'Other' and specify on the line below the exact type of ownership of the agency.

Section III – Branch Offices:

Indicate whether or not this agency currently has a satellite(s) offices or a branch office(s). If the answer is yes, provide the city where each is located, whether it opened for business in the last 12 months, the days that it regularly offers services, and the days for which the location is only on-call.

Section IV – Drop Sites:

Indicate whether or not this agency currently has a drop site, which is a location at which **only** supplies are stored. A drop site may not be staffed, accept referrals, advertise, or operate in a CON approved or exempt county. If a drop site is indicated on the report, list the city of location of the drop site as well as whether the drop site was opened in the last 12 months.

Page 3

Section V – Authorized Service Area:

PLEASE NOTE: THE TOTAL VISITS FROM SECTION V ON PAGE 3 MUST MATCH THE TOTAL VISITS FROM SECTION VIII ON PAGE 5.

Information regarding the total number of visits and persons served are listed for every county in which the provider has been authorized to serve, whether through CON Authority or Contiguous County Authority.

County: This section should list **every** county that the agency is authorized to service through CON Authority or through Contiguous County Authority, **regardless of whether or not the agency served any patients in said county during the reporting period. A contiguous county is not considered to be authorized until the home health agency has accepted the first referral, *has sent the required notification to SHPDA, and has received written authorization.***

Visits: List the total number of visits for each county authorized to be serviced by the agency. **If the agency has authority in a county but has not provided service to that county during the reporting period, list the total number of visits as 0.**

Persons Served: List the total number of persons served for each county authorized to be serviced by the agency. A person receiving services during this reporting period should be counted only once, regardless of whether the person was admitted more than once and/or received more than one service. **If the agency has authority in a county but has not provided service to that county during the reporting period, list the total number of persons served as 0.**

Page 4

PLEASE NOTE: THE TOTAL ADMISSIONS FROM SECTION VI ON PAGE 4 MUST MATCH THE TOTAL ADMISSIONS FROM SECTION VII ON PAGE 5, SECTION IX-A ON PAGE 6, AND SECTION IX-B ON PAGE 6.

Section VI – Admissions by Source of Payment

List the total number of admissions, broken down by county of residence, for each payment source category listed on this page. Since a patient may be discharged and readmitted several times during an annual reporting period, and payment source may vary for subsequent admission(s), most agencies will show more admissions that persons served. Attach additional sheets to the report if necessary.

County of Residence: This section should list **every** county the agency is authorized to service through CON Authority or Contiguous County Authority, **regardless of whether or not the agency served any patients in said county during the reporting period. A contiguous county is not considered to be authorized until the home health agency has accepted the first referral, *has sent the required notification to SHPDA, and received written authorization.***

Self-Pay: List the total number of patients, by county, shoe primary source of payment was not reimbursed by a third party.

Workman Comp: List the total number of patients, by county, whose primary source of payment was workman's compensation reimbursement.

Medicare: List the total number of patients, by county, whose primary source of payment was Medicare reimbursement.

Medicaid: List the total number of patients, by county, whose primary source of payment was Medicaid reimbursement.

Tricare: List the total number of patients, by county, whose primary source of payment was Tricare reimbursement.

Blue Cross: List the total number of patients, by county, whose primary source of payment was Blue Cross/Blue Shield reimbursement.

All Kids: List the total number of patients, by county, whose primary source of payment was All Kids reimbursement.

Other Ins.: List the total number of patients, by county, whose primary source of payment was insurance company reimbursement not otherwise specified.

Charity: List the total number of patients, by county, whose primary source of care was provided without expectation of reimbursement.

HMO: List the total number of patients, by county, whose primary source of payment was through an HMO reimbursement.

Other: List the total number of patients, by county, whose primary source of payment was any other reimbursement not specified.

Page 5

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Section VII – Admissions by Referral Source:

For each listed referral source, list the total number of admissions initiating a patient's service with the agency.

Physician: List the total number of admissions referred by a private physician.

Hospital: List the total number of admissions referred as a result of a hospital discharge.

Nursing Home: List the total number of admissions referred by a nursing home.

Family or Self: List the total number of admissions requested by a family member or the patient.

Department of Human Resources: List the total number of admissions referred by the Department of Human Resources (DHR).

Public Health or Agency Nurse: List the total number of admissions referred by either a Public Health or an Agency Nurse.

Other (including Social Service Agencies): List the total number of admissions referred by any other source not otherwise specified.

Section VIII – Services Offered

List the total number of services provided, broken down by type of service provided, for all visits made during the reporting period.

Skilled Nursing Services: List the total number of visits made by skilled nurses (either RN or LPN) during the reporting period.

Home Health Aide: List the total number of visits made by home health aides during the reporting period.

Homemaker: List the total number of visits made by homemakers during the reporting period.

Orderly: List the total number of visits made by orderlies during the reporting period.

Medical Social Service: List the total number of visits made by medical social service workers during the reporting period.

Physical Therapy: List the total number of visits made by physical therapists during the reporting period.

Speech Therapy: List the total number of visits made by speech therapists during the reporting period.

Occupational Therapy: List the total number of visits made by occupational therapists during the reporting period.

Medical Equipment: List the total number of visits made by medical equipment technicians during the reporting period.

Other: List the total number of visits made by any other specialists in the employ of, or contracted by, the agency during the reporting period.

Page 6

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Section IX – Patient Admission Demographics

A. Admissions By Age and Gender: List, by age and gender, every admission to the agency during the reporting period. A patient should be counted upon initial admission, and on each time of re-admittance.

B. Admissions By Race: List, broken down by race, every admission to the agency during the reporting period. A patient should be counted upon initial admission, and on each time of re-admittance.

Section X – Expenses and Revenues
(Please note that these amounts do not have to be audited)

Payroll: Total expenses for the reporting period spent on payroll and benefits for employees of the provider.

Non-payroll: Total expenses for the reporting period spent on non-payroll activities, i.e. office supplies, etc., for the provider.

Transportation: Total expenses incurred by the agency related solely to transportation to/from a patient's residence.

Bad Debt: Total expenses incurred by the agency related solely due to bad debt. Bad debt is defined by the *Alabama State Health Plan*, section 410-2-2-.06 as "the unpaid charges/rates for services rendered from a patient and/or third party payer, for which the provider reasonably expected payment".

Charity: Total expenses incurred by the agency related solely due to the provision of charity care to patients. Charity is defined by the *Alabama State Health Plan*, section 410-2-2-.06 as "health services for which a provider's policies determine that a patient is unable to pay. Charity Care could result from a provider's policies to provide health care services free of charge to individuals who meet certain pre-established criteria. Charity Care is measured as revenue foregone, at full-established rates or charges. Charity Care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient's bill".

Medicare: Reimbursements received from Medicare.

Medicaid: Reimbursements received from Medicaid.

Commercial Insurance: Reimbursements received from Long Term Care Insurance companies.

Private Pay: Reimbursements received directly from a patient or patient's primary caregiver.

Other: Any/all other revenues not otherwise specified.

REMINDER

The annual report MUST be signed by both the preparer and an administrative official.