OSHPD Discharge Document

Version 1.0
03/06/2023

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General Information

The OSHPD document is utilized in SmartCare to inpatient providers to collect required data needed for reporting.

Navigating to and Creating the OSHPD Document

1.0 From the Client Search or Banner

You can create the document from the client tab. In order to do this, you must first search for the client or select the client from your primary list in the client search drop down.

Navigate to the 'Search OR Open this Client' dropdown. Click the dropdown and select 'Client Search' or choose the client name in the drop down. If using search functionality, see below:

You will be presented with the 'Client Search' screen. On this screen you will be able to search for a client by a number of parameters.

- Broad Search - Allows for the search of a client by name, partial name, sounds like.
- Narrow Search - Returns for search of exact name match
- SSN Search - Social Security Number search
- DOB Search - Date of Birth search
- Primary Clinician Search - Search by assigned primary clinician
- Authorization ID/# - Search by authorization ID or number recorded in SmartCare
- Phone # Search - Client phone number search
- Master Client ID Search - Used in Care Management; Search by client's Master Record ID. Your organization will not use this button.
- Client ID Search
- Insured ID Search-search by insurance ID.

Upon opening the client search you will note that the only button to the bottom right that is actionable is 'Cancel.' Minimally, you must perform a one part search including first and last name, social security number, and date of birth prior to opening a client. Enter information in each of the fields you would like to use for a search parameter and click the corresponding search button for each, as shown outlined in below.
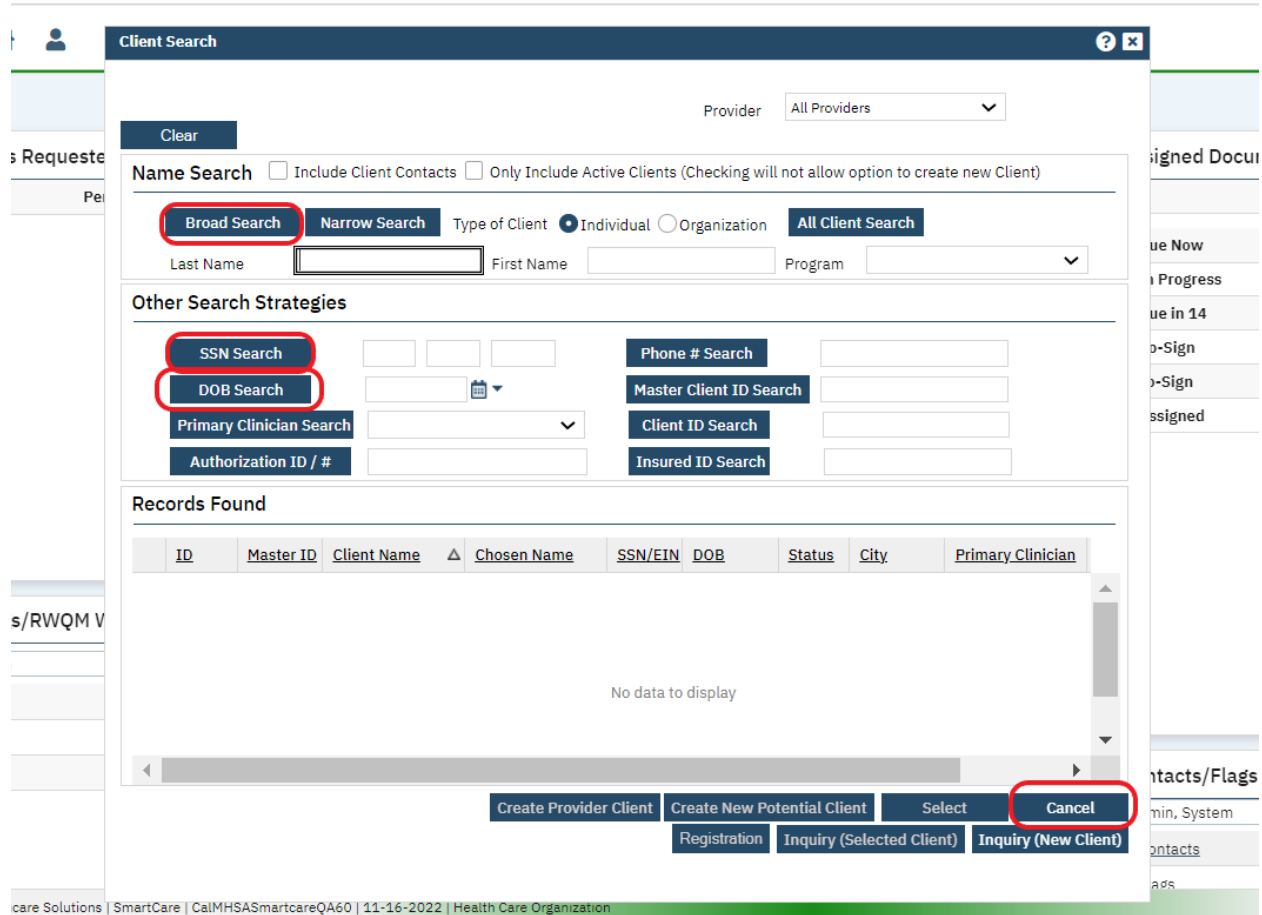
Once your search has been completed, you will note that new buttons are now available at the bottom of client search. If the client was not found in SmartCare, you will now have access to:

- Create Provider Client - Utilized in Care Management to allow providers to create client records. This does not apply to your business process.
- Create New Potential Client - Used to navigate directly to a client record for creation. In some cases you will use the Inquiry to create a new client, which is the next step.
- Inquiry (New Client) - Used to create a new Inquiry for a client that is not already in SmartCare.

If the client for whom you are searching already has a record in SmartCare, you will have the ability to both select the existing record as well as access to additional buttons, including Registration. To navigate directly to the document from this screen, click 'Registration.'

- Select - This will open the selected client's record
- Registration - This will navigate to the registration document for the selected client to either complete or review.

- Inquiry (Selected Client) - This will allow for the creation of a new Inquiry for the selected, existing client.

Click the 'Select' button to open the existing client. Once the client has been opened, you will note that there is a new tab open with the client's name and ID displayed.
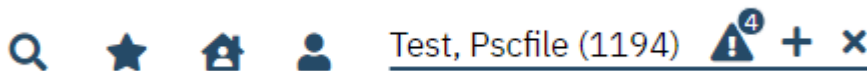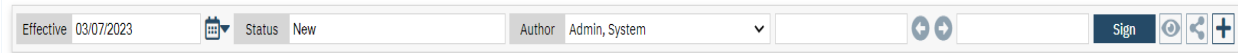

The selected client will be displayed as per the above image near the client search icon.
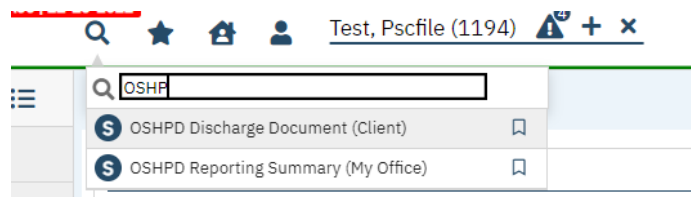
By clicking on the search icon and typing OSHP, OSHPD Discharge Document is displayed as per above image. After selecting 'OSHPD Discharge Document (client)' in the dropdown, the document is opened.

OSHPD Discharge Document

Under the OSHPD Discharge Document label, note the information pertaining to the status of the document.

We will explore these fields more thoroughly when completing the OSHPD Discharge document. However, note at this time that an effective date will be required to complete the document and it is defaulting to today's date.

Beneath the authorship, version, and effective date fields, information in OSHPD Discharge Document is broken out into a single tab.

- OSHPD Discharge

We will look at each section per tab in turn, paying specific attention to which fields have been required by the organization.

1.0 OSHPD Discharge

1.1 General

Following are the fields in the general section:

General

Abstract Record Number	[ ]	Program	Program A: 8/1/22 – 8/20/22 ∨
Type of Care	[∨]	Social Security Number	[ ]
Date of Birth	MM/DD/YYYY 📅 ▾	Sex	[∨]
Ethnicity	[∨]	Race	[∨]
Admission Date	MM/DD/YYYY 📅 ▾	Point of Origin	[∨]
Route of Admission	[∨]	Type of Admission	[∨]
Discharge Date	MM/DD/YYYY 📅 ▾	Disposition of Patient	[∨]
Preferred Language Spoken	[∨]	Pre Hospital Care & Resuscitation – DNR Order	[∨]
Zip Code	[ ]	○ Unknown ○ Homeless ○ Does not reside in the U.S	

- Abstract Record Number – This is a non-editable required text field. This field is initialized from the Client Information > Client ID.

- Program – This is an editable required dropdown field. This display Programs that the client has a program assignment where: Enrolled Date <> null, Discharge Date <> null, Program Custom field > OSHPD Facility Identification Number <> null, no previously completed OSHPD Data Collection Document has been completed matching the above parameters and the logged in user has permission to the program.

- Type of Care – This field is used to select the type of care provided to the client from the list. This is an editable required dropdown field.

- Social Security Number - This field used to identify the unique facility number assigned by OSHPD. This is a non-editable required text field. This field is initialized from the Client Information > Social Security Number

- Date of Birth - This is a non-editable required date field. This field is initialized from the Client Information > DOB

- Sex –This field is used to identify the gender of the client. This is an editable required dropdown field.

- Ethnicity – This is an editable required dropdown field.

- Race – This is an editable required dropdown field.

- Admission Date – This is a non-editable required date field. The field value is initialized from the Program Assignment > Enrolled Date for the selected Program

- Point of Origin – This field is used to show the patient point of origin. This is an editable required dropdown field.

- Route of Admission – This is an editable required dropdown field. This field is used to determine the route of patient admission.

- Type of Admission – This is an editable required dropdown field. This field is used to determine the type of patient admission.

- Discharge Date - This is a non-editable required field. The field is initialized from the Program Assignment > Discharge Date for the selected Program

- Disposition of Patient – This is an editable required dropdown field. The field is used to determine the disposition of the patient.

- Preferred Language Spoken – This field is an editable required dropdown field. This field is used to determine the spoken languages by patients.

- Pre Hospital Care & Resuscitation - DNR Order – The field is editable required dropdown field. This field is used to determine whether the patient had the DNR order.

- Zip Code – This field editable conditional text field. Associated reasons are also displayed in case there is no zip code. If the zip code is null and no reason is selected then the required validation applies.

1.2 Diagnosis

Following are the fields in the diagnosis section:

Diagnosis				
Code [ ]	Description [ ]			🔍
	Present on Admission [▾]	○ Principal Diagnosis		

	DSM5/ICD 10	ICD/DSM Description	Present on Admission	Principal Diagnosis

No data to display

- Code – This field is an editable required text field. Upon entering text and pressing tab or magnifying glass the user is directed to the core diagnosis search pop up. Selecting a diagnosis through the search and clicking okay populates the Code and Description fields.
    - Code = DSM5/ICD10
    - Description = ICD/DSM Description

- Description – This field is an editable required text field. Upon entering text and pressing tab or magnifying glass the user is directed to core diagnosis search pop up. Selecting a diagnosis through the search and clicking okay populates the Code and Description fields.
  - Code = DSM5/ICD10
  - Description = ICD/DSM Description

- Present on Admission – This field is an editable required dropdown field. The field is used to determine the status of a patient whether the patient is present on the admission.
- Principal Diagnosis –This field is a required radio button field. The field is used to tell whether the patient had any principal diagnosis.

Once the above fields are filled and clicked on the 'Insert' button, the details are inserted in the grid. The grid is used to store more than one diagnosis details for the patient.

1.3 Procedure
Following are the fields in the procedure section:

Procedure				
Code		Description		🔍
		Procedure Date	📅 ▾ ○ Principal Procedure	

<div align="right">

Insert   **Clear**
</div>

	ICD 10 PSC Code	Description	Procedure Date	Principal Procedure

No data to display

- Code – This field is an editable required text field. Upon entering text and pressing tab or magnifying glass the user is directed to the ICD 10 PCS search pop up. Selecting ICD10 PCS Code through the search and clicking okay populates the Code and Description fields.
  - Code = ICD10 PCS Code
  - Description = Description

- Description – This field is an editable required text field. Upon entering text and pressing tab or magnifying glass the user is directed to the ICD 10 PCS search pop up. Selecting ICD10 PCS Code through the search and clicking okay populates the Code and Description fields.
  - Code = ICD10 PCS Code
  - Description = Description

- Procedure Date – This field is an editable required calendar field. The field is used to determine the
Date of the procedure went by patient.

- Principal Procedure –This field is a required radio button field. The field is used to tell whether the patient had any principal procedure.

Once the above fields are filled and clicked on the 'Insert' button, the details are inserted in the grid. The grid is used to store more than one procedure details for the patient.

1.4 External Cause(s) of Morbidity
Following are the fields in the External Cause section

- Code – This field is an editable required text field. Upon entering text and pressing tab or magnifying glass the user is directed to the Diagnosis ICD 10 search pop up. Selecting DSM 5/ICD 10 Code through the search and clicking okay populates the Code and Description fields.
  o Code = DSM 5/ICD 10 Code
  o Description = ICD/ DSM Description

- Description – This field is an editable required text field. Upon entering text and pressing tab or magnifying glass the user is directed to the Diagnosis ICD 10 search pop up. Selecting ICD10 PCS Code through the search and clicking okay populates the Code and Description fields.
  o Code = DSM 5/ICD 10 Code
  o Description = ICD/ DSM Description

- Admission Indicators – This field is an editable required dropdown field. This field determines admission indicator details of the patient.

Once the above fields are filled and clicked on the 'Insert' button, the details are inserted in the grid. The grid is used to store more than one external cause details for the patient. Allow up to 12 External Cause of Morbidity records to be inserted to the grid.

1.5 Coverage and Payment
The following are the fields in this section:

Coverage and Payment

Payer Category   [　　　　　　　▾]   Type of Coverage   [　　　　　　　▾]

- Payer Category – This field is an editable required dropdown field. The field determines the payer category of the patient.

- Type of Coverage – This field is an editable dropdown field. Based on Payer Category selection a Type of Coverage is required. If Payer Category = external code 01, 02, 03, 04, 05 or 06 then validation applies. If Payer Category external code = 07, 08, or 09 then the default value is zero and make this field read only.

- Plan Name – This field is an editable dropdown field. A Plan Name must be selected based on the selected Type of Coverage. If Type of Coverage external code = 1 then validation applies. If Type of Coverage external code = 0, 2 OR 3 then hide the field and report 0000.

Set-Up Considerations (Administrative Purpose)

This section outlines all items needed for setting up this document for use with your organization, including any necessary configurations/details around how to set up other areas of your system that work directly with this document.

1.0 Configuration Keys

1. No configuration key identified.

2.0 Global Codes

1. XCAOSHPDTypeOfCare – This category controls what values to appear in the Type of Care field of the document.
2. XCAOSHPDPayerCat - This category controls what values to appear in the Payer Category field of the document.
3. XCAOSHPDSex – This category controls what values to appear in the sex field of the document.
4. XCAOSHPDEthnicity – This category controls what values to appear in the Ethnicity field of the document.
5. XCAOSHPDRace – This category controls what values to appear in the Race field of the document.
6. XCAOSHPDPointOrigin – This category controls what values to appear in the Point Of Origin field in the document.
7. XCAOSHPDRouteOfADM – This category controls what values to appear in the Route of Admission field in the document.
8. XCAOSHPDTypeOfADM – This category controls what values to appear in the Type of Admission field in the document.
9. XCAOSHPDDSPNPatient – This category controls what values to appear in the Disposition of Patient field in the document.

10. XCAOSHPDLanguage – This category controls what values to appear in the Preferred Language Spoken field in the document.
11. XCAOSHPDPresenAd – This category controls what values to appear in the Present on Admission field in the document.
12. XCAOSHPDPlanName – This category controls what values to appear in the Plan Name field in the document.