

Data Elements

Behavioral Healthcare Performance Measurement System™

Complete hospital and client information are required of all participating facilities. The hospital information is updated annually (in January) and as facility structures change. The client information is a complete accounting of all persons served each month.

Compiling information for the other data sets included in the BHPMS is based on the specific performance measures chosen by a facility. Facilities usually monitor a performance measure for at least one year before changing to a new measure.

Below is an outline of the data elements in the BHPMS. The complete specifications for the data elements and file structure are provided in the NRI's *Implementation Guide* © 1999-2008.

Hospital – Unit information

Identifying Information: Hospital, Unit, Active and Inactive dates

Descriptive data

Bed capacity	Locked
Mission: Age and expected LOS	Security level
Specialty: Clinical focus	Seclusion/Restraint policy

Client Data for Each Inpatient Episode

Identifying Information: Hospital, Client Identifier, Client Admission date

Demographic data

Date of birth
Gender

Race/ethnicity
Marital Status
Medicare

Clinical data

Principal diagnosis
17 additional diagnosis including
psychiatric, substance abuse, and/or
medical
Hospital Unit

Admission data

Date
Living arrangement
Referral source
Legal status
Justice system involvement

Discharge data

Date
Discharge clinical status (type)
Primary referral
Living arrangement
Antipsychotic medication (yes/no)

USING DATA, CHANGING PRACTICE™

Incident data for each occurrence

Identifying Information: Hospital, Unit, Client identifier, Client admission date, Event identifier

Descriptive Information

Type: Seclusion, Restraint, Leave, Elopement, Medication Error, Antipsychotic Medication, Client Injury, Staff Injury

Start date / time

End date / time (for most)

Modifiers (up to 3 depending on incident)

Leave: modifier 1 differentiates between acute medical and other reason.

Restraint: modifier 1 differentiates ambulatory, non-ambulatory, manual hold.

Med Error: modifier 1 differentiate for type: prescribing, dispensing, administration, complex; modifier 2 differentiates for severity: no or minimal adverse consequences, short-term, reversible adverse consequences, life-threatening or permanent adverse consequences; modifier 3 differentiates number of treatment variances

Antipsychotic medication: modifier 1 differentiates which new medication.

Client Injury: modifier 1 differentiates for cause: accident, assault, self-inflicted, or unknown; modifier 2 differentiates for degree of injury: no treatment, minor first aid, medical intervention, hospitalization, and death; modifier 3 differentiates for during containment event or not.

Staff Injury: modifier 1 differentiates for cause: accident, assault, or unknown; modifier 2 differentiates for degree of injury: no treatment, minor first aid, medical intervention, hospitalization, and death; modifier 3 differentiates for during containment event or not.

Assessment data for each administration

Identifying Information: Hospital, Client identifier, Client admission date

Descriptive Information

Assessment date

Type: defines which instrument (e.g. BPRS, GAF)

Assessment time period: admission, interim, discharge

One field for each item on the instrument

Rater identifier

Pharmacotherapy dataset

Identifying Information: Hospital, Client identifier, Client admission date, Medication order identifier

Descriptive Information

- Order dates
- Type: scheduled, PRN, or one-time
- Drug code
- Dosing information: frequency, amount, form

Inpatient Consumer Survey dataset

Identifying Information: Hospital, Unit, Survey identifier

Descriptive Information

- Date of administration
- One field for each item on the instrument

Descriptive information of client:

- Age group
- Gender
- Marital status
- Legal status
- Length of stay
- Completed on Discharge or not

Descriptive information on survey administration:

- Distribution type
- Return method
- Anonymity
- Assisted in completion

Core Measure data for each discharge

Identifying Information: Hospital, Client Identifier, Client Admission date

Screening Information

- Risk of Violence to Self Screening Completed and Findings
- Risk of Violence to Others Screening Completed and Findings
- Substance Use Screening Completed and Findings
- Psychological Trauma History Screening Completed and Findings
- Patient Strengths Screening Completed and Findings

Continuing Care Plan

- Reason for Hospitalization Documented
- Diagnosis Documented
- Medications Documented
- Next Level of Care Recommendations Documented

Antipsychotic medications

- Number of medications
- Reason for multiple medications

Other

- Smoking history (screening)
- Smoking counseling or advice
- Aftercare appointment date
- Reason no aftercare appointment
- Procedures