Implementation Guide Version 9.0

Effective January 1, 2017

A resource manual for participation in NRI's operational performance measurement system for psychiatric facilities.

The *Behavioral Healthcare Performance Measurement System Implementation Guide ("Implementation Guide")* is the intellectual property of the National Association of State Mental Health Program Directors Research Institute, Inc. ("NRI"), Falls Church, Virginia.

NRI grants facilities participating in this system the nonexclusive right to copy or reprint this manual solely for measurement purposes, including incorporating the specifications into their data processing protocols. Except as stated above, this manual may not be copied or reprinted by any party, by any means, including electronic, without written permission from NRI.

Copyright© 2016 by National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), 3141 Fairview Park Drive, Suite 650, Falls Church, Virginia 22042.
All rights reserved.

Any other requests for permission to reprint or make copies of all or any part of this *Implementation Guide* should be addressed to NRI.

The following pages include the file specifications limited to a basic definition of each file and list of fields. This version is appropriate for sharing with prospective bidders for a hospital's medical record information system. Complete data element specifications are not provided as the hospital should determine the granularity of each element and the medical record system should have the capacity to create an export with the required information.

Data Layout: Unit File

The HCO Unit file contains more detailed information on the units that constitute the facility. The HCO Unit file will be used to describe the key characteristics of the facility for purposes of ensuring valid comparisons across facilities. HCO Unit files are to be submitted every January showing the facility structure at the beginning of that year. In addition to the yearly submission, HCO Unit files should be submitted whenever changes occur in the facility or unit structure.

The BHPMS maintains a history of all units, identifying when units were active in the facility. When an HCO Unit file is processed, the BHPMS first identifies if the unit was previously submitted by the facility and that a description is currently in the database. If the unit exists in the database, the BHPMS identifies if the description has changed. When the description has changed, the previous record is marked as "inactive" as of the day before the reporting period of the Unit file and the new record is inserted into the database with the "active" date set to the reporting period. If there are no changes, the previous record is maintained. If there is no previous record for the unit, then the BHPMS inserts the new record and creates an "active" date to coincide with the reporting period of the file. The BHPMS then identifies any units previously reported that were not included in the current file and creates an "inactive" date as the day before the reporting period of the Unit file. When a unit closes, the facility must submit a new Unit file where a record with the Unit ID for the closed unit is not included in the file.

Accreditation Type and other descriptors are used to determine inclusion and exclusion for the HBIPS core measure set.

Medicare Certification Type and Medicare Certified Beds are used to determine inclusion and exclusion for the CMS measures.

Corrections to erroneous information can be made during the same reporting period by submitting a new Unit file. In order to make corrections to older data, please contact NRI.

This data layout section identifies the required data elements, special instructions, and edits. The edits component identifies when errors will result in the record and/or the file being rejected.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

HCO Unit Data Set File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
01	HCO ID	Alpha	4	1	4	XX##
02	Unit ID	Alpha	3	5	7	XXX
03	Staffed Bed Capacity	Numeric	3	8	10	###
04	Medicare Certified Beds	Numeric	3	11	13	###
05	Unit Mission	Numeric	2	14	15	##
06	Unit Specialty	Numeric	2	16	17	##
07	Seclusion Restraint Policy	Numeric	1	18	18	#
08	Accreditation Type	Alpha	3	19	21	XXX
09	Medicare Certification Type	Alpha	2	22	23	##

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Data Layout: Episode File

The Episode file consists of data that describe unique episodes of care (e.g. hospitalization) that occur between the first and last days of a given reporting month. This file is created by reporting episodes of care for all active patients at the end of the month and all patients discharged during the month. This includes all patients who are on the census at any time during the month. Individual patients may have more than one record in the Episode file if they have had multiple episodes of care within the same month. Each record is made unique by the identity of the facility, the patient, and the admission date. Episodes of care in which the patient is admitted and discharged on the same day can be reported to NRI.

All data elements, except transmission elements, must be documented in the patient medical record. The facility should be able to identify the forms, both paper and electronic, that are included in the medical record and used as the source of data for this file.

The BHPMS maintains a history of all episodes of care. When an Episode file is processed, the BHPMS first identifies if the episode was previously submitted. If the episode exists in the database from the prior reporting period, the previous record is removed and the new record is inserted. If there are two episode records with the same patient ID, admission date, and reporting period, then a fatal error will be generated for a duplicate record. If the episode does not exist in the database and the admission date is prior to the current reporting period, a fatal error will be generated. If the episode does not exist in the database and the admission date falls within the reporting period, then the record will be inserted into the database.

This data layout section identifies the required data elements, special instructions, and edits. The edits component identifies when errors will result in the record and/or the file being rejected.

If the facility has not submitted valid data in the Comfort Care field and the facility has selected any of the SUB or TOB measures, an informational error message will be displayed. The Global Population Measures file will be rejected and the facility will be required to update the Episode file for all cases in the Global Population Measures file at that time.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Episodic Data Set File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
01	HCO ID	Alpha	4	1	4	XX##
02	Reporting Period	Numeric	6	5	10	CCYYMM
03	Patient ID	Alpha	15	11	25	XXXXXXXXXXXXXXX
04	Admission Date	Numeric	8	26	33	CCYYMMDD
05	Unit	Alpha	3	34	36	XXX
06	Birth Date	Numeric	8	37	44	CCYYMMDD
07	Gender	Numeric	1	45	45	#
08	Race	Numeric	2	46	47	##
09	Hispanic Ethnicity	Numeric	1	48	48	#
10	Marital Status	Numeric	1	49	49	#
11	Prior Living Arrangement	Numeric	2	50	51	##
12	Admission Referral Source	Numeric	2	52	53	##
13	Admission Legal Status	Numeric	2	54	55	##
14	Discharge Date	Numeric	8	56	63	CCYYMMDD
15	Discharge Referral Status	Numeric	2	64	65	##
16	Discharge Provider Location	Numeric	2	66	67	##
17	Living Arrangements After Discharge	Numeric	2	68	69	##
18	Medicare Coverage	Numeric	1	70	70	#
19	Placeholder	Blank	1	71	71	
20	Comfort Care	Numeric	1	72	72	#

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Data Layout: Diagnosis File

The Diagnosis file consists of a list of diagnoses for patients during the specific episode of care reported in the Episode file. All participating facilities must submit a Diagnosis file each month.

This file is created by reporting the diagnoses associated with each episode of care for all active patients at the end of the month and all patients discharged during the month. This includes all patients who are on the census at any time during the month. Individual patients may have more than one record in the Diagnosis file if they have had multiple episodes of care within the same month. Each record is made unique by the identity of the facility, the patient, and the admission date. Episodes of care in which the patient is admitted and discharged on the same day can be reported to NRI.

All diagnoses must be documented in the patient medical record. The facility should be able to identify the forms, both paper and electronic, that are included in the medical record and used as the source of data for this file.

This data layout section identifies the required data elements, special instructions, and edits. The edits component identifies when errors will result in the record and/or the file being rejected.

Reporting of diagnoses will utilize the ICD-10 format.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Diagnosis Data Set File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
01	HCO ID	Alpha	4	1	4	XX##
02	Reporting Period	Numeric	6	5	10	CCYYMM
03	Patient ID	Alpha	15	11	25	XXXXXXXXXXXXXXX
04	Admission Date	Numeric	8	26	33	CCYYMMDD
05	Principal Diagnosis	Alpha	8	34	41	XXX.XXXX
06	Other Diagnosis 1	Alpha	8	42	49	XXX.XXXX
07	Other Diagnosis 2	Alpha	8	50	57	XXX.XXXX
08	Other Diagnosis 3	Alpha	8	58	65	XXX.XXXX
09	Other Diagnosis 4	Alpha	8	66	73	XXX.XXXX
10	Other Diagnosis 5	Alpha	8	74	81	XXX.XXXX
11	Other Diagnosis 6	Alpha	8	82	89	XXX.XXXX
12	Other Diagnosis 7	Alpha	8	90	97	XXX.XXXX
13	Other Diagnosis 8	Alpha	8	98	105	XXX.XXXX
14	Other Diagnosis 9	Alpha	8	106	113	XXX.XXXX
15	Other Diagnosis 10	Alpha	8	114	121	XXX.XXXX
16	Other Diagnosis 11	Alpha	8	122	129	XXX.XXXX
17	Other Diagnosis 12	Alpha	8	130	137	XXX.XXXX
18	Other Diagnosis 13	Alpha	8	138	145	XXX.XXXX
19	Other Diagnosis 14	Alpha	8	146	153	XXX.XXXX
20	Other Diagnosis 15	Alpha	8	154	161	XXX.XXXX
21	Other Diagnosis 16	Alpha	8	162	169	XXX.XXXX
22	Other Diagnosis 17	Alpha	8	170	177	XXX.XXXX
23	Other Diagnosis 18	Alpha	8	178	185	XXX.XXXX
24	Other Diagnosis 19	Alpha	8	186	193	XXX.XXXX
25	Other Diagnosis 20	Alpha	8	194	201	XXX.XXXX
26	Other Diagnosis 21	Alpha	8	202	209	XXX.XXXX
27	Other Diagnosis 22	Alpha	8	210	217	XXX.XXXX
28	Other Diagnosis 23	Alpha	8	218	225	XXX.XXXX
29	Other Diagnosis 24	Alpha	8	226	233	XXX.XXXX

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Data Layout: Event File

The Event file contains data describing specific events or incidents that occur during an episode of care reported in the Episode file. All participating facilities must report overnight leave and overnight elopement events in the Event file and must submit an Event file each month. Reported events must have a corresponding patient record reported in the Episode file. The Event file is created by reporting a record for each event that occurs during a given reporting period or remains active for a given reporting period. Each record is made unique by the identity of the facility and the unique identifier assigned to each separate event by the facility. It is likely that many patients with episodes of care reported in the Episode file will have no events reported in the Event file. However, it is also likely that there will be multiple events reported for the same patient and episode of care. If there are no events of a measure type that was selected by or required of the facility, a record indicating that there were no events of this type will need to be included in the file.

The BHPMS maintains a history of all events reported. When an Event file is submitted, the BHPMS performs several checks on each event as well as overall checks on the contents of the file. Specific checks on each event record include: matching record for patient in Episode file; uniqueness of Event ID; completeness of data elements specific to type of event. Specific checks on the contents of the file include: at least one event record for each measure chosen or a corresponding no events record, at least one event record for overnight leave and for overnight elopement or corresponding no events records, and event types submitted that do not correspond to measures selected. If there are two event records with the same Event ID and reporting period, then a fatal error will be generated for a duplicate record. If the event start date is prior to the current reporting period and the event was not previously submitted, then a fatal error will be generated for a first submission of an old event.

The no events record is composed of: HCO ID, REPORTING PERIOD, EVENT ID field should contain the text “no*events” (do not include the quotations, and the text can be either right or left justified in the field), and EVENT TYPE field should contain the code for the type of event that did not occur. All other fields should be padded with spaces.

This data layout section identifies the required data elements, special instructions, and edits. The edits component identifies when errors will result in the record and/or the file being rejected.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Event Data Set File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
01	HCO ID	Alpha	4	1	4	XX##
02	Reporting Period	Numeric	6	5	10	CCYYMM
03	Event ID	Alpha	30	11	40	XXXXXXXXXXXXXXX
04	Patient ID	Alpha	15	41	55	XXXXXXXXXXXXXX
05	Admission Date	Numeric	8	56	63	CCYYMMDD
06	Event Begin Date	Numeric	8	64	71	CCYYMMDD
07	Event Begin Time	Numeric	4	72	75	####
08	Event End Date	Numeric	8	76	83	CCYYMMDD
09	Event End Time	Numeric	4	84	87	####
10	Event Type	Numeric	3	88	90	###
11	Event Location	Alpha	3	91	93	XXX
12	Event Modifier 1	Numeric	2	94	95	##
13	Event Modifier 2	Numeric	2	96	97	##
14	Event Modifier 3	Numeric	3	98	100	###

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Data Layout: HBIPS Core Measure File

The HBIPS Core Measure file consists of data that describes five content areas from the initial admission screening process and antipsychotic medications post-discharge. Fields previously associated with the continuing care plan have been made into placeholders for future Joint Commission measure changes. The file also includes identifiers that link the records with those reported in other file types. Cases in the file should represent patients **discharged** from inpatient psychiatric care during the reporting period.

Only those facilities selecting the HBIPS core measure set are required to submit this file. The HBIPS Core Measure file is created by reporting a record for each episode of inpatient psychiatric care that ended during the reporting period. Each record is made unique by the identity of the facility, the Patient ID, and the Admission Date. If a patient has multiple episodes of care that ended in the same month, then a record would be reported for each episode. Sampling is available for this file.

The file layout provided is based on the HBIPS core measure set. All data elements, except transmission elements, must be documented in the patient medical record. The facility should define the forms, both paper and electronic, that are included in the medical record. Updates to reporting requirements are determined by The Joint Commission on a cycle determined by them.

If any record is rejected as noted in the "edits," the file will be rejected and the facility must correct missing and invalid data. An unknown code is provided for all required fields. This requirement is based on The Joint Commission missing data policy.

The 95% completeness criterion for each data element does not apply to this file. Fields that are required for specific measures are provided with an available "unknown" code option that will not count negatively in the completeness rate.

If there are no discharges in a reporting period, the HBIPS Core Measure file should consist of a single record composed of the following: HCO ID, Reporting Period, and the Patient ID field should contain the text "no*core" (do not include the quotations); the text can be either right or left justified in the field. All other fields should be padded with spaces.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

HBIPS Core Measure File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
1	HCO ID	Alpha	4	1	4	XX##
2	Reporting Period	Numeric	6	5	10	CCYYMM
3	Patient ID	Alpha	15	11	25	XXXXXXXXXXXXXXX
4	Admission Date	Numeric	8	26	33	CCYYMMDD
5	Screening for Risk of Violence to Self	Numeric	1	34	34	#
6	Findings: Risk of Violence to Self	Numeric	1	35	35	#
7	Screening for Risk of Violence to Others	Numeric	1	36	36	#
8	Findings: Risk of Violence to Others	Numeric	1	37	37	#
9	Screening for Substance Use	Numeric	1	38	38	#
10	Findings: Substance Use	Numeric	1	39	39	#
11	Screening for Psychological Trauma History	Numeric	1	40	40	#
12	Findings: Psychological Trauma History	Numeric	1	41	41	#
13	Screening for Patient Strengths	Numeric	1	42	42	#
14	Findings: Patient Strengths	Numeric	1	43	43	#
15 – 20	Placeholder	Alpha	6	44	49	
21	Aftercare Appointment Date	Numeric	8	50	57	CCYYMMDD
22	Reason for No Aftercare Appointment Date	Numeric	1	58	58	#
23	Number of Antipsychotic Medications Prescribed at Discharge	Numeric	2	59	60	##
24	Reason for 2 or More Prescribed Antipsychotic Medications	Numeric	2	61	62	##

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Data Layout: Global Population Measures File

The Global Population Measures file consists of data that describe four key areas of substance use intervention; four key areas of tobacco use intervention; patient influenza immunization status; antipsychotic medications at discharge; eleven key areas for the transition record for patients and for healthcare professionals; and four key areas for metabolic screening. The file also includes identifiers that link the records with those reported in other file types. Cases in the file should represent patients **discharged** from inpatient psychiatric care during the reporting period.

Facilities selecting any combination of the SUB, TOB, IMM-2, HBIPS-5 for CMS, Transition Record, or Metabolic Screening measures are required to submit this file. The Global Population Measures file is created by reporting a record for each episode of inpatient psychiatric care that ended during the reporting period. Each record is made unique by the identity of the facility, the Patient ID, and the Admission Date. If a patient has multiple episodes of care that ended in the same month, then a record would be reported for each episode. Sampling is available for this file.

The file layout provided is based on the SUB core measure set, the TOB core measure set, and the IMM-2 measure of The Joint Commission; the HBIPS-5 and Metabolic Screening measures of the Centers for Medicare and Medicaid Services (CMS); and the Transition Record measure set of the American Medical Association. All data elements, except transmission elements, must be documented in the patient medical record. The facility should define the forms, both paper and electronic, that are included in the medical record. Updates to reporting requirements are determined by The Joint Commission and CMS on a cycle determined by them.

The file will be rejected for critical missing and invalid data as specified in the “edits” for each field. The facility must correct missing and invalid data. An unknown code is provided for all required fields.

If the facility has not submitted valid data in the Episode file for Comfort Care for each case in this file, this file will be rejected. The facility must correct/update the Episode file.

The 95% completeness criterion for each data element does not apply to this file. Fields that are required for specific measures are provided with an available “unknown” code option that will not count negatively in the completeness rate.

If there are no discharges in a reporting period, the Global Population Measures file should consist of a single record composed of: HCO ID, REPORTING PERIOD, and the PATIENT ID field should contain the text “no*records” (do not include the quotations); the text can be either right or left justified in the field. All other fields should be padded with spaces.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Global Population Measures File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
01	HCO ID	Alpha	4	1	4	XX##
02	Reporting Period	Numeric	6	5	10	CCYYMM
03	Patient ID	Alpha	15	11	25	XXXXXXXXXXXXXXX
04	Admission Date	Numeric	8	26	33	CCYYMMDD
05	Alcohol Use Status	Numeric	2	34	35	##
06	Brief Intervention	Numeric	1	36	36	#
07 – 08	Placeholder	Numeric	2	37	38	#
09	Referral for Alcohol Treatment	Numeric	1	39	39	#
10	Referral for Drug Treatment	Numeric	1	40	40	#
11	Prescription for Alcohol Disorder Medication	Numeric	1	41	41	#
12	Prescription for Drug Disorder Medication	Numeric	1	42	42	#
13	Follow-Up Contact for Alcohol & Drugs	Numeric	1	43	43	#
14	Follow-Up Contact for Alcohol & Drugs Date	Numeric	8	44	51	CCYYMMDD
15	Alcohol Use Status Post Discharge – Quit Status	Numeric	1	52	52	#
16	Drug Use Status Post Discharge – Quit Status	Numeric	1	53	53	#
17	Alcohol Use Status Post Discharge – Counseling	Numeric	1	54	54	#
18	Drug Use Status Post Discharge – Counseling	Numeric	1	55	55	#
19	Alcohol Use Status Post Discharge – Medication	Numeric	1	56	56	#
20	Drug Use Status Post Discharge – Medication	Numeric	1	57	57	#
21	Tobacco Use Status	Numeric	1	58	58	#
22	Tobacco Use Treatment Practical Counseling	Numeric	1	59	59	#
23	Tobacco Use Treatment FDA-Approved Cessation Medication	Numeric	1	60	60	#

Table continues on next page.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
24	Reason for No Tobacco Cessation Medication Offered During the Hospital Stay	Numeric	1	61	61	#
25	Referral for Outpatient Tobacco Cessation Counseling	Numeric	1	62	62	#
26	Prescription for Tobacco Cessation Medication	Numeric	1	63	63	#
27	Reason for No Tobacco Cessation Medication at Discharge	Numeric	1	64	64	#
28	Follow-Up Contact for Tobacco Use	Numeric	1	65	65	#
29	Follow-Up Contact for Tobacco Use Date	Numeric	8	66	73	CCYYMMDD
30	Tobacco Use Status Post Discharge – Quit Status	Numeric	1	74	74	#
31	Tobacco Use Status Post Discharge – Counseling	Numeric	1	75	75	#
32	Tobacco Use Status Post Discharge – Medication	Numeric	1	76	76	#
33	Influenza Vaccination Status	Numeric	1	77	77	#
34	Number of Antipsychotic Medications Prescribed at Discharge	Numeric	2	78	79	##
35	Reason for 2 or More Prescribed Antipsychotic Medications	Numeric	2	80	81	##
36	Transition Record for Patient: Reason for Inpatient Admission	Numeric	1	82	82	#
37	Transition Record for Patient: Major Procedures and Tests	Numeric	1	83	83	#
38	Transition Record for Patient: Principal Diagnosis at Discharge	Numeric	1	84	84	#

Table continues on next page.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
39	Transition Record for Patient: Current Medication List	Numeric	1	85	85	#
40	Transition Record for Patient: Studies Pending at Discharge	Numeric	1	86	86	#
41	Transition Record for Patient: Patient Instructions	Numeric	1	87	87	#
42	Transition Record for Patient: Advance Directives	Numeric	1	88	88	#
43	Transition Record for Patient: 24/7 Contact Information for Emergencies	Numeric	1	89	89	#
44	Transition Record for Patient: Contact Information for Studies Pending at Discharge	Numeric	1	90	90	#
45	Transition Record for Patient: Plan for Follow-up Care	Numeric	1	91	91	#
46	Transition Record for Patient: Primary Physician	Numeric	1	92	92	#
47	Transition Record for Healthcare Professional: Reason for Inpatient Admission	Numeric	1	93	93	#
48	Transition Record for Healthcare Professional: Major Procedures and Tests	Numeric	1	94	94	#
49	Transition Record for Healthcare Professional: Principal Diagnosis at Discharge	Numeric	1	95	95	#
50	Transition Record for Healthcare Professional: Current Medication List	Numeric	1	96	96	#

Table continues on next page.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
51	Transition Record for Healthcare Professional: Studies Pending at Discharge	Numeric	1	97	97	#
52	Transition Record for Healthcare Professional: Patient Instructions	Numeric	1	98	98	#
53	Transition Record for Healthcare Professional: Advance Directives	Numeric	1	99	99	#
54	Transition Record for Healthcare Professional: 24/7 Contact Information for Emergencies	Numeric	1	100	100	#
55	Transition Record for Healthcare Professional: Contact Information for Studies Pending at Discharge	Numeric	1	101	101	#
56	Transition Record for Healthcare Professional: Plan for Follow-up Care	Numeric	1	102	102	#
57	Transition Record for Healthcare Professional: Primary Physician	Numeric	1	103	103	#
58	Metabolic Screening: Body Mass Index (BMI)	Numeric	1	104	104	#
59	Metabolic Screening: Blood Pressure	Numeric	1	105	105	#
60	Metabolic Screening: HbA1c or Glucose	Numeric	1	106	106	#
61	Metabolic Screening: Full Lipid Panel	Numeric	1	107	107	#

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Data Layout: Inpatient Consumer Survey File

A file containing data related to the Inpatient Consumer Survey (ICS) is required for organizations selecting measures from the Inpatient Consumer Survey Measures list. Only those organizations selecting such measures are required to submit the Inpatient Consumer Survey data set. The instrument has three sections: consumer evaluation, consumer demographics, and survey administration. The consumer evaluation section is composed of 28 items. The consumer demographic section is composed of 7 items. The survey administration section is comprised of 4 items. Information on the methods of administering the instrument is required to improve comparability across facilities. In order to protect the integrity of the instrument and improve comparability across facilities, the survey must be used in its entirety. Surveys should be retained for a period of one year.

The BHPMS maintains a history of all surveys reported. When an ICS file is processed, the BHPMS performs several checks on each record including uniqueness of the Survey ID and completeness of data elements.

The no events record is composed of: HCO ID, REPORTING PERIOD, ITEM 1 through ITEM 10 fields should contain the text “no*surveys” (do not include the quotations). All other fields should be padded with spaces.

This data layout section identifies the required data elements, special instructions, and edits. The edits component identifies when errors will result in the record and/or the file being rejected.

The English and Spanish version of the Inpatient Consumer Survey is located online. A full Inpatient Consumer Survey Toolkit can be obtained free of charge to member facilities by contacting your liaison.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

Inpatient Consumer Survey Data Set File Layout

Field Number	Data Element Name	Field Type*	Field Length	Field Start	Field End	Format
01	HCO ID	Alpha	4	1	4	XX##
02	Reporting Period	Numeric	6	5	10	CCYYMM
03	Survey ID	Alpha	15	11	25	XXXXXXXXXXXXXXX
04	Administration Period	Numeric	6	26	31	CCYYMM
05	Unit ID	Alpha	3	32	34	XXX
06	Item 1	Numeric	1	35	35	#
07	Item 2	Numeric	1	36	36	#
08	Item 3	Numeric	1	37	37	#
…	…	Numeric	1	…	…	#
33	Item 28	Numeric	1	62	62	#
34	Age	Numeric	1	63	63	#
35	Gender	Numeric	1	64	64	#
36	Survey Completion at Discharge	Numeric	1	65	65	#
37	Length of Stay	Numeric	1	66	66	#
38	Race/Ethnicity	Numeric	2	67	68	##
39	Marital Status	Numeric	1	69	69	#
40	Legal Status	Numeric	1	70	70	#
41	Distribution Type	Numeric	1	71	71	#
42	Anonymity	Numeric	1	72	72	#
43	Return Method	Numeric	1	73	73	#
44	Assisted in Completion	Numeric	1	74	74	#

*All fields are “text” fields whether listed as alpha or numeric.

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)

© National Association of State Mental Health Program Directors Research Institute, Inc. (NRI)