OMHRS Assessment Types and Data Elements, 2016–2017

Standards and Data Submission

Canadian Institute for Health Information
Institut canadien d'information sur la santé

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OMHRS Assessment Types and Data Elements, 2016–2017

The following tables provide a comparative list of assessment types as well as mandatory and optional data elements for the Ontario Mental Health Reporting System (OMHRS) at the Canadian Institute for Health Information (CIHI). Data elements are from the Resident Assessment Instrument–Mental Health (RAI-MH)©, which was designed by interRAI in collaboration with the Ontario Hospital Association and Ontario Ministry of Health and Long-Term Care.

Brief descriptions of each assessment type and data element are provided, as is limited information on the standardized clinical, care quality and resource utilization measures derived from the OMHRS data set. (For more information on these measures, please write to omhrs@cihi.ca.)

Please refer to the *Ontario Mental Health Reporting System Resource Manual, 2016–2017* for full details on each data element.

Table 1: OMHRS assessment types

Table 2: OMHRS mandatory and optional data elements, by assessment type

Table 3: OMHRS derived data elements and outcome measures

Table 1 OMHRS assessment types

Assessment type	Description
Full Admission	This assessment is completed for all admissions when the net length of stay is greater than 72 hours (3 days).
Short Stay	This assessment is completed whenever the net length of stay is less than or equal to 72 hours (3 days). It includes both admission and discharge information.
Change in Status	This assessment is completed at any time during a single episode of care for people who experience a significant, unexpected change in their clinical status.
Quarterly	This assessment is completed every quarter for all longer-stay people within a maximum of 92 days following the last Full Admission, Quarterly or Change in Status assessment.
Discharge (Full)	This assessment is completed for all planned discharges when the net length of stay is greater than 6 days and when there is no indication that the person will be returning to continue the current episode of care.
Discharge (Short)	This assessment can be completed in lieu of the full Discharge assessment when 1 of the following 2 scenarios applies: • The discharge is unplanned and the net length of stay is greater than or equal to 4 days. • The discharge is planned or unplanned, and the net length of stay is greater than or equal to 4 days and less than or equal to 6 days.

Table 2 OMHRS mandatory and optional data elements, by assessment type

Legend

M — Mandatory; **O —** Optional; **O* —** Optional status is dependent on an associated data element; **Blank —** Element is not applicable

Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
X10	Country of Residence	Indicates the country where the person currently resides	M	M				
X20	Province/Territory Issuing Health Card Number	Indicates the provincial or territorial government that issued the health card number	M	M				
X4	Health Card Number Status	Indicates the person's health card number status (known, unknown or not applicable)	M	M				
AA2	Health Card Number	The person's health card number	O*	O*				
X30	Chart Number	An alphanumeric identifier unique to a person within a facility	M	M	M	M	M	M
AA3	Case Record Number	A hospital registration number assigned to a person for each admission to the facility	M	M	M	M	M	M
AA4	Facility Number	Alphanumeric 5-digit facility identifier	M	M	M	M	M	M
AA5	Unit Identifier	Numeric code identifying the unit type the person is on	M	M	M	M	M	M
BB1	Sex	Indicates the sex of the person	M	M				
BB2	Birthdate	Indicates the person's actual or estimated birthdate	M	M				
X40	Estimated Birthdate	Flag indicating whether the person's date of birth cannot be verified	M	M				
BB3	Marital Status	Indicates the person's marital status	M	O				
BB4	Language	Indicates the language the person generally prefers to use	M	O				
BB5	Education	Indicates the person's highest level of education	M	O				
BB6a–g	Income	Indicates the person's source(s) of income	M	O*				
X50a–i	Responsibility for Payment	Indicates the agency(ies) responsible for payment for this episode of care	M	M				
BB7a–c	Aboriginal Origin	Documents self-identified Aboriginal status	M	O				

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
CC1	Date Stay Began (Admission Date)	Records the date on which the person was admitted	M	M				
CC2a–h	Reasons for Admission	Identifies problems that contributed to the person's present admission	M	M				
X60	Postal Code of Person's Residence	The Canadian postal code or forward sortation area for the person's current residence	M	M				
CC3	Who Lived With at Admission	Indicates who the person was living with at the time of admission	M	O				
CC4a–b	Admitted From and Usual Residential Status	Indicates the type of residence/facility from which the person was admitted and in which the person normally lives	M	M				
X65	Referred From Facility Number	The 5-digit facility number of the referring facility, if applicable	O*	O*				
CC5	Residential Stability	Indicates the permanence of the person's living arrangements prior to admission	M	O				
DD1	Number of Psychiatric Admissions (Recent)	Records the number of previous psychiatric admissions in the last 2 years	M	O*				
DD2	Number of Psychiatric Admissions (Lifetime)	Records the number of previous psychiatric admissions	M	O*				
DD3	Time Since Last Discharge	Indicates the amount of time since the last discharge from a mental health facility	M	O*				
DD4	Amount of Time Hospitalized	Indicates the amount of time that the person was hospitalized for mental health services over the last 2 years prior to this admission	M	O*				
DD5	Contact With Community Mental Health	Identifies involvement with a community-based mental health service in the year prior to this admission	M	O				
DD6	Age at First Hospitalization	Indicates the person's approximate age at first admission for mental health services	M	O				

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
A1	Assessment Reference Date	Indicates the last day of the observation period for the current assessment	M	M	M	M	M	M
A2	Reason for Assessment	Indicates the reason for completing the current assessment	M		M	M	M	O
A3a	Status at Time of Admission	Indicates inpatient status, as outlined in the *Ontario Mental Health Act*, at the time of admission	M	M				
A3b	Status at Time of Assessment	Indicates inpatient status, as outlined in the *Ontario Mental Health Act*, at the time of the current assessment	M	M	M	M	M	M
X9a	Forensic Status at Time of Admission	Indicates the status of forensic patients at the time of admission	O*	O*				
X9b	Forensic Status at Time of Assessment	Indicates the status of forensic patients at the time of the current assessment	O*	O*	O*	O*	O*	O*
A4a–d	Capacity/ Competency	Indicates whether the person is competent to participate in decisions about his or her health care, treatment and/or financial affairs, and whether another person is authorized to make decisions for the person	M	O	M	M	M	O
A5a–b	Police Intervention	Indicates whether the person has been involved with the police (other than as a victim) and the nature of the involvement	M	M	M	M	M	M
B1a–gg	Mental State Indicators	Records the frequency of a number of indicators indicative of the person's mental state over the last 3 days	M	M	M	M	M	M
B2	Insight Into Mental Health	Indicates the person's level of awareness of his or her mental health problems	M	M	M	M	M	M
C1	Alcohol	Documents the number of alcoholic drinks in a single sitting during the last 14 days	M	M	M	M	M	M
C2a–f	Substance Use	Provides an inventory of substances that the person may be taking or has taken in the past	M	M	M	M	M	M

Legend

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
C3	Withdrawal Symptoms	Indicates the severity of signs or symptoms indicative of withdrawal from alcohol or drugs in the last 3 days	M	M	M	M	M	M
C4a–d	Patterns of Drinking or Other Substance Use	Documents behaviours indicating that the person may have had a problem with an alcohol or drug addiction in the last 3 months	M	O	M	M	M	O
C5	Smoking	Indicates whether the person is addicted to nicotine	M	O	M	M	M	O
C6	Gambling	Indicates whether the person has gambled excessively or uncontrollably in the last 3 months	M	O	M	M	M	O
D1a–d	Self-Injury	Indicates whether the person is engaging in or is at risk of engaging in self-injurious behaviour	M	M	M	M	M	M
D2a–c	Violence	Indicates whether the person is or is at risk of becoming violent	M	M	M	M	M	M
D3	History of Sexual Violence or Assault as Perpetrator	Indicates whether the person has engaged in sexual violence toward others in the past	M	M	M	M	M	M
E1a–g	Behavioural Symptoms	Documents the frequency of behavioural symptoms that cause distress to the person or others with whom the person comes in contact, over the last 3 days	M	M	M	M	M	M
E2	Extreme Behaviour Disturbance	Indicates whether caregivers have concern that the person may pose a serious current risk of harm to self or others	M	M	M	M	M	M
F1a–b	Memory/Recall Ability	Documents the person's capacity to remember recent events and perform sequential activities over the last 3 days	M	M	M	M	M	M
F2	Cognitive Skills for Daily Decision-Making	Documents the person's ability and actual performance in making everyday decisions	M	M	M	M	M	M
F3a–f	Indicators of Delirium	Documents behavioural signs observed over the last 3 days that may indicate that delirium is present	M	O	M	M	M	M

Legend

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
F4	Cognitive Decline	Documents change in cognitive status	M	O	M	M	M	O
G1a–e	ADL	Documents the person's performance of activities of daily living during the last 3 days	M	M	M	M	M	M
G2a–e	IADL	Documents the person's performance of instrumental activities of daily living during the last 3 days	M	M	M	M	M	M
G3	Stamina	Documents the person's involvement in physical activities in the last 3 days	M	O	M	M	M	O
G4	ADL Decline	Compares current ADL status with that of 90 days ago (or since the last assessment)	M	O	M	M	M	O
H1	Hearing	Indicates the person's ability to hear during the last 3 days	M	O	M	M	M	O
H2	Vision	Indicates the person's ability to see during the last 3 days	M	O	M	M	M	O
H3	Making Self Understood	Indicates the person's ability to communicate	M	M	M	M	M	M
I1a–q	Health Conditions — Signs and Symptoms	Records specific problems or symptoms that affected, or could have affected, the person's health or functional status over the last 3 days	M	O	M	M	M	O
I2a–g	Extra-Pyramidal Signs and Symptoms	Records signs and symptoms commonly seen as side effects with the administration of neuroleptic medication over the last 3 days	M	O	M	M	M	O
I3	Sexual Functioning	Records whether the person has experienced sexual dysfunction over the last 30 days	M	O	M	M	M	O
I4	Self-Reported Health	Indicates the person's perception of his or her own physical health over the last 3 days	M	O	M	M	M	O
I5	Chewing/Swallowing	Documents the presence of any problem with swallowing or chewing	M	O	M	M	M	O
I6aa–ab	Skin Problems	Documents the presence of skin conditions or changes in the last 3 days	M	O	M	M	M	O
I6b	Foot Problems	Documents the presence of problems with feet in the last 3 days	M	O	M	M	M	O

Legend

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
I7a	Falls	Documents whether the person fell in the last 90 days and the number of falls the person sustained in the last 30 days	M	O	M	M	M	O
I7b	Recent Falls	Documents whether the person has a recent history of falling			O		O	O
I8a–b	Pain Frequency/ Intensity	Records the frequency and intensity of the signs and symptoms of pain in the last 3 days	M	O*	M	M	M	O*
I9	Bladder Continence	Records the person's bladder continence over the last 3 days	M	O	M	M	M	O
I10	Bowel Continence	Records the person's bowel continence over the last 3 days	M	O	M	M	M	O
I11a–g	Medical Diagnoses	Documents the presence of selected medical diseases or infections for which the person is currently being treated or monitored, and that have a relationship to the person's current mental or physical health status or behaviour	M	M	M	M	M	M
I11h–m	Other Medical Diagnoses (ICD-10-CA Code)	Alphanumeric codes indicating the presence of additional medical diseases or infections for which the person is currently being treated or monitored, and that have a relationship to the person's current mental or physical health status or behaviour	O*	O*	O*	O*	O*	O*
J1a–l	Life Events	Indicates whether and how recently the person has experienced selected life events	M	O	M	M	M	M
J1m–p	Life Events	Indicates whether and how recently the person has experienced selected life events	M	M	M	M	M	M
J2	Life Event (J1) Causes Sense of Horror or Intense Fear	Indicates the subjective impact of any of the recorded life events on the person	M	O*	M	M	M	O*

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
J3a–b	Other Indicators	Indicates whether the person has experienced any form of abuse or assault by a family member, and whether the person fears a family member, caregiver, friend or staff	M	O	M	M	M	O
K1	History of Medication Adherence	Indicates whether the person was taking medication as prescribed during the month prior to admission	M	O				
K2	Medication Refusal	Documents any refusal to take prescribed medication during the last 3 days	M	O	M	M	M	M
K3	Stopped Taking Psychotropic Medication	Indicates whether the person has stopped taking psychotropic medication in the last 90 days due to side effects	M	O	M	M	M	M
K4	Intentional Misuse of Medication	Indicates whether the person uses medication as recommended or prescribed	M	M	M	M	M	M
K5	Acute Control Medications	Records the frequency with which acute control medication was administered to the person over the last 3 days	M	O	M	M	M	O
K6	Allergy to Drugs	Indicates whether the person has any known drug allergies to medication	M	O	M	M	M	O
L1a–h	Service Utilization — Formal Care	Indicates the number of days where the person had contact with selected formal caregivers in the last 7 days (or since admission)	M	O	M	M	M	O
L2a–d	Nursing Interventions	Indicates the extent to which the person receives nursing services	M	O	M	M	M	O
L3a–d	Treatment Modalities	Indicates the type of treatment modalities offered to the person during the last 7 days (or since admission)	M	O	M	M	M	O
L4a–l	Focus of Intervention	Indicates the focus of the recorded treatment modalities	M	O	M	M	M	O
L5	Adherence to Treatments, Therapies, Programs	Indicates whether the person has adhered to treatments, therapies or programs as planned	M	O	M	M	M	O

Legend

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
L6	ECT	Documents the person's history of receiving electroconvulsive therapy (ECT)	M	O	M	M	M	O
X6	Number of ECTs Since Last Assessment	Documents the number of electroconvulsive therapy (ECT) treatments since last assessment	O*	O*	M	M	M	M
M1a–f	Control Interventions	Records the frequency with which the person was restrained at any time over the last 3 days	M	O	M	M	M	O
M2a–d	Observation Levels	Documents the level of supervision required over the last 3 days	M	O	M	M	M	O
M3	Psychiatric Intensive Care	Documents the number of days spent in a psychiatric intensive care unit during the last 3 days	M	O	M	M	M	O
M4	Authorized Activities Outside Facility	Indicates whether the person has left the facility or locked unit at any time in the last 3 days	M	O	M	M	M	O
N1a–b	Height and Weight	Indicates the person's current height and weight	M	O	M	M	M	O
N2a–d	Nutritional Problems	Documents issues related to nutrition	M	O	M	M	M	O
N3a–c	Eating Disorder Indicators	Documents any potential signs of eating disorders in the last month	M	O	M	M	M	O
N4	Polydipsia	Documents any excessive intake of fluids in the last 3 days	M	O	M	M	M	O
O1	Family Roles	Indicates perceptions of the quality of relationships with family members	M	O	M	M	M	O
O2a–g	Social Relations and Interpersonal Conflict	Documents several important features of a person's current social network	M	O	M	M	M	M
O3	Employment Status	Documents the person's present employment status	M	M	M	M	M	O
O4a–d	Risk of Unemployment/ Disrupted Education	Documents factors that place the person at risk for employment and/or education difficulties	M	O	M	M	M	O

Legend

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
O5	Trade-Offs	Indicates whether the person made trade-offs to purchase required medications, home heating, heath care or food due to limited funds in the last month	M	M	M	M	M	O
O6a–c	Social Relationship	Documents the nature and recentness of social interactions	M	O	M	M	M	O
P1a–d	Available Social Supports	Documents the availability of family or close friends to provide support the person will require following discharge	M	O	M	M	M	M
P2a–b	Discharge Readiness	Documents indicators of discharge readiness	M	O	M	M	M	O
P3	Projected Time to Planned Discharge	Indicates the person's estimated remaining length of stay	M	O	M	M	O	O
P4	Overall Change in Care Needs	Documents the person's overall change in clinical status as compared with 30 days ago (or since admission/last assessment)	M	O	M	M	M	O
P5	Discharged To	Indicates the living arrangement to which the person is being discharged		M			M	M
X140	Discharged to Facility Number	The 5-digit facility number to which the person was discharged, if applicable		O*			O*	O*
Q1a–v	DSM-5 Provisional Diagnostic Category	Indicates up to 3 diagnoses, according to broad *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) categories	M	M	M	M	M	M
Q2a–f	DSM-5 Code	Indicates the specific psychiatric diagnoses	O	O	O	O	O*	O
Q3	Intellectual Disability	Documents conditions associated with intellectual disability	M	O	M	M	M	O
Q4	GAF Score	Documents the person's most current Global Assessment of Functioning (GAF) score	O	O	O	O	O	O
Q5	Patient Type	Provides a general categorization of patient type	M	M	M	M	M	M
R1	Prescribed Medications	Indicates whether the person has had any medication prescribed in the last 3 days	M	O	M	M	M	M

Legend

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Element ID	Element name	Description	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
X8a	Admitted Through Emergency Department	Indicates whether the person was admitted through the emergency department		M			M	M
X8b	Arrived on Inpatient Unit	Indicates whether the person arrived on a mental health inpatient unit after being admitted through the emergency department		O*			O*	O*
X8c	Date Arrived on Inpatient Unit	Indicates the date that the person arrived on a mental health inpatient unit from the emergency department		O*			O*	O*
X75	Days in Alternate Level of Care Since Last Assessment	Indicates the number of days the person was determined to be in alternate level of care			M	M	M	M
X80	Discharge Date	Indicates the date on which the person was discharged from the facility		M			M	M
X90	Discharge Reason	Indicates the most accurate reason for the person's discharge		M			M	M
X130	Total Days Away From Bed	Indicates the total number of days the person was away from the mental health bed since the last assessment (or since admission)	M	M	M	M	M	M
X131	Total Days Away From Bed in Previous Fiscal Year	Indicates the total number of days the person was away from the mental health bed since the last assessment (or since admission) that occurred in a previous fiscal year	O*	O*	O*	O*	O*	O*
X200 A, B	Project Code	A unique code assigned by CIHI that is used to identify a project that could be used to collect supplemental data	O*	O*	O*	O*	O*	O*
X210 A, B	Project Data	Provides supplemental data as needed	O	O	O	O	O	O
X70	Drug Identification Number (DIN)	Identifies each medication the person has taken in the past 3 days using the 8-digit DIN assigned by Health Canada	O	O	O	O	O	O
R2b–f	Medication Dose/ Form/Frequency/ PRN/Discontinued	Provides additional information on all medications the person has taken in the last 3 days	O	O	O	O	O	O

Table 3 OMHRS derived data elements and outcome measures

Output type	Examples	Clinical uses
Clinical Assessment Protocols (CAPs)	Substance Use Harm to Others	Guide care planning to resolve problems and increase the potential for improvement
Outcome scales	Severity of Self-Harm Scale Cognitive Performance Scale	Summarize functional characteristics, such as behaviour, cognition and self-care Establish baseline scores and indicate the success of care planning interventions
Quality indicators	Self-Injury Capacity to Manage Medications	Allow for comparative reporting of important dimensions of mental health care Flag potential quality issues
System for Classification of In-Patient Psychiatry (SCIPP) 49 SCIPP groups in 9 categories	n/a	Describe each patient's resource utilization based on clinical characteristics and care needs

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