RAI-MH

Resident Assessment Instrument–Mental Health (RAI-MH)

CIHI Coding Reference Guide

2024–2025

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Introduction

The *CIHI Coding Reference Guide for the Resident Assessment Instrument–Mental Health* was developed by the Canadian Institute of Health Information (CIHI). This guide provides supplemental information to assist coders in completing items of the RAI-MH assessment.

Purpose

This document is intended to act as a companion guide to the *Ontario Mental Health Reporting System (OMHRS) Resource Manual*. The purpose of this document is to assist assessors in completing the RAI-MH assessment accurately. Quick reference points were compiled to assist in the interpretation of data elements and provide clarification as needed when coding the RAI-MH assessment. This document is to be used in conjunction with clinical expertise and relevant best practice guidelines when completing the RAI-MH assessment.

Additional resources

The *OMHRS Resource Manual* remains the comprehensive resource to guide the understanding and documentation of assessment findings. There are additional resources available to assessors to assist with accurate coding on the assessment.

The following OMHRS supporting documents provide information and guidance to enhance the understanding and completion of the RAI-MH assessment. These documents are available in CIHI's online store.

- *Schizophrenia Care in Hospitals — Frequently Asked Questions*
- *Significant Change-in-Status Assessments for the Ontario Mental Health Reporting System (OMHRS)*
- *Ontario Mental Health Reporting System I11 Medical Diagnosis Quick Reference Guide*

The publication *OMHRS Assessment Types Data Elements* provides a comparative list of assessment types as well as mandatory and optional data elements for OMHRS at CIHI.

CIHI tips by assessment section

Section AA Name and Identification Numbers

Item	CIHI tip
AA2 — Health Card Number	OMHRS accepts up to 12 digits for the health card number (HCN), which includes a version code if provided. The first 10 digits of the HCN are used to link same persons. If a person comes to a facility without a health card and with no fixed address, it is appropriate to code those 2 elements as -90 (not applicable). While not being able to find an HCN within the 3-day assessment period is unusual, when that is the case, it is important to record that fact by coding -90.
AA3 — Case Record Number	AA3 is the unique number for an episode of care and must remain the same after a return from leaves or passes.
AA4 — Facility Number	The Ministry of Health's master numbers for all Ontario hospitals, including mental health master numbers, are available on the Health Data Branch Web Portal. These numbers are used when completing elements AA4, X65 and X140. Element AA4 is mandatory and is coded using the 4-digit mental health master number for your facility. Elements X65 and X140 are completed as required to track facilities across the province that persons have been discharged to. In the box preceding the 4-digit master number, enter the 1-digit provincial code as appropriate (e.g., 5 for Ontario).

Section BB Personal Items

Item	CIHI tip
X50h — Responsibility for payment: Self-pay — Other country	This category is intended to reflect that the person is responsible for paying for services via personal resources (e.g., private insurance, personal money) and is not a Canadian resident. You may select all applicable options when coding. For example, you may code 1 (yes) for both X50h and X50a — Provincial/territorial responsibility if both apply.

Section CC Referral items

Item	CIHI tip
CC1 — Date Stay Began	The OMHRS episode of care begins when the decision is made to admit to a designated mental health bed. Code CC1. When the decision is made in the emergency department (ED), CC1 reflects the date on which the decision was made to admit the person to the mental health inpatient unit and includes time spent waiting in the ED for an inpatient bed. CC1 is the date the ED doctor made the decision to admit, even if the person leaves or is discharged, never making it to the inpatient unit. If the decision to admit was made in the community, CC1 reflects the date the person was admitted as a patient into the inpatient mental health bed from the community. The RAI-MH assessment is initiated in the ED with the decision to admit to the designated mental health bed. The 72-hour assessment period for completing the RAI-MH begins when the decision is made to admit the person, not when they arrive in the inpatient mental health bed. A National Ambulatory Care Reporting System (NACRS) abstract would be expected to be completed for time spent in the ED prior to the decision to admit to a mental health bed.
CC4 — Admitted From and Usual Residence	The intent of CC4 is to document the type of residence from which the person was admitted and the type of residential setting where the person normally lives. CC4a (Admitted from) refers to the actual place from which the patient was admitted. CC4b (Usual residence) refers to the type of residential setting where the patient normally lives. Coding of CC4a (Admitted from) depends on the organization's process for admitting persons who live at home to a designated inpatient bed. Organizations may or may not have an emergency department (e.g., a general hospital, a stand-alone psychiatric facility). An organization with an emergency department may also have a process that allows for a planned admission or for a person who is registered in an outpatient mental health program to proceed directly to the inpatient mental health unit without going through the emergency department. Coding of CC4b (Usual residence) will capture the specific location prior to arrival at the emergency department (e.g., person lives at home). **Examples** A person who lives at home is admitted to a mental health bed through the emergency department of the same or different facility: CC4a = 12 and CC4b = 1 A person who lives at home is admitted as a planned admission directly to a mental health bed on the inpatient unit (for an organization with or without an emergency department): CC4a = 1 and CC4b = 1 A person who lives at home and is registered in an outpatient mental health program is admitted directly to a mental health bed on the inpatient unit (for an organization with or without an emergency department): CC4a = 1 and CC4b = 1 A person who lives at home is admitted to a mental health bed (for an organization without an emergency department): CC4a = 1 and CC4b = 1

Item	CIHI tip
CC5 — Residential Stability	To assess residential stability, establish whether the person presently has a residence (a dwelling where they live), and then determine if this is a stable or temporary residence. If the situation is such that the present residence is not stable, as reported by the person, other sources or the staff's judgment, code 1 (yes). For example, if a student moved back home from university 2 weeks ago following graduation and plans to remain there until they find adequate employment and save enough money for rent on an apartment, code 0 (no). The student has a dwelling and plans to remain there for as long as it takes to get a job and save some money. For example, if a student quit university and moved back home because of illness, and the parents are making it clear that they can stay with them for only a few weeks after discharge and then they are "on their own," code 1 (yes). For example, if a person is admitted to hospital following an episode of domestic abuse and is planning to go to a shelter on discharge but is uncertain where they will go after that, code 1 (yes). The person left a permanent residence, does not plan to return to this dwelling, has plans to go to a temporary shelter and has no alternative residence as of this time.

Section DD Mental Health Service History

Item	CIHI tip
DD1 — Number of Psychiatric Admissions (Recent)	Recent refers to how many times in the last 2 years the person was admitted to hospital as an inpatient for mental health services and stayed 1 or more nights. If there are no sources of information available and the person is unable or unwilling to provide this information, treat this admission as the first for this person when coding DD1.
DD5 — Contact With Community Mental Health	DD5 is to be coded on admission assessments only. It does not capture contact with community mental health as part of discharge planning, which is captured in L4a — Community reintegration.

Section A Assessment Information

Item	CIHI tip
A1 — Assessment Reference Date	Do not confuse Assessment Reference Date (ARD) with the date on which the RAI-MH assessment is being completed or "filled in." The ARD is the last day of the observation/assessment period and ensures that, regardless of length (# days, 7 days, 30 days, 1 year, etc.), all observation/assessment periods end on the same date.

Item	CIHI tip
A5 — Police Intervention	Capture police escorts for inpatients going to and from scheduled appointments, persons who are brought to the emergency room for assessment, and police involvement in not criminally responsible (NCR) or community treatment order (CTO) situations. To determine the nature of the involvement, use the most recent incident of police intervention and determine whether the person's behaviour is violent or non-violent. Violent circumstances include incidents that result in (or could potentially result in) some form of bodily harm to others. Included are threats, intimidations and attempts to be violent toward others. A police intervention involving violence would be coded under A5a — Violent. Police intervention determined to be non-violent would be coded using A5b — Non-violent. Most police escorts for scheduled appointments are non-violent.

Section B Mental Status

Item	CIHI tip
B1 — Mental State Indicators	For coding option 1 (indicator not exhibited in last 3 days, but is reported to be present), if an indicator in Section B1 was not exhibited in the last 3 days, the indication is to refer to the recent past. The assessor must use clinical judgment concerning context and opportunity when determining what constitutes the "recent past." "Recent past" was not given an absolute period because the key issue is an indicator that occurred "recently" and continues to present concern for the person's care needs.
B1o — Anxious complaints	If it is very likely that the person would experience anxious complaints without the continuing treatment, then code 1 is most appropriate. During a longer stay, if after 3 months the person has not had anxiety complaints and treatment is now stable and unchanging, a quarterly assessment may indicate anxious complaints were not present in the last 3 days. As the indicator has not been reported for this extended period, management is stable and treatment not being adjusted to be successful, code 0 (indicator not exhibited in the last 3 days).
B1q — Obsessive thoughts	If it is very likely that the person would experience obsessive thoughts without the continuing treatment, then code 1 is most appropriate. During a longer stay, if after 3 months the person has not had obsessive thoughts and treatment is now stable and unchanging, a quarterly assessment may indicate obsessive thoughts were not present in the last 3 days. As the indicator has not been reported for this extended period, management is stable and treatment not being adjusted in order to be successful, code 0 (indicator not exhibited in the last 3 days).
B1gg — Sleep problems	If a person has been sleeping well with the use of a prescribed medication, capture that a sleep problem existed at some point before the medication was prescribed. If there is no evidence of a sleep problem over the 3-day assessment window as the person is sleeping well with the use of the medication, code 1 (indicator not exhibited in the last 3 days but is reported to be present).

Section C Substance Use and Excessive Behaviours

Item	CIHI tip
C2 — Substance Use	Use clinical judgment when coding substance use. A clinician uses all resources available to determine whether and what substance is being used, but if the substance cannot be identified then code 0 (never or more than 1 year ago) is most appropriate.

Section D Harm to Self and Others

Item	CIHI tip
D1b — Intent of any self-injurious attempt was to kill self	Therapeutic interviewing must be used to determine whether the intent of the self-injurious act was to cause self-injury but the act was followed by a change of mind, or whether it was an unconscious, self-destructive behaviour.

Section E Behaviour Disturbance

Item	CIHI tip
E1 — Behavioural Symptoms	Code for the absence or presence of the behaviour, not based on the intent or perceived cause of the behaviour. For coding option 1, the assessor must use clinical judgment concerning context and opportunity when determining what constitutes the “recent past.” “Recent past” was not given an absolute period because the key issue is behaviour that occurred “recently” and continues to present concern for the person and/or the people around them. Generally, behaviour that happened several weeks ago would not be considered. However, in some situations, the behaviour will have occurred as much as 1 month ago and is still significant in terms of the risk and the actions others need to take in relation to risks presented by the behaviour. For example, a client set a fire 1 month ago and has since been in hospital on close observation. They have not had the opportunity to set another fire but continually threaten to set a fire. This would be important to keep in the forefront of staff attention. Depending on the answers to these types of questions, clinical judgment will determine whether a current risk of serious harm exists.

Item	CIHI tip
E1c — Physical abuse	Family or friends, and documentation from the community agency or physician may report that this behaviour occurred prior to admission and that it was significant enough that it needs to be addressed in the current plan of care. **Examples** 1. The reported behaviour of physical abuse was a 1-time act of self-defence. In this case, the behaviour will not likely continue to have a meaningful impact on the patient's care needs and will not likely be a focus of treatment. Code 0 is appropriate. 2. The reported physical abuse is exhibited on a regular basis within the family home **and** a. *Either* the behaviour hasn't been exhibited in the last 3 days in hospital where there is greater control exerted and/or the targeted family members are not present; b. *Or* perhaps the reported physical abuse is a behaviour that the person exhibits on a regular basis with their children, but they were removed from the family home a week ago; however, the behaviour was exhibited up until the children were removed from the home. In example 2a and b, the behaviour continues to have a meaningful impact on the patient's care needs and will be a focus of treatment. Code 1 is appropriate.

Section F Cognition

Item	CIHI tip
F2 — Cognitive Skills for Daily Decision-Making	F2 is about actual performance of activities of daily living during the assessment period. The assessor is advised to enter the number that most accurately characterizes the patient's cognitive performance in making decisions regarding the tasks of daily life over the 3-day observation period. Code what the patient is actually doing, not what you believe the patient is capable of doing.
F3 — Indicators of Delirium — Periodic Disordered Thinking/Awareness	Persons with mental illness often exhibit the behavioural symptoms or disordered thinking described in F3 because of their ongoing mental illness. It is necessary for the assessor to use clinical judgment to differentiate the behavioural symptoms present due to mental illness from behavioural symptoms that may be indicative of a delirium. For example, when completing F3 for a person who is not restless and not as easily distracted as was the case 2 weeks ago, code 1 would be appropriate because the behaviour was present in the last 3 days but is not of recent onset. This indicates that these behavioural symptoms are related to the patient's ongoing mental illness rather than to a delirium.

Item	CIHI tip
F4 — Cognitive Decline	The intent of F4 is to document change in cognitive status to determine whether there is a difference from 90 days ago. On an admission assessment, the assessor will have been unable to observe the person at the previous 90-day mark. If possible, speak with those who were with the person at the time in order to determine the person's ability to make daily decisions then. If no one is available to provide this information and no documentation is available, there is insufficient evidence to make a clear decision; code 0 (no or unsure) is most appropriate.

Section G Self-Care

Item	CIHI tip
G1 — 3-Day ADL Self-Performance	Record the patient's actual level of involvement, not your assessment of the patient's capacity for involvement or the level of assistance the patient should be receiving. Record actual performance in the last 3 days. Assigning code 6 means that the patient was **never** involved in the task in any way, however small, **at any time** over the complete 3-day assessment period. Assigning code 8 means that the activity **never** occurred **at any time** over the complete 3-day assessment period. For example, if assigned for toilet use, it means that the patient did not void or have a bowel movement **at any time** in the 3 days; if assigned for eating, the patient did not take in nourishment by any method **at any time** in the 3 days.
G1b — Walking	G1b specifically refers to how the person moves about the unit. It does not capture whether or not the person needs assistance to come to a standing position, for example. For example, a person is unable to walk about the unit, once standing, without the assistance of 1 staff walking beside them to provide weight-bearing assistance. Since the person is up and walking but is requiring weight-bearing support from 1 person, then it is appropriate to code 4 (extensive assistance) for G1b.
G1c — Wheeling	G1c specifically refers to how the person moves about the unit. It does not capture whether or not the person needs assistance to transfer from the bed to the wheelchair, for example. For example, a person is unable to wheel about the unit, once in the chair, without the assistance of 1 staff person to push them in the chair. If a staff person pushed the wheelchair at all times during the entire 3-day assessment period, then code 6 (total dependence).

Item	CIHI tip
G1e — Eating	The intent is to capture how the person eats and drinks (regardless of skill), including the intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition). For example, a person physically is able to feed themselves independently, but daily nourishment is supplemented by tube feeding due to inadequate intake. The person is completely dependent on the nurse to assist with these feedings (to fill the bag, flush the tube, clean around the site, etc.). The person performed less than 50% of the tasks on their own and there was full performance by others of certain tasks. Therefore, it would be appropriate to code 5 (maximal assistance).
G2 — Instrumental Activities of Daily Living (IADL) Capacity	The assessment's focus on the last 3 days evaluates the person's capacity to perform the activity. For example, if the person is very disorganized and over the last 72 hours required assistance for more than 50% of the subtasks involved in meal preparation, then code 4 (extensive assistance). Assigning code 6 means that full performance by another person was required or, based on clinical judgment, would have been required at all times for all the tasks for this activity. As some IADL activities may not occur in the hospital setting, the clinician will need to use best clinical judgment to determine the person's capacity to perform the activity.

Section H Communication/Vision Patterns

Item	CIHI tip
H2 — Vision	H2 directs the assessor to ". . . ask the person to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures." (*OMHRS Resource Manual*, p. 90) In a scenario where an interpreter is desirable but not available, it is necessary to be creative. The assessor could write numbers of different sizes and ask the person to show fingers to reflect the numbers that they see. If the person is indicating some functional vision and, unless the assessor observes indications to the contrary, code 0 (adequate) — indicating least disability — is the most appropriate. The assessor may choose to make a note in the chart that the item was coded to the best of the assessor's clinical judgment without a translator present but that the evidence was used to make the determination. This documentation note is not a requirement of CIHI.

Section I Health Conditions and Possible Medication Side Effects

Item	CIHI tip
I2 — Extrapyramidal Signs and Symptoms	If a person is exhibiting a symptom (e.g., tremors) and does not take a psychoactive medication, code the symptom for the frequency it was present.
I5 — Chewing/ Swallowing	If the patient requires a modified diet to manage swallowing/chewing problems, even if the modified diet is managing the problems, it is appropriate to code 1 (yes). If the problems resolve and the modified diet is no longer required, code 0 (no).
I7a — Falls	Coding options 0 (no fall in last 90 days) and 1 (no falls in last 30 days but fell 31 to 90 days ago) capture whether there was a fall between 31 and 90 days ago. Coding options 2 (1 fall in last 30 days) and 3 (2 or more falls in last 30 days) capture single or multiple falls in the last 30 days. The last 30 days is the focus because the recent history is felt to be the most clinically significant.
I8 — Pain	Clinical judgment should be used when there is a discrepancy between what a person says about pain and what the person's behaviours and body language indicate. Clinicians should use clinical judgment to determine the intensity of the pain based on observations to ensure that the pain is being explored, treated and resolved to the extent required.
I11 — Medical Diagnosis	If the person requires active treatment or monitoring, or a medical condition or its sequelae are contributing to the patient's current mental health problem, then it should be captured in I11.
I11f — HIV+	If a person has not been tested for HIV, I11f should be coded 8 (unknown).
I11g — Hepatitis C	If a person has not been tested for hepatitis C, I11g should be coded 8 (unknown).
I11h–m — Other medical diagnoses	A medical diagnosis may be coded using the appropriate ICD-10-CA code in I11h–m to provide specificity for associated medical conditions when DSM-5-TR diagnostic codes are captured in Q2 (Psychiatric Diagnosis) for • A major or mild neurocognitive disorder due to another medical condition; and/or • A major or mild neurocognitive disorder due to multiple etiologies; and/or • An unspecified neurocognitive disorder.

Section J Stressors

Item	CIHI tip
J1 — Life Events	These must be actual life events, not those based in a delusion. Code for the patient's subjective reaction, not what others expect or believe the reaction should be.
J1o — Victim of emotional abuse	A person may have been traumatized by teasing, verbal abuse and the rejection relating to these activities to the point of affecting their self-esteem or functioning in society. If the person or family report that this is indeed the case, code the abuse under J1o if relevant to that person.
J1p — Parental abuse of alcohol or drugs	A person may have been traumatized by teasing, verbal abuse and the rejection relating to these activities to the point of affecting their self-esteem or functioning in society. If the person or family report that this is indeed the case, code the abuse under J1p if relevant to that person.

Section K Medications

Item	CIHI tip
K5 — Acute Control Medications	The process relating to acute control medications is to count the number of times an acute control medication was given to a patient by any route in the last 3 days. A medication (either regular or PRN) given as part of the ongoing treatment plan is not an acute control medication. The same medication given as an immediate response to an escalation of the patient's behaviour that puts the patient or others at risk is an acute control medication. **Example** Day 1: The clinician administers the PRN and successfully calms the person before the person's behaviour escalates to the point at which the patient is at risk to themself or others. Day 2: The PRN dose was given but was not successful in calming the person, and their behaviour escalated to the point that the person was at risk of harming themself and others, so a STAT dose was given to restrain the person. The PRN psychotropic medication given to the person on Day 1 would not constitute an acute control medication for K5. The STAT dose of psychotropic medication given to the patient on Day 2 would constitute an acute control medication for K5.

Section L Service Utilization/Treatments

Item	CIHI tip
L — Service Utilization/Treatments	The time frame of the past 7 days is used because some services are offered at intervals greater than every 3 days, such as once or twice a week (e.g., weekly Alcoholics Anonymous meeting, twice-weekly group therapy). The 7-day time frame applies to quarterly, change-in-status or planned discharge assessments. For an admission assessment, the time frame will be from admission.
L1b — Nurse practitioner or MD (non-psychiatrist)	An authorized physician assistant may also be coded under L1b. An authorized physician assistant includes non-psychiatric medical staff, residents and interns.
L1e — Occupational therapist	If assessments for walkers, wheelchairs and other similar equipment were provided by an occupational therapist, it could be coded under L1e.
L2a — Medical interventions	Only time spent in the specified activity is to be counted. For example, a nurse escorts a forensics patient to a neighbouring acute care facility for an MRI. The patient required a nursing escort at all times. The nursing intervention associated with an MRI in another facility cannot be coded in L2a because, although the patient was in the constant care of the nurse escort, the MRI was not administered/performed by the nurse escort.
L2b — One-to-one counselling, teaching	L2b refers to a specific nursing intervention. For example, L2b would include the discussion a nurse has with a client diagnosed with depression about treatment care planning, teaching the client about coping with depression or issues related to patient's medications.
L3a — Individual therapy	Individual therapy is a treatment modality provided by mental health workers such as social workers and psychologists, as well as nurses. An example of L3a could be a psychometrist or a mental health worker providing one-to-one anger management therapy to a client.
L3b — Group therapy	Group therapy is therapist-led and theory-based (e.g., cognitive behavioural therapy).
L3d — Self-help group	Self-help group therapy is often peer-led, and the focus is on mutual support (e.g., Alcoholics Anonymous).
L4b — Social/family functioning	Family functioning and social support are important factors in psychiatric treatment. The focus is to educate the patient and the patient's family about aspects of the patient's illness in relation to family dynamics, healthy social functioning and social engagement. For example, the clinician may assess the current family approach and teach the family some different ways of working with the patient. The clinician may also help the patient see how their current behaviour is affecting the family dynamics.
L4e — Alcohol/drug treatment	If a psychiatrist or nurse has spent time discussing the issue of substance abuse with the person, such as the effect it is having on quality of life and treatment options, this should be captured in L4e with the appropriate coding: that it has or has not occurred, has been offered but refused or is scheduled to begin within the next 7 days.

Item	CIHI tip
L4f — Smoking cessation	If a clinician has spent time discussing the issue of smoking cessation with the person, such as the effect it is having on quality of life and treatment options, this should be captured in L4f with the appropriate coding: that it has or has not occurred, has been offered but refused or is scheduled to begin within the next 7 days.
L4i — Eating disorder	The focus of L4i is on services/treatments provided to people who have a diagnosis of eating disorder per the DSM-5-TR. (e.g., anorexia nervosa, bulimia nervosa) and the psychological issues usually underlying the disorder (e.g., distorted self-image, poor self-esteem). For example, an older adult who does not wish to eat has dementia or has delusions around the food that is being put in their body; that would be related to a psychotic disorder. This is not an eating disorder per se. Potential signs of eating disorder are fasting or major restriction of diet. This can be captured in N3 — Indicators of Eating Disorder.
L6 — ECT **X6 — Number of ECT Treatments Received Since Last Assessment**	Code the actual number of ECT treatments received since the last assessment. If this is an admission, focus on the current episode of care.

Section M Control Procedures/Observation

Item	CIHI tip
M1b — Chair prevents rising	A person with no voluntary movement who is in a reclined chair with laptop attachment, for example, should not be coded as restrained.
M1d — Confinement to unit	M1d applies when the person's activity level is restricted to the unit only and there is a formal confinement order in place, and not when a mental health unit is locked as a practice. When coding M1d, focus on risk (i.e., whether or not a patient is permitted to leave without accompaniment); the focus should not be on whether or not the door is locked. For example, a person on a locked unit has 2 passes that allow them to leave the unit for a half-hour unaccompanied by staff. For the remainder of the day, the client is confined to the unit. As the person has passes that are limited to use during the day only, the most appropriate coding for M1d would be 3 (daily use — day only).

Section N Nutrition

Item	CIHI tip
N1 — Height and Weight	At times, it may be necessary for clinicians to use clinical judgment to estimate height and weight. Some clinicians may wish to document in the person's clinical record that height and weight were recorded in this manner and that it will be updated if more accurate information becomes available. This documentation note is optional on short stay and short discharge assessments.
N2 — Nutritional Problems	At times, it may be necessary for clinicians to use clinical judgment to estimate weight, weight gain or weight loss. Some clinicians may wish to document in the person's clinical record that weight was recorded in this manner and that it will be updated if more accurate information becomes available. This documentation note is optional on short stay and short discharge assessments.

Section O Role Functioning and Social Relations

Item	CIHI tip
O3 — Employment Status	As the intent of this item is to document the patient's present employment status as it relates to the need for care planning around vocational issues, homemakers, students or retirees who are not seeking employment would be coded as 3 (other), since in these situations, not seeking employment is not an issue that needs to be addressed with care planning. For a person working in a sheltered workshop for which they receive some remuneration for work completed on a regular basis, code 0 (employed). If this person is being discharged and will be seeking employment in the community, on the discharge assessment O3 can be coded as 1 (unemployed, seeking employment) to ensure that any need for support with employment is not overlooked. If the person identified that they are not seeking employment after discharge, then O3 can be coded 2 (unemployed, not seeking employment).

Section P Resources for Discharge

Item	CIHI tip
P1 — Available Social Supports	This item is intended to code the presence of these supports, if needed; it is not intended to code whether or not the patient needs this type of support.
P5 — Discharged To	Code 1 (private home/apartment/rented room): Although quite different from each other, these residences are indicative of independent living in the community. “Community” includes any house, condominium or apartment and any rented room such as a resident hotel. “Community” would also include retirement communities and independent housing for seniors or people with disabilities. (*OMHRS Resource Manual, p. 138*) Codes 2 (board and care) and 3 (assisted living or semi-independent living) are different in name only so that different provinces can code the applicable designation. Board and care refers to a non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc. (*OMHRS Resource Manual, p. 138*) Assisted living or semi-independent living refers to a second type of non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc. (e.g., retirement homes in Ontario). (*OMHRS Resource Manual, p. 138*) Code 12 (acute care hospital): Code here for patients discharged from a mental health bed for medical treatment. When a client is discharged to a retirement home (a private facility without a facility number) code 3 to represent a retirement home. Leave X140 — Discharged to Facility Number blank.

Section Q Psychiatric Diagnostic Information

Item	CIHI tip
Q1 — DSM-5-TR Diagnostic Category	It is understood that, in subsequent assessments (if this is an initial assessment), the coding of Q1 may change, as further information concerning the patient’s diagnosis may come to light during a patient’s stay in the mental health bed.
Q2 — Psychiatric Diagnosis	The code for primary diagnosis is listed in Q2a. If a code is listed in Q2b–f, it will not be considered the primary diagnosis. It is also important to code comorbidities, if known. If Q2a = 1 of the 3 codes F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*, items X160 to X164 cannot be blank and must be completed on all planned and unplanned full and short discharges. If Q2a = 1 of the 3 codes F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*, item X160 = 1.

Item	CIHI tip
Q5 — Current Patient Type	Item Q5 is about the patient, not the bed (AA5 is about the bed, not the patient).
X160 — Schizophrenia Primary Diagnosis	To identify all patients with a primary diagnosis of schizophrenia or schizoaffective disorder, an additional data element was added to capture this information on planned and unplanned full discharge and short discharge assessments. A confirmed diagnosis of schizophrenia or schizoaffective disorder is defined by the following ICD-10-CM codes in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision* (DSM-5-TR) that have been confirmed by the psychiatrist or attending physician: F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*. These are the only codes acceptable to identify schizophrenia or schizoaffective disorder as the primary diagnosis in the RAI-MH. When the primary diagnosis is identified as schizophrenia or schizoaffective disorder (F20.9, F25.0, F25.1) on a planned or unplanned full discharge or short discharge assessment, then X160 is coded as 1 (yes). Items X161 to X164 must be completed and cannot be blank.
X161 — Long-Acting Injectable Medication	If Q2a = 1 of the 3 codes F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*, item X161 cannot be blank and must be completed on all full discharge and short discharge assessments. For all short discharges and full discharges , if X160 — Schizophrenia Primary Diagnosis is coded 1 (yes), then X161 — Long-Acting Injectable Medication cannot be blank and must be completed. If X160 is coded 0 (no), indicating that schizophrenia/schizoaffective disorder is not the primary diagnosis, then X161 does not have to be completed. When a person has received a long-acting injection prior to admission to hospital and the long-acting injection was not administered in hospital, it is appropriate to code X161 as 2 (treatment was LAI medication received prior to admission and not required during the hospital stay). Administration of the long-acting injectable prior to or during admission — regardless of the time interval of administration (e.g., monthly, every 3 months) — is coded in item X161. The intent is to identify those who are actively being treated with a long-acting injectable.
X162 — Treatment Resistant	If Q2a = 1 of the 3 codes F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*, item X162 cannot be blank and must be completed on all short discharge and full discharge assessments. For all short discharges and full discharges, if X160 — Schizophrenia Primary Diagnosis is coded 1 (yes), then X162 — Treatment Resistant cannot be blank and must be completed. If X160 is coded 0 (no), indicating schizophrenia/schizoaffective disorder is not the primary diagnosis, then X162 — Treatment Resistant does not have to be completed. Determining whether a person is treatment resistant is at the discretion of the psychiatrist or attending physician and must be documented. If a review of the clinical record and the psychiatrist or attending physician documentation does not indicate whether a person is treatment resistant, the psychiatrist or attending physician should be consulted for clarification. Documenting a person as treatment resistant in the clinical record is a process developed by the facility in consultation with the psychiatrist.

Item	CIHI tip
X163 — Treatment With Clozapine	If Q2a = 1 of the 3 codes F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*, item X163 cannot be blank and must be completed on all short discharge and full discharge assessments. For all short discharges and full discharges, if X160 — Schizophrenia Primary Diagnosis is coded 1 (yes), then X163 — Treatment With Clozapine cannot be blank and must be completed. If X160 is coded 0 (no), indicating schizophrenia/schizoaffective disorder is not the primary diagnosis, then X163 does not have to be completed. For X163 the intent is to capture patients with a primary diagnosis of schizophrenia or schizoaffective disorder who have received treatment with clozapine and for whom the clozapine is expected to continue at discharge. Code 0 (no) if the person started or is admitted on clozapine and it is discontinued for whatever reason during the hospital stay. For example, if a patient was admitted on clozapine, the clozapine was discontinued and the patient was discharged on a long-acting injectable (LAI) medication, as the patient is not continuing treatment with clozapine after discharge, code 0 (no). This includes persons for whom clozapine has been tried but who will not continue it after discharge. If treatment with an LAI has been received during the hospital stay, code X161 as 1 (yes). Code 1 (yes) only if the person is receiving treatment with clozapine and is prescribed to continue at discharge. Code 2 if the person was offered treatment with clozapine but refused. Code 3 if the person received clozapine but was discontinued due to adverse effects. For example, the person was prescribed and received clozapine during the hospital stay. Prior to discharge, the clozapine was discontinued due to potential risk for low numbers of white blood cells (i.e., agranulocytosis), as indicated upon review of the required bloodwork regime.
X164 — Care Plan Sent	If Q2a = 1 of the 3 codes F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, bipolar type* or F25.1 *Schizoaffective disorder, depressive type*, item X164 cannot be blank and must be completed on all short discharge and full discharge assessments. For all short discharges and full discharges, if X160 — Schizophrenia Primary Diagnosis is coded 1 (yes), then X164 — Care Plan Sent cannot be blank and must be completed. If X160 is coded 0 (no), indicating schizophrenia/schizoaffective disorder is not the primary diagnosis, then X164 does not have to be completed. When completing X164, the observation period is based on calendar days. A care plan is defined as a discharge summary or discharge plan, where the comprehensive interprofessional assessment and physical health assessment inform the care plan. Patient-oriented discharge summaries or other forms of discharge plans used in the hospital are counted as care plans.

Section R Medications

Item	CIHI tip
R2 — List of Medications	If a long-acting injectable medication is prescribed during the 3-day assessment observation period, record the type, dose, route of administration and frequency following the guidelines for coding. Please note this can also be recorded in a record of medication orders. This list should not be used for the purposes of active medication administration.

Section S Service History

Item	CIHI tip
X90 — Reason for Discharge	Death due to suicide includes patients who die in acute care after being transferred as a result of a suicide attempt while in the mental health bed. Death not due to suicide includes patients who die in acute care after being transferred as a result of medical issues emerging while in the mental health bed. If the discharge is planned/expected, always code 1 (planned discharge), including when the person • Leaves the mental health unit as planned to go to another program within the same hospital and is not expected to return to the mental health unit; • Is moved to a different hospital as planned and is not expected to return to the mental health unit; and • Is discharged home (former or new). If the person is expected to return to the mental health unit but fails to return after being transferred to another service in your hospital or another hospital, code 4 (transferred, unplanned). This option applies for persons who • Do not return as expected to the mental health bed after receiving treatment/care in another medical service in your hospital or another hospital; and • Are expected to return to the mental health bed but die while in the care of another service or another hospital.
X130 (Total Days Away From Bed)	X130 captures occasions when a person leaves the mental health bed for a period of time (equal to or greater than 24 hours and less than or equal to 92 calendar days) with the expectation of returning to the mental health bed to continue treatment. It includes both planned absences (e.g., weekend passes) and unplanned absences (e.g., a temporary transfer to another level of care).

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