

SECTION S

DRAFT

S1. Subpart S

Intent: The intent of this item is to identify residents that meet Illinois Department of Public Health, 77 Ill. Adm. Code 300, Section 300.4000 Applicability of Subpart S criteria.

Definition Subpart S is defined using commonly accepted indicators for identification of serious mental illness: major mental illness diagnosis, extended duration, and substantial functional limitation due to the mental illness. Skilled licensed and intermediate nursing facilities providing services to residents with serious mental illness shall meet the requirements of Subpart S and shall comply with Subpart S Sections 300.4000 through 300.4090 to provide specialized services to residents that meets Subpart S criteria.

Process: Facilities shall identify through assessment, resident history and other applicable information, which residents have serious mental illness, in accordance with Section 300.4000 and determine the facility profile of SMI residents, including age groups, levels of functioning, strengths and risks and shall comply with Subpart S Sections 300.4000 through 300.4090.

Coding: **0 = No**
 1 = Yes

Code “0” if the resident does not meet IDPH Subpart S criteria.

Code “1” if the resident does meet IDPH Subpart S criteria.

Psychiatric Services

S2. SMI Diagnoses

Intent: The intent of this item is to document the serious mental disease(s) of the resident that meets Subpart S criteria, as defined by Illinois Department of Public Health, 77 Ill. Adm. Code 300, Section 300.4000 Applicability of Subpart S. The nursing facility shall comply with Subpart S Sections 300.4000 through 300.4090 to provide specialized services to the resident that meets Subpart S criteria.

Definition: The SMI diagnoses are defined as the presence of a major disorder as classified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) American Psychiatric Association, excluding alcohol and substance abuse, Alzheimer’s Disease, and other forms of dementia based upon organic or physical disorders.

Process: The disease conditions in this section require a physician-documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

Coding: **Check all that apply**
Diseases

- a. Schizophrenia
- b. Delusional disorder
- c. Schizoaffective disorder
- d. Psychotic disorder not otherwise specified
- e. Bipolar disorder I mixed, manic, and depressed
- f. Bipolar disorder II
- g. Cyclothymic disorder
- h. Bipolar disorder not otherwise specified I
- i. Major depression, recurrent

Section S3. SUBSTANCE USE AND EXCESSIVE BEHAVIORS

The data collected in this section will be used for early detection and intervention of addictions. This is important to know because of the impact of substance abuse on the course of the psychiatric illness.

S3A. Alcohol

Intent: The intent of this item is to document the number of alcoholic drinks in a single sitting during the **past 14 days**. This information can be helpful in determining the presence of a potential problem and subsequent care planning.

Definition: **Alcoholic drinks** — includes beer, wine, liquor or liqueurs.

Single sitting — a single sitting refers to any given point in time (e.g., at dinner, after work, while out at a social event).

Process: Ask the resident and, if possible, family members about the amount of alcohol consumption at various times in the last 14 days. If there is a discrepancy in reporting amount taken at a single sitting, use your best clinical judgment to code this item.

Coding: **Code for single sitting with highest number.**

Code "0" if no alcoholic drinks were consumed in the past 14 days.

Code "1" if the resident or others report that the resident had only one drink at any given sitting in the past 14 days.

Code “2” if the number of alcoholic drinks had been 2, 3, or 4 during any given sitting in the past 14 days.

Code “3” if the resident had consumed 5 or more alcoholic drinks in any given sitting in the past 14 days.

Examples of Alcohol Coding

Case Study 2: Anthony goes out drinking at the “pub” and it is reported that he has up to 6 or 7 bottles of beer a night. Code = 3

Case Study 3: Tom’s parents report that he had a number of drinks on the Saturday night before his admission (this would be “one sitting”). Code = 3

S3B. Substance Use

Intent: The intent of this item is to obtain an inventory of substances that the resident may be taking or has taken in the past. These substances can have particularly harmful effects when combined with certain medications that the resident may be taking concurrently.

- Definition:**
- a) **Inhalants** — Hydrocarbons found in inhalants are sniffed by users to achieve a .high. and include substances like glue, gasoline, paint, paint thinner, or solvents.
 - b) **Hallucinogens** — Examples include phencyclidine or .angel dust,. LSD or .acid,. magic mushrooms and ecstasy. These substances are known for the hallucinations they produce.
 - c) **Cocaine and crack** — A powerful stimulant derived from the coca plant which can be inhaled or smoked.
 - d) **Stimulants** — Examples include amphetamines, such as uppers, speed, and methamphetamine. Stimulants are often used to control normal fatigue and create feelings of euphoria.
 - e) **Opiates** — E.g. heroin
 - f) **Cannabis** — Any of various preparations of different parts of the hemp plant which are smoked, chewed or drunk for their intoxicating or hallucinogenic properties.

Process: Asking about substance-related problems can be introduced to the resident by letting him or her know that this information is important for care planning or treatment (e.g., possible medication interactions). Observe body language and reluctance in responding. If unsure of the accuracy of

the resident's response, you may want to check with others (family, friends, community workers) to determine if they know whether the resident has used these substances.

Coding: Code for most recent time the substance was used.

Code "0" if the resident has not taken the substance at any time in the past year, OR if the substance was used but it was more than a year ago.

Code "1" if the substance was used in the past year, but not within the last 3 months.

Code "2" if the substance was used in the past 3 months, but not in the last month.

Code "3" if the substance was used in the last month, but not in the last 7 days.

Code "4" if the substance was used in the last 7 days, but not in the past 3 days.

Code "5" if the substance was used in the last 3 days.

Examples of Substance Use Coding

Case Study 1: Although Fatima takes a great deal of Tylenol, the focus of this section is on psychoactive drugs and Tylenol is not an example of one of the categories noted here. Her excessive use of Tylenol will be noted in another section (K4).

Code = 0

Case Study 3: Although parents report that Tom does not use street drugs and Tom has refused to discuss this with staff, his community health worker reports that Tom has admitted to her that he uses marijuana. To the best of her knowledge, she thinks that he was smoking it as recently as last week. This is a situation where there are sources of conflicting information. Clinical judgment was used to decide the best response for this item, with the information from the community worker being seen as the best source. **Code = 4**

Note: Items 1 and 2 above may serve as a good example of instances where the assessor must rely on his or her best clinical judgment when no reliable source of information is available. This situation may occur when the resident is non-communicative or uncooperative. For example, the resident may be unable or unwilling to provide information on his or her substance use. Family members, referral sources, and/or other staff also cannot provide any information related to substance use, nor do the resident's clinical records address this issue. In a situation like this, if the assessor has no reason to suspect that the resident has used any of these substances

in the past, then Code “0.”

Also, consider the situation where there are conflicting sources of information given about the resident’s use of these substances. For example, residents may not admit to having used these substances for fear of retribution. However, although the resident may respond that no substances have been taken, other sources may indicate otherwise. This resident may have admitted to another staff member that he or she has smoked marijuana recently, or clinical records may indicate that the resident was known to use stimulants within the past year. Even though the resident’s response is in disagreement with these sources, the assessor must go with his or her best clinical judgment in completing this section.

SECTION S4. HARM TO SELF AND OTHERS

S4A. Self-injury

Intent: To identify individuals engaging in self-injurious behavior or who are at risk of engaging in self-injurious behavior. Such individuals may require close or constant observation or may require that other protective measures be put in place.

- Definition:**
- a) **Self-injurious behavior** — includes both lethally motivated suicidal behavior (intentional, self-inflicted attempt to kill oneself), and behavior inflicting intentional self-injury without suicidal intent (e.g., self mutilation). Non-intentional, accidental, or unconscious self-destructive behaviors that may lead to injury or premature death (e.g., chronic substance abuse, hyper-obesity, non-compliance with treatments for illness, risk-taking behavior) are not considered self-injurious behaviors for the purposes of this item.
 - b) **Intent of any self-injurious behavior was to kill him/herself** — the resident’s self-injuries actions were carried out with the intent of ending his/her life, regardless of the potential lethality of the method.
 - c) **Considered performing a self-injurious behavior** — the resident has thought about performing an act of self-injury but has not attempted such behavior (**in the last 30 days**); this includes a command hallucination that is telling the resident to harm him or herself.
 - d) **Family/caregiver/friend/staff express concern that resident is at risk for self-injury** — the resident may or may not be verbalizing thoughts of self-injury but his/her behavior is an indicator to someone else, including a member of the health care team, that the resident is at risk for self-injury.

Process: Interview the resident and consult the resident’s family. Family should be interviewed separately from the resident so that they may express their feelings openly. Check the resident’s clinical record.

Coding: Item S4a: **self-injurious attempt** — code for most recent instance.

Code “0” if there is no reported incident of self-injurious behavior.

Code “1” if the attempt was more than one year ago, regardless of how long ago the attempt may have been.

Code “2” if the attempt was in the last year but not in the last 7 days.

Code “3” if the attempt was in the last week but more than 3 days ago.

Code “4” if the attempt was in the last 3 days.

Item S4b, c and d — **Code “0”** if there is no history of self-injury or if the intent of the self-injurious behavior was not to kill him/herself, if there has been no consideration of self-injury in the last month, or if others have not expressed concerned about potential self-injury.

Examples of Self-injury Coding

Case Study 3: Tom cut off a finger five months ago; he did so because of his belief that it was gangrenous and not as a suicide attempt. He denies thoughts of self-harm, but his parents are concerned that he may do something similar to what happened prior to this admission. **Code = 2 for item “a”; Code = 0 for item “b”; Code = 0 for item “c”; Code = 1 for item “d”**

Case Study 4: Mr. Smith has no history of self-injurious behavior. **Code = 0 for “a”, “b”, “c” and “d”**

S4B. Violence

Intent: The intent of these items is to identify violent residents or those who are at risk of becoming violent. These items focus on acts of ill-will, active opposition, hostility, or antagonism that may be directed to others or inanimate objects. Awareness of individuals with violent tendencies can help the health care team with management strategies.

Definition: a) **Violence to others** — past violence is often the best predictor of future violence. This item is a subset of violent behavior and is specifically designed to pick up on violent acts resulting in physical harm to another, which are characterized by **purposeful, malicious, or vicious intent** by

the perpetrator. This can include violence driven by command hallucinations. Violent actions can include, but are not limited to, any physical act of harm to another such as stabbing, choking, or beating (with or without a weapon).

- b) **Intimidation of others or threat of violence** — the resident attempts to force or deter someone else using threatening gestures, threatening stance with no physical contact and/or shouting angrily, yelling personal insults and/or curses directed at someone else, using foul language in anger, kicking the wall, throwing furniture, etc. The resident may also make explicit threats of violence against others.
- c) **Violent ideation** — reports premeditated thoughts, statements, or actions of violence toward others.

Process: This information can be obtained through family, therapist, or self-report, hospital charts, arrest records, and other records of judicial proceedings, if available. Family members should be interviewed separately from the resident in order to allow them to speak openly.

Coding: For each item, code for the most recent instance.

Code “0” if there is no reported incident of violence.

Code “1” if violent incident(s) occurred prior to the last year.

Code “2” if there was a violent instance in the last year but not in the last 7 days.

Code “3” if there was a violent instance in the last week but more than 3 days ago.

Code “4” if a violent instance occurred in the last 3 days.

Examples of Violence Coding

Case Study 2: Although Anthony’s wife has suspicions that he has physically abused one of the children, this has not yet been substantiated and therefore would not be considered as a violent act. However, he has verbally threatened his wife over the course of the past few months and as recently as the evening of his admission, he threatened his brother. **Code = 0 for “a”;** **Code = 4 for “b” and “c”**

Case Study 3: Tom threatened and punched the person who owned the car that he had broken in to on the night of his admission. He denies violent ideation. **Code = 4 for “a” and “b” and Code = 0 for “c”**

Case Study 4: Although Mr. Smith is verbally abusive and resists care, these are not acts of maliciousness or antagonism directed toward an individual with the intent of causing physical harm. **Code = 0 for “a”, “b” and “c”**

S4C. Sexual Violence

Intent: The intent of this item is to specifically document the resident's history of sexual violence towards others.

Definition: **Sexual violence/assault** — any attempted or completed instances of sexual violence such as heterosexual pedophilia, heterosexual incest, homosexual pedophilia, homosexual incest, rape of adult males/females, exhibitionism to adult males/females, exhibitionism to child, or sexual violence toward family members.

Process: The resident may disclose this information; however, the information can also be obtained through family, therapists, arrest records or other documentation available.

Coding: *Code "0"* if there is no known history of sexual violence.

Code "1" if a history is reported.

Examples of Sexual Violence Coding

Case Study 2: There is no evidence that Anthony has been sexually violent toward another person. **Code = 0**

Case Study 3: There is no evidence that Tom has a history of being sexually violent to another. **Code = 0**

S5. Close or Constant Observation

Intent: The intent of this item is to document the level of supervision required over the past three days, as well as to assist in determining the acuity of the resident's condition. The use of close or constant observation should be documented in the resident's record, including (a) the reason for use; (b) confirmation that the procedure was performed in accordance with the definitions below, with staff initials recorded at appropriate intervals; and (c) brief explanation of the resident's condition and reason for terminating the observation.

Definition: a) **Checked hourly** — resident is observed by a staff member on a regular basis at hourly intervals.

b) **Checked at 15-minute intervals** — resident is observed by a staff member on a regular basis at 15-minute intervals.

c) **Checked at 5-minute intervals** — resident is observed by staff at regular 5-minute intervals.

- d) **Constant observation** — resident is not left unattended at any time for a designated period of time that is less than 1 hour. For example, constant observation may be required for less than an hour while the resident settles following use of an acute control medication, following meals, or following a medical procedure. (Constant observation may be required for longer periods and in this case, *item “d”* would be used.) *Do not include psychiatric intensive care units in assessment of these items.*
- e) **Constant observation for more than 1 hour** – resident is not left unattended at any time and this constant observation is in effect for more than 1 hour. *Do not include psychiatric intensive care units in assessment of these items.*

Process: Review the chart or consult with staff.

Coding: Record the actual number of days that **each** of the types of observation was in place in the last 3 days. If the type of observation was not used in the last 3 days, **Code “0”**.

Examples of Close or Constant Observation Coding	
Case Study 1:	Fatima was on close observation (15-minute interval check) for the first 2 days of her admission. Code = 2 for “a” and 0 for “b”, “c” and “d”
Case Study 2:	Anthony was on close observation during the first day of his admission. He was then moved to a Psychiatric Intensive Care Unit (not to be included in this item). Code = 1 for “a” and 0 for all other items

S6. Medication Refusal

Intent: To document any refusal to take prescribed medication, regardless of reason, *during the last 3 days* and to determine if the resident required support or prompting to take medication.

Definition: **Support/prompting** — e.g., individual reminders, taking medication to the person in order to ensure it was received, seeking out the resident to give him/her the medication, accompany the resident to take medication

Process: Observe the resident, consult with other staff, or review the medical record to determine adherence patterns.

Coding: **S6a**

Code “0” if the resident took all prescribed medications as ordered or if the resident has no prescribed medication.

Code “1” if the resident refused to take one or more medication(s) at a given time or had refused on one or more occasions to take all medication, regardless of reason for refusing.

S6b

Code “0” if the resident did not require any support or reminders to take medication except for ordinary practices such as general announcements. Also code “0” if the resident has no prescribed medication.

Code “1” if staff provided special individual reminders, sought out the resident, accompanied him/her, or took medication to him/her **3 or more times** in the last 3 days. Do not include ordinary announcements (e.g., over the PA system).

Examples of Medication Refusal Coding

Case Study 1: Since being in hospital, Fatima has been taking medication as prescribed. **Code = 0**

Case Study 3: During the three days of this admission, Tom has refused to take medication on 3 occasions. **Code = 1**

S7. Skills Training

Intent: The intent of this item is to document skills training provided in accordance with Illinois Department of Public Health, 77 Ill. Adm. Code 300 Adm. Code Section 300.4050 Psychiatric Rehabilitation Services for Facilities Subject to Subpart S, and Illinois Department of Healthcare and Family Services 89 Ill. Adm. Code 147 Table A.

Definition: Skills training is specific methods for assisting residents who need and can benefit from this training, to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training must meet all of the following criteria.

- Skills and capabilities must be assessed with the use of a standardized skills assessment, a cognitive assessment and assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.
- Addresses identified skill deficits related to goals noted in the treatment plan.
- Skills training is to be provided by facility staff, trained in leading skills groups, who are paid by the facility.

- Training is to be provided in a private room with no other programs or activities going on at the time. The environment must be conducive to learning in terms of comfort, noise, and other distractions.
- Training must be provided in groups no larger than 10, with reduced group size for residents requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and should be identified in the care plan.
- Training must utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for SMI and MISA populations are available for use and as models).
- The curriculum addresses discrete sets of skill competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.
- The specific written content must provide the rationale for learning, connecting skill acquisition to resident goals.
- Training must employ skill demonstration/modeling, auditory and visual presentation methods, role-playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.
- There must be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.
- Each training session is provided and attended in increments of minimum of 30 minutes each (not counting time to assemble and settle) at least 3 times per week. Occasional absences are allowable, with individual coverage of missed material as necessary.

Process: The facility shall develop and implement a psychiatric rehabilitation program in accordance with the Illinois Department of Public Health Section S Adm. Code 300.4050 Psychiatric Services for Facilities Subject to Subpart S.

Coding: 0 = No
1 = Yes

Code "0" if the resident **does not** receive Skills training in accordance with Subpart S.

Code "1" if the resident **does** receive skills training in accordance with Subpart S.

S8. Ancillary Provider Services

Intent: The intent of this item is to identify Subpart S residents that are receiving direct ancillary services by non-facility providers to meet requirements of Subpart S, excludes medical/physical management by primary psychiatrist/physician.

Process:

- These are services that are provided by direct non-facility psychiatric service providers in order to meet Subpart S requirements.
- Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity must meet the needs of the Subpart S resident as determined by the individual treatment plan (ITP).
- Facilities must ensure compliance with Illinois Department of Public Health, 77 Ill. Adm. Code 300 Section 300.4050 when utilizing non-facility or outside ancillary providers.

Coding:
0 = No
1 = Yes

Code “0” if the resident **does not** receive direct services delivered by non-facility providers.

Code “1” if the resident **does** receive direct services delivered by non-facility providers.