**Behavioral Health**

**Competency**

**Leader’s Guide**

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“Providing behavioral health care and services is an integral part of the person-centered environment. This involves an interdisciplinary approach to care, with qualified staff demonstrating the competencies and skills necessary to provide appropriate services to the resident. Individualized approaches to care (including direct care and activities) are provided as part of a supportive physical, mental, and psychosocial environment, and are directed toward understanding, preventing, relieving, and/or accommodating a resident’s distress or loss of abilities.

The facility must provide necessary behavioral health care and services which include:

* Ensuring that the necessary care and services are person-centered and reflect the resident’s goals for care, while maximizing the resident’s dignity, autonomy, privacy, socialization, independence, choice, and safety;
* Ensuring that direct care staff interact and communicate in a manner that promotes mental and psychosocial well-being.
* Providing meaningful activities which promote engagement, and positive meaningful relationships between residents and staff, families, other residents and the community. Meaningful activities are those that address the resident’s customary routines, interests, preferences, etc. and enhance the resident’s well-being;
* Providing an environment and atmosphere that is conducive to mental and psychosocial well-being;
* Ensuring that pharmacological interventions are only used when non-pharmacological interventions are ineffective or when clinically indicated. For concerns about the use of pharmacological interventions, see Pharmacy Services requirements at §483.45.

**Individualized Assessment and Person-Centered Planning:**

In addition to the facility-wide approaches that address residents’ emotional and psychosocial well-being, facilities are expected to ensure that the residents’ individualized behavioral health needs are met, through the Resident Assessment Instrument (RAI) Process.

All areas are to be addressed through the:

• Minimum Data Set (MDS);

• Care Area Assessment Process;

• Care Plan Development;

• Care Plan Implementation; and

• Evaluation.

Sections of the MDS related to behavioral health needs that may be helpful include, but are not limited to:

• Section C. Cognitive Patterns;

• Section D. Mood;

• Section E. Behavior; and

• Section F. Activities.

Utilizing Care Areas such as Psychosocial Well-Being, Mood State, and Behavioral Symptoms will also help to ensure the assessment and care planning processes are accomplished. It is also important for the facility to use an interdisciplinary team (IDT) approach that includes the resident, their family, or resident representative.

The following section discusses general information pertaining to depression, anxiety, and anxiety disorders, conditions that are frequently seen in nursing home residents and may require facilities to provide specialized services and supports that vary, based upon residents’ individual needs.

**Depression**

Although people experience losses, it does not necessarily mean that they will become depressed. Depression is not a natural part of aging; however, older adults are at an increased risk. Symptoms may include fatigue, sleep and appetite disturbances, agitation, expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation. Late life depression may be harder to identify due to a resident’s cognitive impairment, loss of functional ability, the complexity of multiple chronic medical problems that compound the problem, and the loss of significant relationships and roles in their life. Depression presents differently in older adults and it is the responsibility of the facility to ensure that an accurate diagnosis is established.

**Anxiety and Anxiety Disorders**

Anxiety is a common reaction to stress that involves occasional worry about circumstantial events. Anxiety disorders, however, include symptoms such as excessive fear and intense anxiety and can cause significant distress. Anxiety disorders are prevalent among older adults and may cause debilitating symptoms. The distinction between general anxiety and an anxiety disorder is subtle and can be difficult to identify. Accurate diagnosis by a qualified professional is essential. Anxiety can be triggered by loss of function, changes in relationships, relocation, or medical illness. Importantly, anxiety may also be a symptom of other disorders, such as dementia, and care must be taken to ensure that other disorders are not inadvertently misdiagnosed as an anxiety disorder (or vice versa).

The intent of the F741 requirement is to ensure that the facility has sufficient staff members who possess the basic competencies and skills sets to meet the behavioral health needs of residents for whom the facility has assessed and developed care plans. The facility must consider the acuity of the population and its assessment in accordance with §483.70(e). This includes residents with mental disorders, psychosocial disorders, or substance use disorders. Facility staff members must implement person-centered, care approaches designed to meet the individual needs of each resident. Additionally, for residents with behavioral health needs, non-pharmacological interventions must be developed and implemented.”[[1]](#footnote-1)

**“Sufficient Staff to Provide Behavioral Health Care and Services**

The facility must address in its facility assessment under §483.70(e) (F838), the behavioral health needs that can be met and the numbers and types of staff needed to meet these needs.

If a resident qualifies for specialized Level II services under PASARR, refer to §483.20(k) (F645). If the resident does not qualify for specialized services under PASARR, but requires more intensive behavioral health services *(e.g.,* individual counseling), the facility must demonstrate reasonable attempts to provide for and/or arrange for such services. This would include ensuring that the types of service(s) needed is clearly identified based on the individual assessment, care plan and strategies to arrange such services.

Facilities must have sufficient direct care staff (nurse aides and licensed nurses) with knowledge of behavioral health care and services in accordance with the care plans for all residents, including those with mental or psychosocial disorders.

Facilities may be concerned about accessing sufficient professional behavioral health resources (*e.g.,* psychiatrists) to meet these requirements due to shortages in behavioral and mental health providers in their area. A facility will not be cited for non-compliance, if there are demonstrated attempts to access such services.

Facilities are not expected to provide services that are not covered by Medicare or Medicaid. They are expected to take reasonable steps to seek alternative sources (state, county or local programs) but if they are not successful, it is not the basis for a deficient practice.

**Skill and Competency of Staff**

The facility must identify the skills and competencies needed by staff to work effectively with residents (both with and without mental disorders and psychosocial disorders). Staff need to be knowledgeable about implementing non-pharmacological interventions. The skills and competencies needed to care for residents should be identified through an evidence-based process that could include the following: an analysis of Minimum Data Set (MDS) data, review of quality improvement data, resident-specific and population needs, review of literature, applicable regulations, etc. Once identified, staff must be aware of those disease processes that are relevant to enhance psychological and emotional well-being.

Competency is established by observing the staff’s ability to use this knowledge through the demonstration of skill and the implementation of specific, person-centered interventions identified in the care plan to meet residents’ behavioral health care needs. Additionally, competency involves staff’s ability to communicate and interact with residents in a way that promotes psychosocial and emotional well-being, as well as meaningful engagements.

Under §483.152 Requirements for approval of a nurse aide training and competency evaluation program, nurse aides are required to complete and provide documentation of training that includes, but is not limited to, competencies in areas such as:

• Communication and interpersonal skills;

• Promoting residents' independence;

• Respecting residents' rights;

• Caring for the residents' environment;

• Mental health and social service needs; and

• Care of cognitively impaired residents.

In phases one and two of implementation of the Reform of Requirements for Long-term Care Facilities, it is the expectation that all facility staff members, including non-nurse aide staff, assisting residents living with behavioral health needs, be competent in care areas, such as those mentioned previously. However, in phase three, under §483.95(i) (F949), Behavioral health, formalized training programs must be completed and documented for all staff that support and provide care for residents that have behavioral health needs.

All staff must have knowledge and skills sets to effectively interact with residents (communication, resident rights, meaningful activities.) Person-centered approaches to care should be implemented based upon the comprehensive assessment, in accordance with the resident’s customary daily routine, life-long patterns, interests, preferences, and choices, including the interdisciplinary team (IDT), the resident, resident’s family, and/or representative(s). The IDT must be aware of potential underlying causes and/or triggers that may lead to expressions or indications of distress. Identifying the frequency, intensity, duration, and impact of a resident’s expressions or indications of distress, as well as the location, surroundings or situation in which they occur, may help the IDT identify individualized interventions or approaches to care to support the resident’s needs. Individualized, person-centered approaches to care must be implemented to address expressions or indications of distress. Staff must also monitor the effectiveness of the interventions, changing those approaches, if needed, in accordance with current standards of practice. Additionally, they must accurately document these actions in the resident’s medical record and provide ongoing assessment as to whether they are improving or stabilizing the resident’s status or causing adverse consequences.

The following discussion of non-pharmacological interventions supports all residents, however, residents living with behavioral health needs may require a more formalized, documented intervention plan.

**Non-pharmacological Interventions**

Examples of individualized, non-pharmacological interventions to help meet behavioral health needs may include, but are not limited to:

* Ensuring adequate hydration and nutrition (e.g., enhancing taste and presentation of food, addressing food preferences to improve appetite and reduce the need for medications intended to stimulate appetite); exercise; and pain relief;
* Individualizing sleep and dining routines, as well as schedules to use the bathroom, to
* reduce the occurrence of incontinence, taking into consideration the potential need for increased dietary fiber to prevent or reduce constipation, and avoiding, where clinically inappropriate, the use of medications that may have significant adverse consequences (e.g., laxatives and stool softeners);
* Adjusting the environment to be more individually preferred and homelike (e.g., using soft lighting to avoid glare, providing areas that stimulate interest or allow safe, unobstructed walking, eliminating loud noises thereby reducing unnecessary auditory environment stimulation);
* Assigning staff to optimize familiarity and consistency with the resident and their needs (e.g., consistent caregiver assignment);
* Supporting the resident through meaningful activities that match his/her individual abilities (e.g., simplifying or segmenting tasks for a resident who has trouble following complex directions), interests, and needs, based upon the comprehensive assessment, and that may be reminiscent of lifelong work or activity patterns (e.g., providing an early morning activity for a farmer used to waking up early);
* Utilizing techniques such as music, art, massage, aromatherapy, reminiscing; and
* Assisting residents with substance use disorders to access counseling programs (e.g., substance use disorder services) to the fullest degree possible.

For additional examples of individualized non-pharmacological interventions, see §483.15(f), Activities.

While there may be situations where a pharmacological intervention is indicated first, these situations do not negate the obligation of the facility to also develop and implement appropriate non-pharmacological interventions.”[[2]](#footnote-2)

The intent of the F742 regulation is “to ensure that a resident who upon admission, was assessed and displayed or was diagnosed with a mental or psychosocial adjustment difficulty or a history of trauma and/or post-traumatic stress disorder (PTSD), receives the appropriate treatment and services to correct the initial assessed problem or to attain the highest practicable mental and psychosocial well-being. Residents who were admitted to the nursing home with a mental or psychosocial adjustment difficulty, or who have a history of trauma and/or PTSD, must receive appropriate person-centered and individualized treatment and services to meet their assessed needs.”[[3]](#footnote-3)

“Residents who experience mental or psychosocial adjustment difficulty, or who have a history of trauma and/or post-traumatic stress disorder (PTSD) require specialized care and services to meet their individual needs. The facility must ensure that an interdisciplinary team (IDT), which includes the resident, the resident’s family and/or representative, whenever possible, develops and implements approaches to care that are both clinically appropriate and person-centered. Expressions or indications of distress, lack of improvement or decline in resident functioning should be documented in the resident’s record and steps taken to determine the underlying cause of the negative outcome.

For additional information regarding non-pharmacological interventions, see §483.40(a)(2) (F741), Implementing non-pharmacological interventions.

**What is appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being?**

The facility must provide the “appropriate treatment and services” to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. The determination of what is “appropriate” is person-centered and would be based on the individualized assessment and comprehensive care plan. To the extent that the care plan identifies particular treatment and services, the facility must make reasonable attempts to provide these services directly or assist residents with accessing such services.

A facility must determine through its facility assessment what types of behavioral health services it may be able to provide. Some examples of treatment and services for psychosocial adjustment difficulties may include providing residents with opportunities for autonomy; arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and maintaining contact with friends and family. The coping skills of a person with a history of trauma or PTSD will vary, so assessment of symptoms and implementation of care strategies should be highly individualized. Facilities should use evidence-based interventions, if possible.

**Background on Trauma and PTSD**

A close relationship exists between mental and psychosocial adjustment difficulties, histories of trauma, and PTSD.

• Adjustment difficulties:

o Occur within 3 months of the onset of a stressor and last no longer than 6 months after the stressor or its consequences have ended;

o Are characterized by distress that is out of proportion to the severity or intensity of the stressor, taking into account external context and cultural factors, and/or a significant impairment in social, occupational, or other important areas of functioning;

o May be related to a single event or involve multiple stressors and may be recurrent or continuous;

o May cause a depressed mood, anxiety, and/or aggression;

o May be diagnosed following the death of a loved one when the intensity, quality, or persistence of grief exceeds what normally might be expected; and

o Can occur for individuals with or without PTSD or a history of trauma.

• History of Trauma:

o Involves psychological distress, following a traumatic or stressful event, that is often variable;

o May be connected to feelings of anxiety and/or fear;

o Often involves expressions of anger or aggressiveness; and

o Some individuals who experience trauma will develop PTSD.

o *Some individuals who experience trauma will develop PTSD.*

• PTSD:

o Involves the development of symptoms following exposure to one or more traumatic, life-threatening events;

o Usually develops within the first 3 months after the trauma occurs, although there may be a delay in months or even years;

* Symptoms may include, but are not limited to, the re-experiencing or re-living of the

stressful event (e.g., flashbacks or disturbing dreams), emotional and behavioral expressions of distress (e.g., outbursts of anger, irritability, or hostility), extreme discontentment or inability to experience pleasure, as well as dissociation (e.g., detachment from reality, avoidance, or social withdrawal), hyperarousal (e.g., increased startle response or difficulty sleeping); and

o May be severe or long-lasting when the stressor is interpersonal and intentional (e.g., torture or sexual violence).

(Adapted from American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013.)

Although PTSD is commonly viewed as a disorder experienced only by military veterans, it is not exclusively a consequence of combat or war zone exposure. Individuals who have been physically or sexually assaulted or who experienced a terrorist attack or natural disaster, among other things may also be affected by PTSD. Additionally, some older nursing home residents may have lived through a time of genocide and witnessed or been subjected to the intentional and systematic destruction of a racial, political, or cultural group such as that which occurred during the Holocaust in World War II.

Moving from the community into a long-term care facility, for an individual with a history of trauma or PTSD, can be a very difficult transition and cause worsening or reemergence of symptoms. Additionally, the structured environment of the nursing home can trigger memories of traumatic events and coping with these memories may be more difficult for older adults.”[[4]](#footnote-4)

The intent of the regulation F743 is “to ensure that a resident who, upon admission was not assessed or diagnosed with a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder (PTSD), does not develop patterns of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors while residing in the facility. However, after admission, if the resident is diagnosed with a condition that typically manifests a similar pattern of behaviors, documentation must validate why the pattern was unavoidable (e.g., symptoms did not initially manifest, family was unaware of previous trauma or were unavailable for interview, etc.). Development of an unavoidable pattern of behaviors refers to a situation where the interdisciplinary team, including the resident, their family, and/or resident representative, has completed comprehensive assessments, developed and implemented individualized, person-centered approaches to care through the care-planning process, revised care plans accordingly, and behavioral patterns still manifest.”[[5]](#footnote-5)

“Nursing home admission can be a stressful experience for a resident, his/her family, and/or representative. Behavioral health is an integral part of a resident’s assessment process and care plan development. The assessment and care plan should include goals that are person-centered and individualized to reflect and maximize the resident’s dignity, autonomy, privacy, socialization, independence, choice, and safety.

Facility staff must:

• Monitor the resident closely for expressions or indications of distress;

• Assess and plan care for concerns identified in the resident’s assessment;

• Accurately document the changes, including the frequency of occurrence and potential triggers in the resident’s record;

• Share concerns with the interdisciplinary team (IDT) to determine underlying causes, including differential diagnosis;

• Ensure appropriate follow-up assessment, if needed; and

• Discuss potential modifications to the care plan.

For additional information regarding non-pharmacological interventions, see §483.40(a)(2) (F741), Implementing non-pharmacological interventions.”[[6]](#footnote-6)

**F744** deals with dementia care and is covered in a separate competency program.

The intent of F745 is “to assure that sufficient and appropriate social services are provided to meet the resident’s needs.”[[7]](#footnote-7)

“All facilities are required to provide medically-related social services for each resident. Facilities must identify the need for medically-related social services and ensure that these services are provided. It is not required that a qualified social worker necessarily provide all of these services, except as required by State law.

If there are concerns about requirements involving qualified social workers, refer to §483.70(p) (F850), Social worker.

Examples of medically-related social services include, but are not limited to the following:

* Advocating for residents and assisting them in the assertion of their rights within the facility in accordance with §483.10, Resident Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Transitions of Care, §483.20, Resident Assessments (PASARR), and §483.21, Comprehensive Person-Centered Care Planning;
* Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs;
* Assisting or arranging for a resident’s communication of needs through the resident’s primary method of communication or in a language that the resident understands;
* Making arrangements for obtaining items, such as clothing and personal items;
* Assisting with informing and educating residents, their family, and/or representative(s) about health care options and ramifications;
* Making referrals and obtaining needed services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);
* Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);
* Transitions of care services (e.g., assisting the resident with identifying community placement options and completion of the application process, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);
* Providing or arranging for needed mental and psychosocial counseling services;
* Identifying and seeking ways to support residents’ individual needs through the assessment and care planning process;
* Encouraging staff to maintain or enhance each resident’s dignity in recognition of each resident’s individuality;
* Assisting residents with advance care planning, including but not limited to completion of advance directives (For additional information pertaining to advance directives, refer to §483.10(g)(12) (F578)), Advance Directives);
* Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident; and
* Meeting the needs of residents who are grieving from losses and coping with stressful events.

Situations in which the facility should provide social services or obtain needed services from outside entities include, but are not limited to the following:

* Lack of an effective family or community support system or legal representative;
* Expressions or indications of distress that affect the resident’s mental and psychosocial well-being, resulting from depression, chronic diseases (e.g., Alzheimer’s disease and other dementia related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and resident to resident altercations;
* Abuse of any kind (e.g., alcohol or other drugs, physical, psychological, sexual, neglect, exploitation);
* Difficulty coping with change or loss (e.g., change in living arrangement, change in condition or functional ability, loss of meaningful employment or activities, loss of a loved one); and
* Need for emotional support.”[[8]](#footnote-8)

Organizational leaders will need to ensure competency of all staff members involved in the Behavioral Health Program. Adequate resources for the program will need to be evaluated using information from the Facility-Wide Resource Assessment including:

* Staff Resources
  + Licensed Nurses
  + CNAs
  + Social Services Staff
  + Activities/Therapeutic Recreation Staff
* Documentation Considerations
  + Paper vs. Electronic
  + Assessment/Evaluation forms
  + Care planning
* Education
  + Communication
  + Assessment/Evaluation skills
  + Recognizing changes in behavioral symptoms
  + Disease-specific protocols
* Evaluation and Monitoring
  + Observations, Interviews, and Record Reviews
  + QAPI
* Supplies and Equipment, *Etc.*
  + Activities/Therapeutic Recreation
  + Physicians, Physician extenders, Psychologists, Pharmacists

**References and Resources:**

* Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>
* LTC Survey Pathways (Download)

[https://www.cms.gov/medicare/provider-enrollment-and- certification/guidanceforlawsandregulations/nursing-homes.html](https://www.cms.gov/medicare/provider-enrollment-and-%20%20certification/guidanceforlawsandregulations/nursing-homes.html)

* Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User’s Manual, Version 1.16. October 2018: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
* American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth edition. Arlington, VA: American Psychiatric Association Publishing, 2013
* Substance Abuse and Mental Health Services Administration (SAMHSA) at: <http://www.samhsa.gov/disorders/substance-use>

1. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-1)
2. 2,3 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-4)
5. 5,6,7 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-5)
6. [↑](#footnote-ref-6)
7. [↑](#footnote-ref-7)
8. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-8)